El Camino Health

AGENDA
QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE OF THE EL CAMINO HEALTH BOARD OF DIRECTORS

Tuesday, September 3, 2024 – 5:30 pm

El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

Krutica Sharma, MD, will be participating from 775 12th Street NW, Washington, District of Columbia, 20005

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 913 3781 1462 # No participant code. Just press #.**

To watch the meeting, please visit: Quality Committee Meeting Link

Please note that the livestream is for meeting viewing only and there is a slight delay; to provide public comment, please use the phone number listed above.

NOTE: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:30 pm**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
5.	**CONSENT CALENDAR ITEMS** a. Approve Minutes of the Open Session of the Quality Committee Meeting (08/05/2024) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (08/05/2024) c. Approve Quality Committee Charter as Reviewed and Recommended for Approval by Governance Committee d. Receive Committee Governance Policy e. Receive Progress Against FY25 Committee Goals f. Receive FY25 Pacing Plan	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:30 – 5:40**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
6.	**VERBAL CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair	Information	**5:40 – 5:50**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Discussion	**5:50– 6:00**
8.	**PATIENT EXPERIENCE REPORT**	Christine Cunningham, Chief Experience Officer	Discussion	**6:00 – 6:20**
9.	**Q4 FY24 / FY25 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:20 – 6:40**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**6:40 – 6:41**
11.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (08/07/2024) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Carol Somersille, MD Quality Committee Chair	Information	**6:41– 6:46**
12.	**ANNUAL CULTURE OF SAFETY SURVEY RESULTS** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Mark Adams, MD, Chief Medical Officer	Discussion	**6:46 – 7:01**
13.	**ANNUAL PATIENT SAFETY REPORT** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Mark Adams, MD, Chief Medical Officer Sheetal Shah, MD, Senior Director, Risk Management and Patient Safety	Discussion	**7:01 – 7:21**
14.	**RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT** *Health and Safety Code Section 32155 and Gov't Code Section 54957 – Deliberations concerning reports on Medical Staff quality assurance committee and report regarding personnel performance of the Medical Staff*	Mark Adams, MD, Chief Medical Officer	Motion Required	**7:21 – 7:31**
15.	**VERBAL SERIOUS SAFETY EVENT REPORT** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**7:31 – 7:36**
16.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:36 – 7:37**
17.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during the Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:37 – 7:38**
18.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Discussion	**7:38 – 7:44**
19.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:44 – 7:45**

Next Meetings: November 4, 2024, December 2, 2024, February 3, 2025, March 3, 2025, May 5, 2025, June 2, 2025

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, August 5, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD, Chair	**Melora Simon,** Vice Chair	**Dan Woods,** CEO
Pancho Chang		**Theresa Fuentes**, CLO
Shahram Gholami, MD		**Mark Adams,** MD**,** CMO
Steven Xanthopoulos, MD **		**Cheryl Reinking,** DPN, RN, CNO
Jack Po, MD		**Shreyas Mallur,** MD, Associate Chief Medical Officer / Interim CQO
Krutica Sharma, MD		**Tracey Lewis Taylor,** COO
John Zoglin		**Christine Cunningham,** Chief Experience and Performance Improvement Officer
	**via teleconference	**Lyn Garrett,** Senior Director, Quality
		Ute Burness, ECHMN, VP, Quality & Payer Relations
		Jaideep Iyengar, MD, Co-Chair, ECHMN Quality Committee
		Tracy Fowler, Director, Governance Services
		Gabriel Fernandez, Coordinator, Governance Services

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:33 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present.	Call to order at **5:33 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	There were no AB-2449 requests by any members of the Quality Committee.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Consent Calendar Item (c) FY25 Pacing Plan was pulled for further discussion. A discussion regarding item (c) FY25 Pacing Plan ensued. The Committee requested that the footnote be updated to reflect the request for the Enterprise Quality Dashboard to be presented in alignment with the quarterly review of the STEEEP dashboard. **Motion**: To approve the consent calendar with the requested revision to item (c) FY25 Pacing Plan. **Approval**: (a) Minutes of the Open Session of the Quality Committee Meeting (06/03/2024), (b) Minutes of the Closed Session of the Quality Committee Meeting (06/03/2024) **Received**: (c) FY25 Pacing Plan **Movant**: Chang **Second**: Po **Ayes**: Somersille, Chang, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	***Consent Calendar Approved***
6. COMMITTEE EXPERTISE REPORT	Committee Member Chang presented the Committee Expertise Report. Mr. Chang presented the High Reliability Practices to Patient Safety Advocates in Indonesia. Mr. Chang discussed the statistics of healthcare, focus on patient safety, and institutional tactics to strategically address patient safety initiatives in Indonesia.	
7. PATIENT STORY	Ms. Reinking presented a patient story highlighting an instance where essential items were missing from a patient's room at the time of admission. She explained that the necessary items for the patient's continued care were not available. Ms. Reinking outlined the steps being implemented to prevent this issue in the future, including the use of checklists and tracking when items are borrowed from patient rooms to ensure they are fully prepared for the next patient. Discussion from the Committee included best practices from other industries and robust checklists.	
8. Q4 FY24 STEEEP DASHBOARD REVIEW/ FY25 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur presented the Q4 FY24 STEEEP Dashboard. Dr. Mallur discussed the Center for Medicare and Medicaid Services (CMS) Hospital Compare star rating. Dr. Mallur proceeded to provide an overview of the Q4 FY24 STEEEP Dashboard data. The Committee inquired regarding the reasoning behind the timelines for improvements. Dr. Mallur shared that the full-scale integration of certain implementation practices provides varied timing for improvements in the	

	reported data. The sepsis mortality explanation revealed higher than expected sepsis rate and mortality rates due to failure to adequately assess the denominator. Committee members stated that we have to be careful not to unnecessarily place patients in palliative care in order to make the numbers look better. The CMQCC (California Maternity Quality Care Collaborative) saw an average decrease in Cesarean Section rate of approximately 3% over 4 years when initiatives were implemented. The committee members expressed that perhaps we were a little too ambitious and should readjust for next year since we improved from 26.4 to 24.6 %, which is an acceptable decrease over one year.	
9. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Ms. Burness and Dr. Iyengar presented the Medical Network Report. Ms. Burness shared the Core Quality Measures trends through Q2 CY24. Ms. Burness continued to provide updates on quality initiatives for 2024, including specific actions taken by the Quality department to execute the initiatives. The Committee inquired regarding readmission rates, and a robust discussion ensued regarding the tracked core measures. The committee expressed that the addition of an explanation of quality initiatives is greatly appreciated and requested regular updates in order to better coordinate inpatient and outpatient care	
10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:13 pm **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Chang, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	***Recessed to Closed Session at 7:13 PM***
11. AGENDA ITEM 17: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors, by a unanimous vote of all Committee members present.	***Reconvened Open Session at 7:26 PM***
12. AGENDA ITEM 18: COMMITTEE ANNOUNCEMENTS	Dr. Somersille encouraged the Committee to attend conferences that would be beneficial to the scope of the Committee.	

13. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:29 p.m. **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Chang, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	***Adjourned at 7:29 PM.***

Attest as to the approval of the foregoing minutes by the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital:

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Gabriel Fernandez, Governance Services Coordinator

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by: Theresa Fuentes. Chief Legal Officer; Tracy Fowler, Director of Governance Services

El Camino Health

El Camino Hospital Board of Directors
Quality, Patient Care, and Patient Experience Committee Charter

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Hospital ("Hospital") per the Hospital Bylaws and through reporting by the El Camino Health Medical Network (ECHMN) per the operating agreement between the Hospital and Silicon Valley Medical Development (SVMD). For purposes of this policy, "Organization-wide" refers to Hospital and ECHMN/SVMD~~ealth~~. For the Hospital, ~~The~~the Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP). ECHMN/SVMD reporting utilizes the merit-based incentive payment system (MIPS) established by the Centers for Medicare and Medicaid (CMS), the Healthcare Effectiveness Data and Information Set (HEDIS) quality measures established by the National Committee for Quality Assurance (NCQA), or such other reporting as recommended by ECHMN Board of Managers.

The Hospital and ECHMN/SVMD ~~El Camino Health~~ management will provide the Committee with standardized quality metrics with appropriate benchmarks, when available, so that the Committee can adequately assess the quality of care being provided. Hospital and ECHMN/SVMD ~~ECH~~ Management and Quality Committee members will collaborate to identify and improve opportunities for quality improvement.

Authority

The Committee is an Advisory Committee of the Board pursuant to Article VII, Sec. 7.6 of the Hospital Bylaws. All governing authority for the Hospital ~~the Organization~~ resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. ~~for ECH~~. All governing authority for ECHMN/SVMD resides with ~~and with~~ the boards of ~~-~~those ~~e~~ affiliated entities except that which may be lawfully delegated. Any reporting by ECHMN/SVMD or other affiliated entities to the Committee shall be consistent with the operating and governing documents of those affiliated entities. ~~to a specific board committee~~.

The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee, *ex-officio* members and alternates and external (non-director) members appointed to the Committee.

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members who shall be appointed and removed pursuant to the El Camino Hospital Board Committee Governance Policy. ~~. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.~~

- The Committee shall also include as *ex officio* voting members of the Committee the following individuals: (1) the Enterprise Chief of the Medical Staff, (2) ~~and~~ the Los Gatos Campus Chief of Staff as *ex officio* voting members of the Committee. The Enterprise Vice Chief of Staff or the Los Gatos Vice Chief of Staff shall serve as alternate voting members of the Committee and replace, respectively the Enterprise Chief of Staff or the Los Gatos Chief of Staff if such person is absent from a Committee meeting.

- The Quality Committee may also include 1) no more than nine (9) Community members[1] with expertise in assessing quality indicators, quality processes, patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) as well as other areas as needed; ~~and~~ 2) no more than two (2) patient advocate members who have had significant exposure to the Organization ~~ECH~~ as a patient and/or family member of a patient. ~~Approval of the full Board is required if more than nine Community members are recommended to serve on this Committee.~~

- All Committee members, Chairs and Vice Chairs ~~, with the exception of new Community members, *ex-officio* members and alternates,~~ shall be appointed and removed in accordance with the El Camino Hospital Board Committee Governance Policy. ~~appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of a minimum of 12 months expiring on June 30th each year, renewable annually.~~

- ~~It shall be within the discretion of the Chair of the Committee to appoint a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.~~

Executive Support and Participation

The Chief Quality Officer (CQO) shall serve as the primary executive to support ~~to~~ the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as members of the executive team may participate in the Committee meetings upon the recommendation of the CQO and subsequent approval from both the CEO and Committee Chair.

General Responsibilities

The Committee will collaborate with management to identify opportunities for quality and safety improvement. The Committee will support the implementation and monitoring of process improvement plans to address and close quality and safety gaps. Members of the Quality

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors or *ex-officio* members or alternates.

Committee will model behaviors, attitudes and actions consistent with the Organization's ~~ECH~~ tenets of a High Reliable Organization, specifically, focusing on creating strong relationships between everyone on the team to engender a culture of psychological safety which promotes our Organization's ~~ECH~~ mission to achieve zero patient harm. The management team shall develop dashboard metrics that will be used to measure and track quality, safety and patient experience performance for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for 1) ensuring performance metrics meet the Board's expectations; 2) aligning those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring communication to the Board and external constituents is well executed.

Specific Duties

The Committee shall partner with management to support the following activities:

1. Quality Planning—Advocate for an enterprise strategy plan that is quality-centric.
2. Quality Control—Review quality processes and performance on a regular basis.
3. Quality Improvement—Review performance of major process improvement projects on a regular basis.

Specific duties of the Committee include the following:

- Review and approve which measures to include and track on the quarterly Board Quality Report (STEEEP)~~.~~ "Quality Dashboard" for tracking purposes.

- Oversee management's development of the Organization's goals encompassing the measurement and improvement of quality, safety and patient experience as tracked on the Enterprise Quality, Patient Care and Patient Experience Dashboard

- Review reports related to Organization-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:

    - Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - Organization-wide patient safety goals and hospital performance relative to patient safety targets.
    - Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
    - Organization-wide patient satisfaction and patient experience surveys.
    - Organization-wide provider satisfaction surveys.

- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements including, but not limited to The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).

- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements.

- Review annual report on actions taken to improve patient safety as per the Safety Event Reporting policy that is maintained in policy and procedure management software.

- Oversee organizational quality and safety performance improvement for ~~both the Organization's and~~ Hospital's medical staff activities.

- Review the Hospital Medical Executive Committee's monthly credentialing and privileging reports and make recommendations to the Board.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be shared with~~to~~ the Board for information.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24-hour notice.

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August 14, 2024

Coverage:
All Members of the El Camino Hospital Board of Directors ("Board") and Board Advisory Committees ("Committees"). The Governance Committee shall review this policy at least every three (3) years to ensure that it remains relevant and appropriate.

Authority:
The Board has established the following standing Advisory Committees pursuant to Article 7.6 of the El Camino Hospital Bylaws: Compliance and Audit Committee; Executive Compensation Committee; Finance Committee, Governance Committee, Investment Committee; and Quality, Patient Care, and Patient Experience Committee. The Committees have the authority granted to them per the Hospital Bylaws, the Committee Charter, and majority action of the Board. Committees may study, advise and make recommendations to the Board on matters within the committee's area of responsibility as stated in the Committee Charter. The authority of committees is limited to advisory recommendations except in responsibilities directly delegated by the Board. Committees may provide recommendations for the Board to consider, which recommendations may be considered, adopted, amended or rejected by the Board in the Board's sole discretion. Committees shall have no authority to take action or otherwise render decisions that are binding upon the Board or staff except as otherwise stated in the Bylaws, the Committee's Charter, or majority action of the Board. To the extent of any conflict with the Committee Charter, this policy controls.

Membership:
Each committee shall have the membership as stated in the Committee Charter but must be composed of at least two members of the Board ("Director Members"), as well as people who are not members of the Board ("Community Members"). Director membership on any single Committee shall not constitute a quorum of either Board or Healthcare District Board membership. The Chair of a committee is its presiding officer. In the absence of the Chair, the Vice-Chair (or if no Vice-Chair, any member of the Committee as determined by the Chair or the Board) shall perform the duties of the Chair.

Appointment and Removal:
The Board Chair (or Board Chair-elect in Board officer election years) shall appoint the Director Members and Committee Chairs, subject to approval of the Board. Community Members shall be appointed by the Committee, subject to approval of the Board. All Board Chair appointments shall be reviewed by the Governance Committee before submission to the Board.

Committee Chairs may appoint and remove a Vice-Chair at the Committee Chair's discretion. However, if the Committee Chair is not a Director Member, a Vice Chair must be appointed who is a Director, in which case the Director Vice-Chair shall be appointed the same as any other Director Member.

The Board has the authority to remove Director Members and Community Members at any time either with or without the Committee's recommendation, in the Board's sole discretion.

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August 14, 2024

Term

Director Members and Community Members serve a term of *three* full or partial fiscal years depending on date of appointment and eligibility to serve. Director and Community Members shall be divided into three appointment categories, as nearly equal in number as possible, as follows: (a) Class 1, the initial term of which shall expire June 30, 2025, and subsequent terms shall be three years each; (b) Class 2, the initial term of which shall expire June 30, 2026, and subsequent terms shall be three years each; (c) Class 3, the initial term of which shall expire June 30, 2027, and subsequent terms shall be three years each. Each class shall hold committee membership until successors are appointed.

Committee Chair and Vice Chair appointments shall be reviewed annually by the Board Chair (or Chair-Elect). Chair and Vice Chair appointments may be changed at any time without effecting the term of that person's membership on the Committee.

Director Members, Community Members, Chairs, and Vice Chairs may serve consecutive terms.

If a community member wishes to vacate a position, the committee member shall submit a written resignation letter addressed to the Chair of the Committee and the Chair of the Board, with a copy to the CEO and Governance Services.

Attendance:

Committee members are expected to attend in person and meaningfully participate in all committee meetings absent extenuating circumstances. Remote virtual participation is generally only allowed for just cause or emergency situations such as physical or family medical emergency, childcare, illness, disability, or Board or Committee related travel. Remote virtual participation must comply with the requirements of the Ralph M. Brown Act. Committee members may be removed from the Committee for repeated failure to satisfy attendance requirements.

If a member is physically not present for more than two meetings in a calendar year, the Committee Chair shall contact that member and remind the member of this policy. If the member continues to be physically absent despite the warning, the Committee shall consider a recommendation to the Board for removal.

Meetings:

All Committees shall have a Committee Charter approved by the Board.

Committee meetings shall be open to the public except for items permitted to be discussed in closed session and held in accordance with the provisions of the Ralph M. Brown Act. At least 72 hours before a committee meeting, Governance Services shall post an agenda containing a brief, general description of each item of business to be discussed at the committee meeting. The posting shall be accessible to the public.

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August 14, 2024

The minutes of each committee meeting, including any recommendation of a committee, shall include a summary of the information presented and the recommended actions. ECHB staff will prepare minutes for each meeting. Draft minutes will be provided to the committee at the next available committee meeting for committee member review and approval. Once approved, minutes will be made a part of the Board's permanent records.

A majority of the members of each committee shall constitute a quorum for the transaction of business.

Only members of the committee are entitled to make, second or vote on any motion or other action of the committee. Each committee member shall be entitled to one vote on all matters considered by the committee. A simple majority vote of the members of the Committee shall designate approval of a motion.

All committee communications must go through the designated committee Chair.

The specific committees and their respective responsibilities are as stated in the Charter for each Committee.

El Camino Health

FY25 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health ("ECH"). The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

STAFF: Chief Quality Officer (Executive Sponsor)

The CQO and Senior Director of Quality shall serve as the primary staff to support the Committee and are responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan.	Q4FY24 review and update which measures to include on the FY25 Quality Dashboards.	Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered.
2. Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY24 review FY25 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY25.	Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report".
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee.	Fiscal Year 2025	• Attend a minimum of 6 meetings in person. • Actively participate in discussions at each meeting. • Review of annual committee self-assessment results
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2025	Attend a conference and/or session with a subject matter expert. • Verbal/Written report of key learnings to the Quality Committee.

Chair: Carol Somersille, MD
Executive Sponsor: Chief Quality Officer

Quality, Patient Care, and Patient Experience Committee
FY25 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Verbal Committee Member Expertise Sharing or Chair's Report		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Recommend Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
Quality Council Minutes		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Quarterly Board Level Quality/ Experience Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Committee Self-Assessment Results Review												✓
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience Report			✓						✓			
Health Equity Report						✓						✓
Recommend Safety Report for the Environment of Care					✓							
PSI Report						✓						
Value-Based Purchasing Report									✓			
Recommend Quality Assessment & Performance Improvement Plan (QAPI)					✓							
Refresh Quality/Experience Dashboard measures for FY26												✓
Artificial Intelligence Report						✓						
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Recommend Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Recommend FY Committee Meeting dates											✓	
Propose Organization Goals									✓			
Recommend Organization Goals											✓	
Propose Pacing Plan									✓			
Recommend Pacing Plan											✓	
Review & Revise Charter									✓			
Recommend Charter											✓	

1: Includes Approval of Minutes (Open & Closed), Progress Against FY Committee Goals (Quarterly), Current FY Pacing Plan (Quarterly), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: September 3, 2024
Subject: Voice of the Patient/Family Feedback

Purpose: To provide the Committee with written patient feedback that is received by the hospital from patients and/or families who received care at El Camino Health.

Summary:

Background: This patient was concerned about her late discharge due to waiting for the hospitalist to confer with the cardiologist. This patient was happy with the hospitalist and the overall care. However, her last impression was regarding the time she had to wait for her hospitalist to review the case with the cardiologist. The delay disappointed the patient who was ready for discharge.

Assessment: Coordinating care during the inpatient stay amongst the whole care team is challenging but achievable. In this situation, the patient may not have had to wait for discharge had the coordination occurred the day before the discharge, allowing for a smooth transition home.

Outcomes: With the advent of our revised comprehensive multidisciplinary rounds (MDR) in each nursing unit, the plan of care is reviewed, and barriers are addressed early in the patient's stay. The new MDR was started on 2 units and is being activated on all the other units in the first quarter of FY 25. The pilot units saw a .5 decrease in LOS with the new MDR. We believe experiences such as the one described in this letter will be minimized with the new MDR.

List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What else is the team doing to address length of stay barriers?

2. Who participates in MDR?

Patient Story

“The hospitalist was great, she came in and explained everything thoroughly but unfortunately she was so very busy during that day and couldn’t get discharged because she had to talk to one of the specialists and it felt like we waited around much longer than we should have but I want to emphasize that I am not upset about the hospitalist, she was wonderful and I know she had a lot of things on her plate, but it was late in the afternoon when I got out of there and I was just waiting to be discharged and I don’t know if she was waiting on the cardiologist and they were busy but I understand that but it didn’t seem efficient.”

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Christine Cunningham, Chief Experience Officer
Date: September 3, 2024
Subject: Patient Experience Report

Purpose:

To provide the Committee with an update on our Patient Experience FY24 progress and plans for FY25.

Summary:

El Camino Health tracks our patient experience goals and metrics through an outside vendor Press Ganey. This memo will describe our FY24 outcomes as well as our plans for FY25.

All of our patients at El Camino Health are sent a survey via paper, email or text within 24 hours of discharge or their outpatient visit. Our various surveys have 12-62 questions and results are tabulated and reviewed on a continuous basis. We set our targets based on past performance and industry standards.

El Camino Health exceeded their Likelihood to Recommend (LTR) targets across the enterprise in our key service areas.

ECH exceeded its target in our key service areas of Inpatient, Mother/Baby, and the Emergency Department.

List of Attachments: Patient Experience Presentation

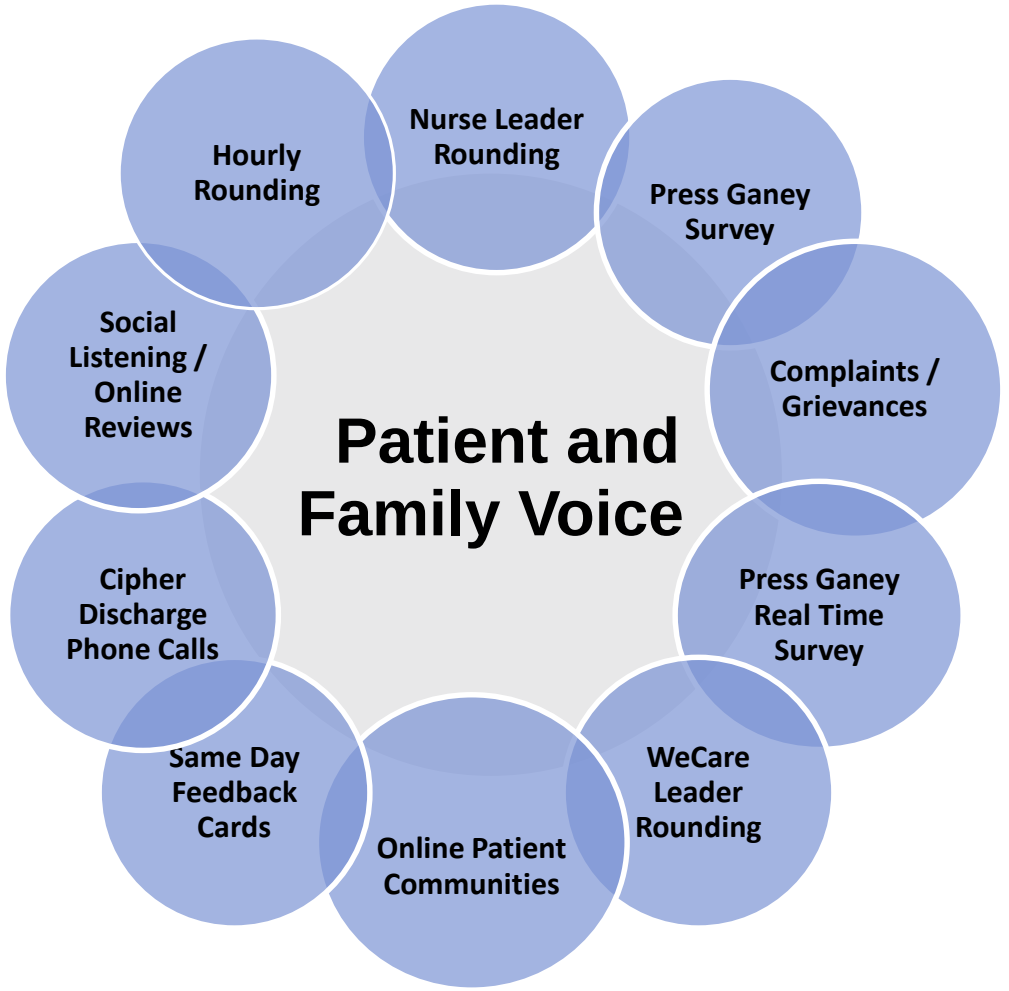
El Camino Health

Quality Committee
Patient Experience Update
September 5th , 2024

Christine L. Cunningham, CPXP, MBA

“Setting the standard for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way”

Listening to the Power of Patient and Family Voice



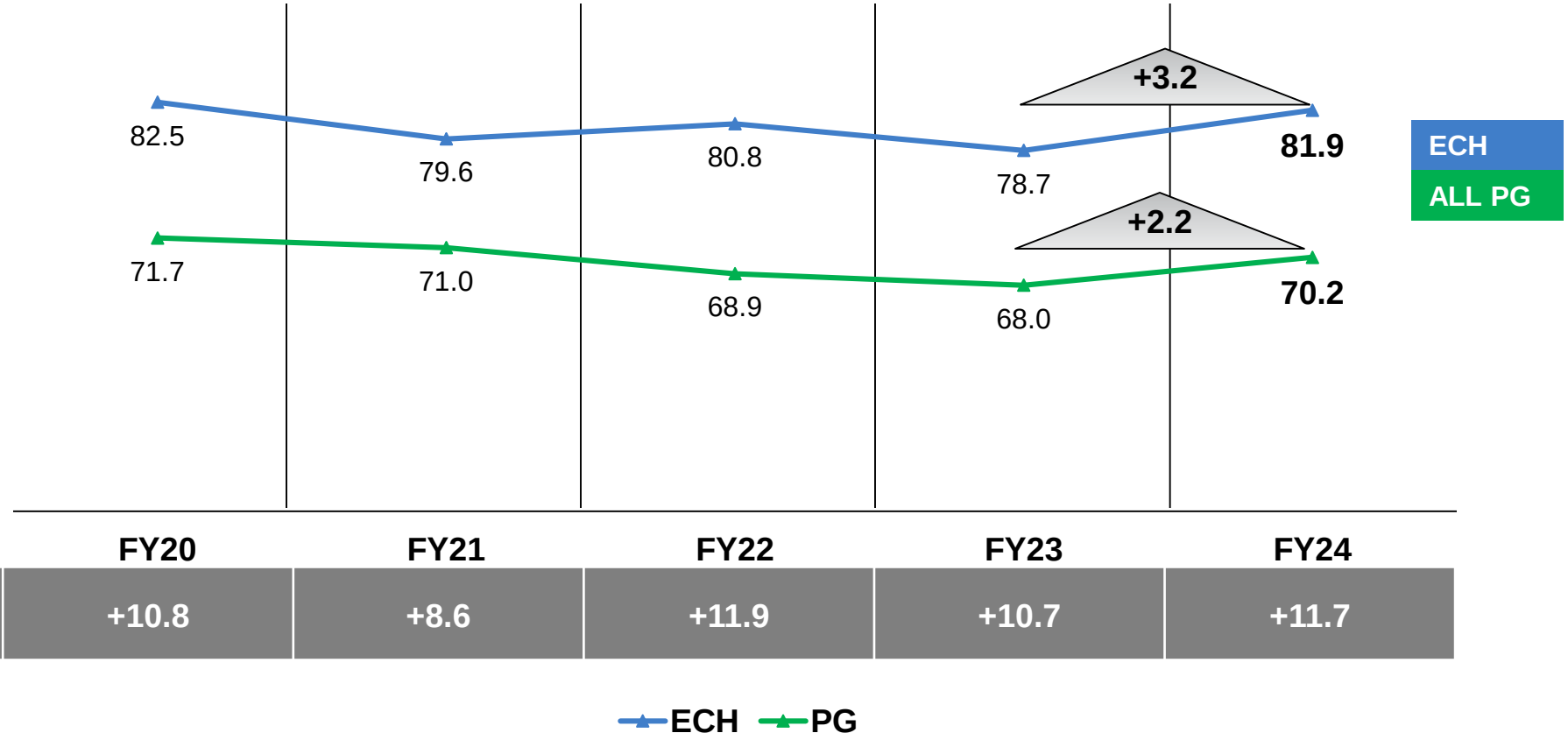
The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

FY24 Year in Review

ECH versus National HCAHPS – 5 years

ECH outperforms market Year over Year
Nationwide Improvement in FY24
ECH Improvement outpaced PG market

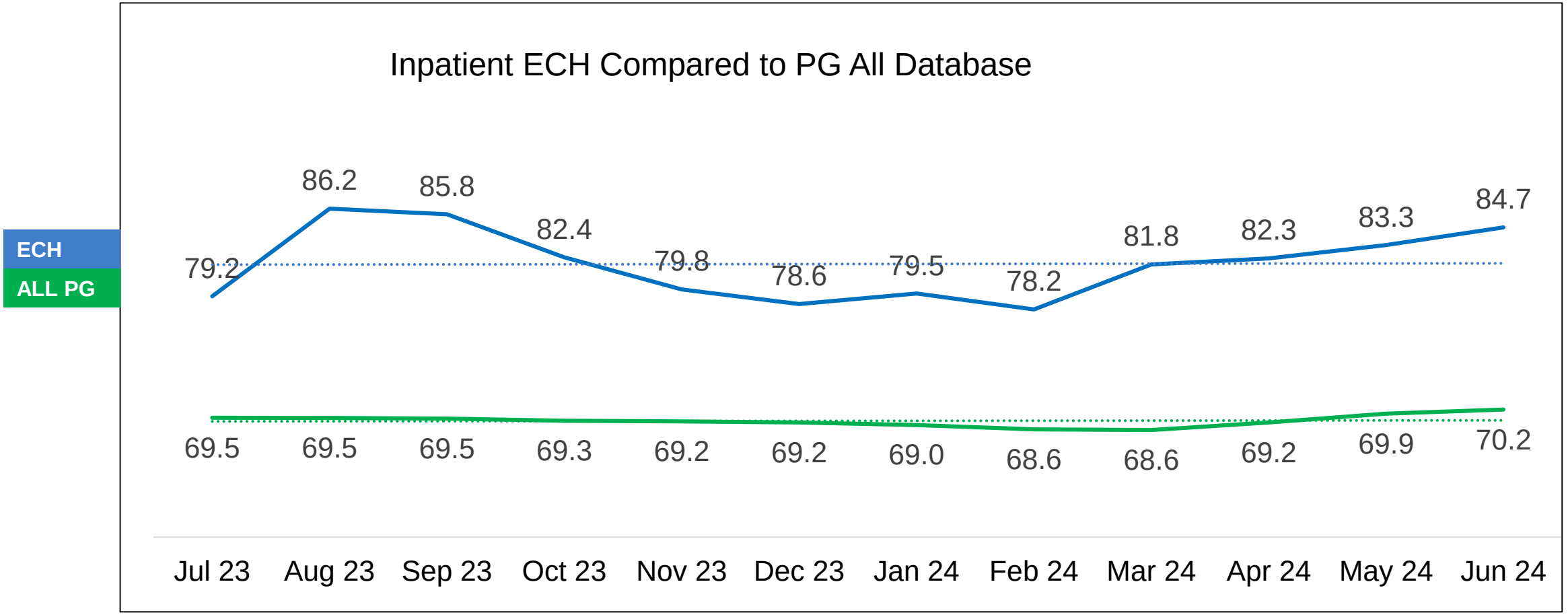
Inpatient ECH Compared to PG All Database Market



	FY20	FY21	FY22	FY23	FY24
ECH over PG All DB	+10.8	+8.6	+11.9	+10.7	+11.7

ECH versus National HCAHPS – FY24

FY24 ECH LTR performance exceeded PG Market Month over Month



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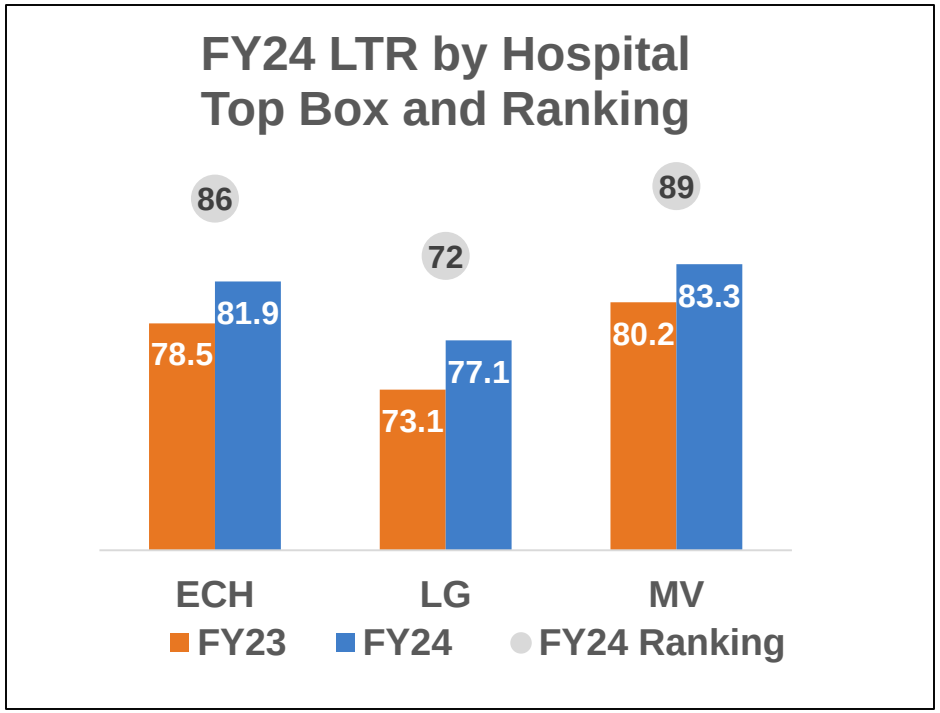
ECH Inpatient



ECH Target: 76.4
Exceeded by 5.5

Best Practices Focus

- **New Nurse Communication Training Program Los Gatos**
- **New MD Communication** Care Team Coaching / Shadowing
- Power of 3: Nurse leader rounding, hourly rounding, bedside shift report – emphasis on purposeful rounding
- Nurse Leader Rounding: Continuous improvement
- Nurse Communication: Continuous improvement HCAHPS domain. Individual unit targets
- Teamwork: Continuous improvement
- Monthly PEX LTR Meetings: Keep pulse on progress to target, resolve barriers and celebrate success
- Focus on Discharge: Multi-Disciplinary Rounding, Discharge by 11:00 a.m., Discharge Lounge

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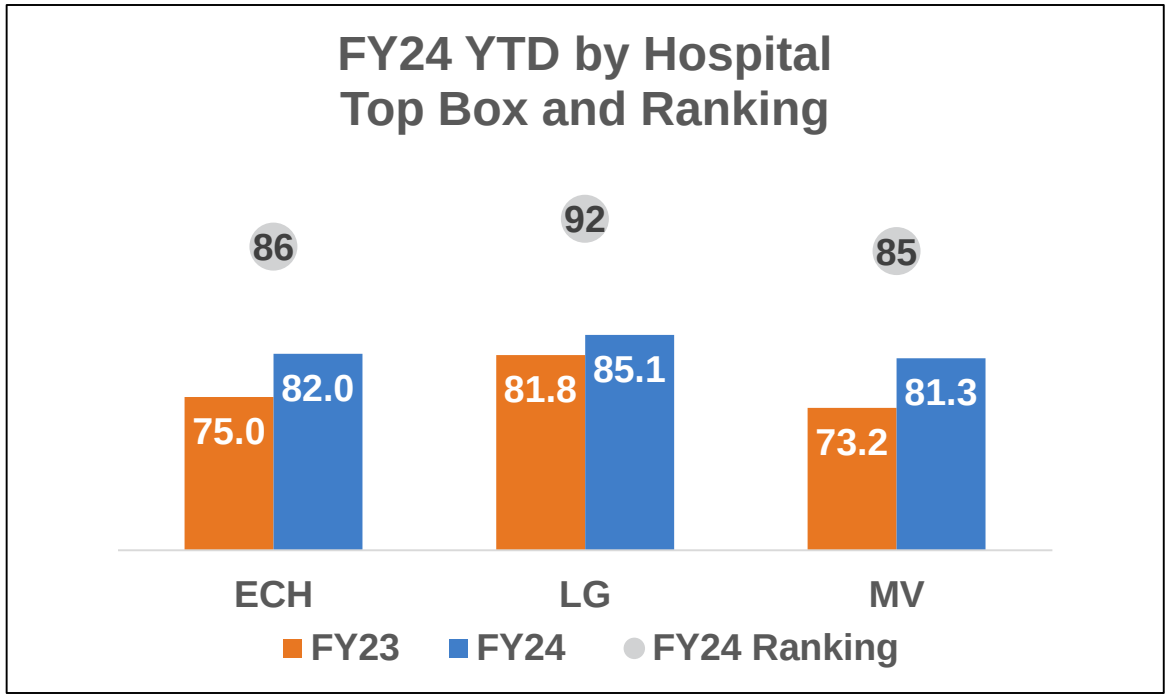
ECH Mother Baby



Best Practices

- **New Mountain View Rooms**: Improved patient and family space
- **New Los Gatos call light system** greatly improved
- Nurse Leader Rounding: Continuous improvement
- Service Recovery: Ongoing construction noise
- HVAC/Insulation efforts = moderate improvement

ECH Target: 75.0
Exceeded by 7.0

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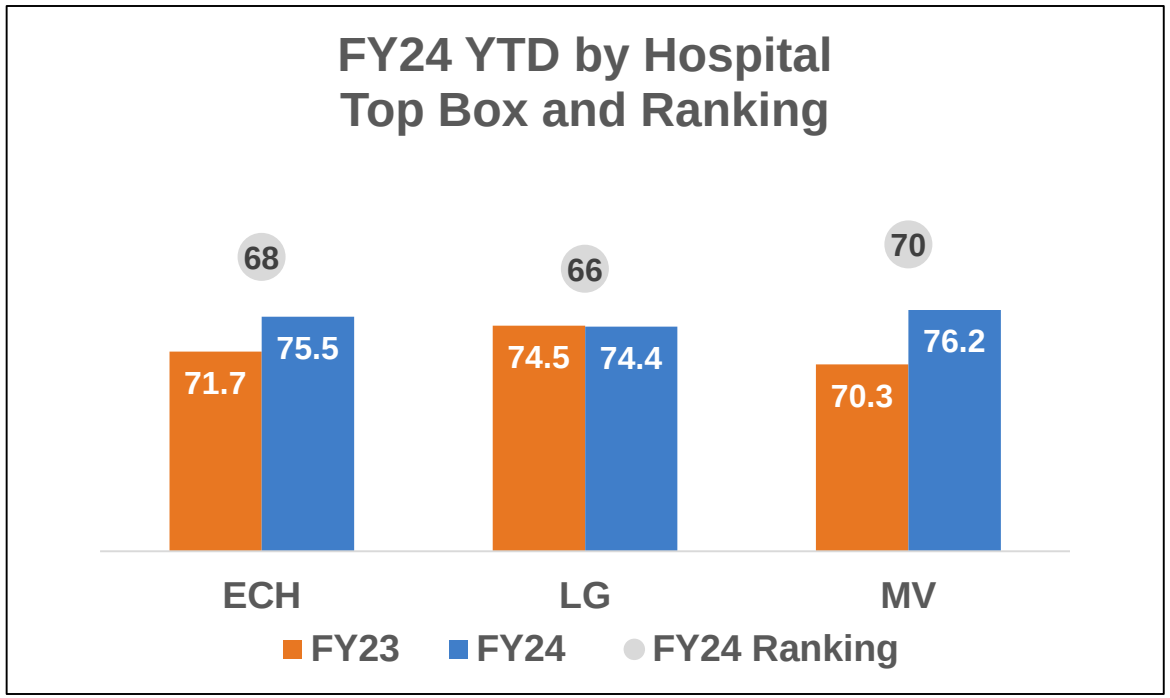
ECH Emergency Room



ECH Target: 71.7
Exceeded by 3.8

Best Practices

- **New Physician Engagement in Teamwork**: Partnered with Vituity and Marketing to improve provider information on ECH website
- **New Improved patient engagement**: Deployed tactics to increase survey response especially at LG campus
- Nurse Leader Rounding: Continuous improvement in % of patients perceiving a visit from an ED nurse leader.
- Focus on Teamwork: Continuous improvement on this Ganey metric with best practice behaviors including caregiver introductions, shift change hand off and managing up
- Monthly PEX ED Meetings: Keep pulse on progress to target, resolve barriers and celebrate success
- Process Improvement: Leadership focused on reduction in Arrival to ED Departure times (Throughput)
  - ✓Increased use of discharge lounge
  - ✓Triage related tactics

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El Camino Health FY25 Plan

FY25 LTR Goal Setting Methodologies and Targets

- Continuous improvement across the enterprise
- ECH goal is to achieve or exceed the top quartile (above 75th percentile)

ENTERPRISE	FY24 (Baseline)	FY25 Target
***IP Units Enterprise**	**81.9**	**81.9**
%tile	86	86
MCH Enterprise	**82.0**	**82.0**
%tile	86	86
ED Enterprise	**75.5**	**77.2**
%tile	68	75

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FY25 Plan – aligning key drivers with a detailed plan

IP-Enterprise	TB Ratio	MV	TB Ratio	LG	TB Ratio
Nurses treat with courtesy/respect (CAHPS)	2.38	**Nurses treat with courtesy/respect (CAHPS)**	2.34	**Staff worked together care for you**	2.33
Staff worked together care for you	1.89	**Staff worked together care for you**	1.77	**Nurses treat with courtesy/respect (CAHPS)**	2.49
Doctors treat with courtesty/respect (CAHPS)	2.03	Doctors treat with courtesty/respect (CAHPS)	1.98	Attention to needs	1.83
MCH - Enterprise	TB Ratio	MV	TB Ratio	LG	TB Ratio
Staff worked together care for you	2.01	**Staff worked together care for you**	2.02	**Doctors treat with courtesy/respect (CAHPS)**	3.44
Nurses treat with courtesy/respect (CAHPS)	2.09	**Nurses treat with courtesy/respect (CAHPS)**	2.17	**Doctors listen carefully to you (CAHPS)**	3.14
Nurses' attitude toward requests	1.78	Nurses listen carefully to you (CAHPS)	1.7	Staff concern inform prog/baby cond	1.67
ED - Enterprise	TB Ratio	MV	TB Ratio	LG	TB Ratio
Staff worked together care for you	3.87	**Staff worked together care for you**	3.		
Staff cared about you as person	3.66	**Staff cared about you as a person**	3.		
Courtesy of doctors	4.38	Courtesy of doctors	4.		
OAS- Enterprise	TB Ratio	MV	TB R		
Staff ensure you were comfortable(CAHPS)	3.06	**Staff treat w/ courtesy, respect (CAHPS)**	5.		
Staff treat w/ courtesy, respect (CAHPS)	3.62	**Staff ensure you were comfortable(CAHPS)**	3.		
How safe/secure you felt facility	1.79	How safe/secure you felt facility	1.		
OP Services - Enterprise	TB Ratio	MV	TB R		
Staff worked together care for you	4.08	**Staff worked together care for you**	4.		
Treated you with respect/dignity	4.02	**Treated you with respect/dignity**	3.		
Response to concerns/complaints	2.65	**Response to concerns/complaints**	2.		
OP Oncology	TB Ratio	MV	TB R		
Staff worked together care for you	2.37	**Staff worked together care for you**	2.		
Safety and security felt in center	2.43	**Safety and security felt in center**	2.		
IT staff concern for comfort	2.55	IT staff concern for comfort	2.		

El Camino Health

FISCAL YEAR '25 PATIENT EXPERIENCE ACTION PLAN

El Camino Health - Patient Experience Department

Patient Experience Mission: *The Patient Experience Department is a catalyst and partner that aims to amplify the patient and family voice, remove obstacles, and inform and strengthen value driven operations that restore the human connection in healthcare.*

FY25 Service Goal: 85% ile (Inpatient)

CATEGORY	DESCRIPTION	INITIATIVES / PRIORITIES	GOALS
AMPLIFY THE PATIENT VOICE	*Listen and give a voice to our patients and their experiences to inform high-impact experience initiatives*	• **Data Sharing:** Deliver PX data and insights to responsible leadership and their teams on a recurring schedule, and in a way that is actionable and tailored to their specific needs and priorities • **Discharge Phone Calls:** Developed and launched cipher discharge phone call in the INPT & OAS. Need expansion and data analysis plan • **Feedback:** Added Forsta, a real-time feedback tool designed to quickly get feedback from our patients and families in areas currently outside our PG survey scope, including underserved who may not receive or respond to a survey (text/email/home modes). Add to three (3) new areas • **Survey Accessibility:** Monitor language needs for survey. Recent add includes Chinese language (clinics) to survey. Also available in English, Spanish • **Survey Methodology:** Develop new survey methodology in preparation for CMS changes coming in 2025. Will limit the number of additional questions and include a CMS eligible web-based mode for HCAHPS (discuss current e-survey adjustment). Review all ECH surveys including Magnet requirements • **Nurse/Leader/Executive Rounding:** Managers and above encouraged to connect with patients- 6 patient rounds required in current guidelines. Nurse leaders' expectation, every patient every stay-new rounding software to be deployed FY25. Launch rounding recognition program • **Language Pilot 2C & 3C:** Interpreter tablets inside every room making it quickly accessible for care team. Includes staff training • **Expand survey:** Review adding Acute Inpatient Rehab survey- currently managed by Lifepoint. Review other service lines • **New vendor:** Research new vendor options for feedback and surveying • **iSAFE:** Handle and respond to grievances under 28 days, CMS required is 30 days. Coach staff on documenting patient feedback in iSafe module	• Deliver PX data by campus and unit by the 10th of the following month. • Develop monthly reports and distribution strategy by Q1 • Add to three (3) new areas to survey for Forsta real time survey • Quarterly review of language and service needs for surveys • Review and implement new survey methodology in preparation for CMS changes coming in 2025 by Q2 • Launch FY25 Leader Rounding Program by July 15 (include review of questions) • Participate in 2C/3C and review and present findings monthly • Close grievances under 28 days
ELEVATE THE PATIENT EXPERIENCE	*Service metric focused. Projects aimed to drive improvement of patient experience metrics, driven by patient feedback*	• **Power of Three:** Build into daily management system our P3 best practice (purposeful rounds, bedside handoff, and nurse leader rounding • **Survey questions review:** Review and adjust questions as needed. Change current rounding question to align with ECH practice (remove word "hourly" to focus on purposeful rounds) • **Key Driver Metrics:** Teamwork/Nurse Communication focus: Key driver focus and best practice sharing across the service lines • **Inpatient Units:** Each unit receives key driver report, bi-weekly comments, monthly LTR and nurse domain scores. Meet monthly for the INPT LTR meeting to discuss obstacles and share successes. Create unit specific action plan and adopt a unit relationship • **Outpatient/ ED/ OAS:** Monthly meetings with leadership, regular reporting, and partnership with a dedicated patient experience team member for support. • **Nutrition/EVS:** Receive monthly comments specific to their respective areas. Meet on a quarterly basis • **GetWell TV**: Instant notification to unit leader on patient experience questions- proactive vs reactive rounding. Utilize and expand GW features • **MD/RN rounding:** 4B Pilot designed to alert nursing team to join MD during round • **LG Nurse Communication Plan:** Launch Practicing Excellence program designed to improve RN communication at LG campus • **Personal Belongings Taskforce:** Work with clinical leadership, risk and staff regarding personal belongings process to reduce loss belongings	• Improve hourly rounding percentage from FY24 baseline • Review key drivers, and nurse communication metrics monthly with Inpatient LTR team • Launch Practicing Excellence Nurse Communication in LG MS/Ortho Q1 • Develop communication plan for updated personal belongings policy • Meet on a quarterly basis with Nutrition and EVS to review their data
STRENGTHEN PATIENT EXPERIENCE SKILLS	*Internal trainings and coaching for team members focused on strengthening patient experience skills (WeCare)*	• **WeCare Behavior Standards**: Message of the Month (M.O.M.) sent out via our voices. Video tutorials, Patient Experience Literature/Articles Library available on engage/ intranet. Update standards to include DEI. PDCA Training program and new leader expectations • **Service Recovery:** Training offered quarterly and Lost Belonging Task Force in development • **New Employee and Nurse Orientation:** focused on patient experience and wecare service excellence standards (bi- weekly) • **New Provider Orientation:** focuses on ensuring our providers are equipped with tools and best practices • **MD Coaching**: Coaching for Team Health providers (100%) focused on patient communication, looking to expand. Los Gatos Physician coaching program coming soon • **Health Stream**: WeCare attestation via health stream required annually. Include videos • **New Leader WeCare training**: Binder and overview of wecare provided for leaders across the organization, with the goal of improving skills around leading in Patient Experience	• Distribute MOM by the first of the following month. Conduct vis board audits to ensure compliance • Create WeCare HealthStream annual refresher module • Annual refresher of orientation presentations • Complete 95% of TeamHealth MD Coaching Q2 • Expand MD Coaching Program to other hospitalists • Create virtual (online) WeCare New Leader Training Binder (Q2)
PATIENT EXPERIENCE PROGRAMS	*Focusing on foundational programs that apply patient experience best practices on a continuous basis*	• **Staff Recognition**: Spot recognition available in addition to WOW mail for MD and other staff who are not available on the platform. WOW mail recognition on WeCare behaviors • **Staff and Patient amenity cart program**: Staff snack cart and patient amenity cart provide much needed items to patients/staff across both campuses • **PFAC / Community engagement:** Redesign and engage community insights • **WOW Cup Program:** Units and departments qualify to win WOW cup monthly when meeting or exceeding LTR goal. WOW cup celebration for winner • **Schwartz Rounds:** Launch committee and multidisciplinary rounds for staff • **Patient Handbook:** Revise and add electronic (QR code) version for all new admits • **New Welcome Video:** Create a new welcome video for inpatients and MCH as a way to welcome patients to ECH • **Visitor Management**: Develop and manage visitor policy and guidelines (based on county guidelines). Front entrance and digital displays used as first impressions upon entry to ECH • **Discharge Experience**: Create a journey map to determine gaps in the discharge experience • **Patient and Visitor Website**: Monitor and update information on ECH website as it relates to patient and visitor information • **Volunteer Onboarding:** Onboard non-auxiliary volunteers that assist in various departments throughout the hospital	• Research and implement new Community Engagement program by Q3 • Schwartz Rounds kick off meeting (Q1) and launch by Q2 • Create QR code and electronic version of Patient Handbook (mobile) by Q2 • Create committee and new welcome video by Q4 • Quarterly review of patient and family website information • Annual audit of volunteer paperwork compliance • Create a journey map to determine gaps in the discharge experience (Q3)

El Camino Health

FY25 Plan – best practices, new and ongoing

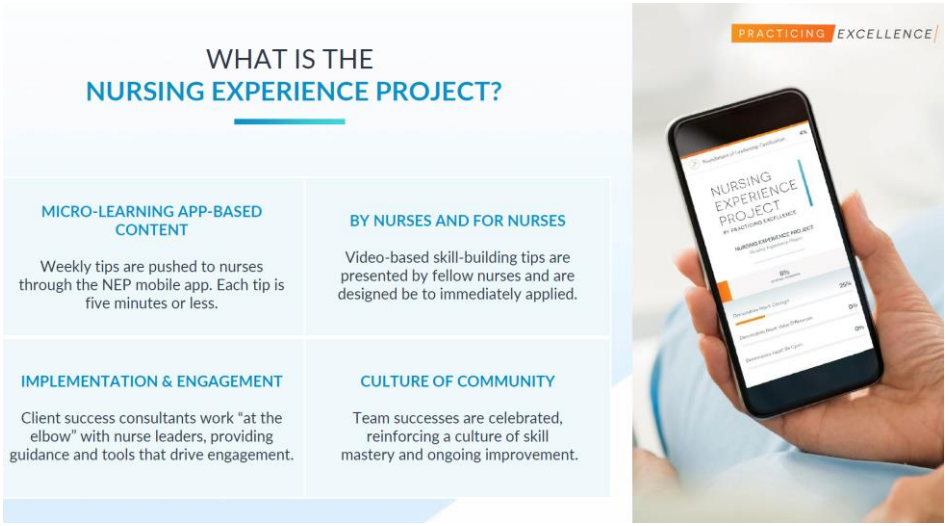
Patient Experience Focus	Description
WeCare Leader Rounding	Managers and above (non-nursing) rounding requirement 12 rounds per FY
WeCare Service Standards	Message of the Month communication, service recovery trainings, new leader training, new employee orientation, and refresher courses
WeCare Services and Programs	Staff wellness wagon, patient amenity cart, badge buddies, service recovery kits
Key Driver Focus: Staff Worked Together	Teamwork, multidisciplinary rounds, bedside handoff best practice coaching
Key Driver Focus: Nurse Communication	Visible tracking (tableau), unit dashboards, UPC and monthly LTR meeting review
Power of 3 (P3)	Nurse leader rounding, hourly/purposeful rounding, bedside shift report – emphasis on purposeful rounding in Inpatient and Mother/Baby
Key Driver Focus: MD Communication	MD Care Team coaching, includes shadowing and 1:1s
Service Line and unit targeted goals	Goal Setting and measures across the service lines (INPT /Out-pt/ Surgery/ED/ Cancer center)
Real Time Feedback	Amplify patient voice across continuum of care, ex discharge lounge and other non-surveyed areas
Interpreter Services Pilot	Voyce interpreter services iPad accessibility per room 3C and 2C
GetWell Television Instant Notifications	Patient Experience Pathway responses trigger instant notification to responsible leader regarding low rating (nurse communication, medication info)

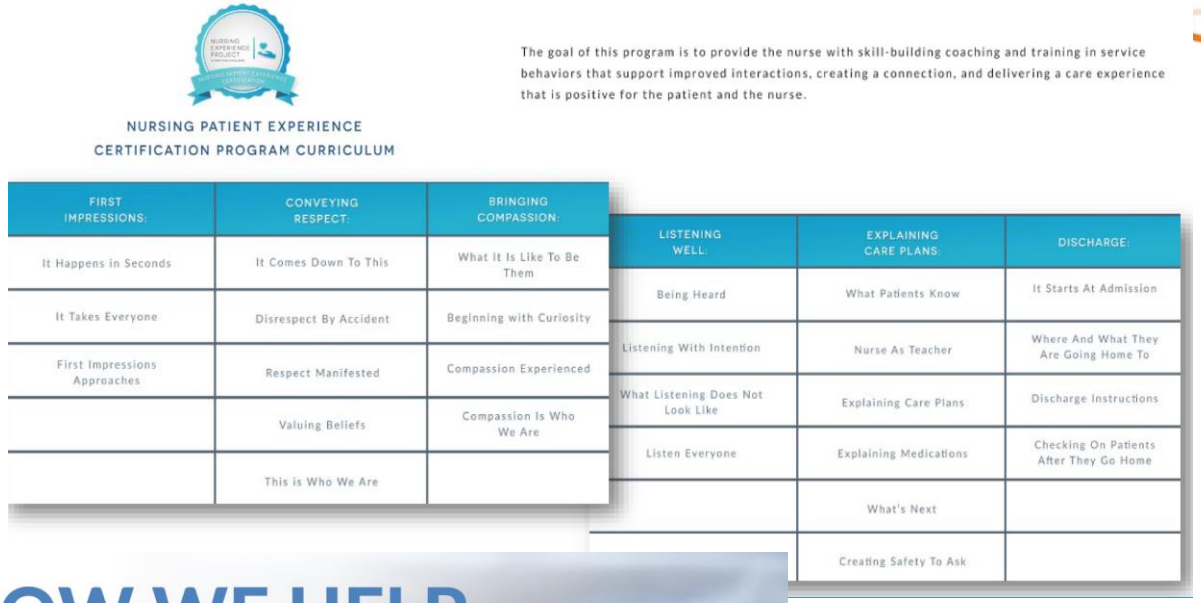
FY25 Plan – best practices, new and ongoing

Patient Experience Focus	Description
GetWell Television Welcome Video	Update and refresher for “Welcome” video on GetWell TV (MV/LG)
Discharge Phone Calls (Cipher)	Cipher discharge phone calls continue sharing of feedback, recorded messages (patient voice), pharmacy questions. Currently looking to expand to other service areas.
Brand Reputation- Google	Google feedback request post discharge to improve the online star rating and brand
Patient Satisfaction Surveys/ Response rates	Ongoing tracking of survey methodology and response rate. Added new language (Chinese). Promoting and encouraging patients to complete survey at discharge. Added verbiage to ECH site, GetWell informing patients on value of completing it
New, Coming soon FY25	
Patient Satisfaction Survey Press Ganey- expansion	Inpatient Acute Rehab looking to utilize Press Ganey survey. Currently administered by Lifepoint. Working on additional languages
Schwartz Rounds	Develop team and deploy Schwartz rounds, by staff for the staff. Forum to openly discuss the emotional aspects of healthcare and the impact of being care givers
Nursing Communication Training Coaching (Practicing Excellence)	Nurse Communication Training in Los Gatos campus (Med Surg and Ortho)
Nurse Leader Rounding Vendor	New vendor deployment for rounding data and tracking.
Key Driver Focus: MD Communication	MD Care Team coaching, includes shadowing and 1:1s (expand beyond TeamHealth)

Los Gatos Nurse Communication Coaching

- Nurse Communication Micro-learning program for nurses in LG Med Surg & Ortho
- Five (5) minutes a week for 26 weeks





El Camino Health

Questions

El Camino Health

El Camino Health

El Camino Health Board of Directors
Quality, Patient Care, and Patient Experience Committee Memo

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, Chief Quality Officer and Lyn Garrett, MHA, MS, CPHQ
Date: September 3, 2024
Subject: Enterprise Quality, Safety and Experience Dashboard FY24 through June 2024, and FY25 July 2024

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through June 2024 (unless otherwise noted) and FY 25 July . This memo will describe performance for end of FY 2024 and changes to the FY 2025 Dashboard.

Summary:

Situation: The FY 24 & FY 25 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks nineteen quality measures.

Assessment:

Hospital Acquired Condition Index 2.0 (for FY24)

This measure is a composite of four measures as illustrated below.

FY 24 HAC 2.0 weighting and targets			
Component	**Denominator**	**Weighting**	**Weighted Rate**
CLABSI	per 1,000 central line days	25%	aa
CAUTI	per 1,000 catheter days	25%	bb
C. Diff	per patient days x 10,000	25%	cc
nvHAP	per patient days x 1,000	25%	dd
		SUM	HAC Index

1. HAC Index 2.0 is the strategic quality and safety goal for FY24. For the month of June (0.6584) and Fiscal Year-To-Date (0.9851) we are favorable to target of (1.201). The HAC Index 2.0 has been retired in FY 25 to focus on CDIFF, CAUTI, and Hand Hygiene.

   a. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 year to date (2.33) are favorable to target (2.83). There have been 28 hospital acquired infections in FY24. Areas of focus to decrease C. Diff are twofold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program have been implemented. (Timeline for improvement: We met and exceeded the target for FY24)

   FY 25 for the month of July we are at (1.00) cases with a target of (2.25/month)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infections per catheter days for FY 24 (0.92) is better than target of (1.05). There have been eleven CAUTI in FY 24 year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and no more than one per month in August 2024 through June 2024. There were zero CAUTI's enterprise wide in January, March, May and June of 2024. Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. This intervention is likely contributing the improved performance in the fourth quarter of FY24. (Timeline for improvement: CAUTI target was met for FY24)

   FY 25 we are at (1.00) versus a target of (0.83/month).

c. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for the end of FY 24 year to date (0.025) is favorable to target (0.650). There were three CLABSIs in FY 24. FY 25 we have had zero CLABSIs and are achieving target. This time in FY23 there were eight CLABSIs. Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. In FY23 the majority of CLABSIs were related to hemodyalsis catheters. (Timeline for improvement: CLABSI target was met for FY24)

   FY 25 we are at (0) cases versus a target of (0.42/month)

d. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 nvHAP we did not meet the nvHAP target and ended the year at (2.25) and is above target of (1.94). Two key interventions, mobilizing our patients out of bed, and having regular oral care are in place. Both practices are contributing to the successful decrease in nvHAP infections affecting our patients. We ended the year with 26 cases of nvHAP as against a target of 23 cases. The quality manager and team have increased rounding focused on oral care and in the moment education of staff and patients about the importance of preventing nvHAP. FY 25 nvHAP has been retired from the EQD as it has not been added to the TJC/CMS benchmarking metrics. (Timeline for improvement: we will continue to monitor nvHAP and continue best practices to reduce the incidence. Our prediction is that we should see improvement in Q1/Q2 of FY 2025)

2. **Surgical Site Infection**. The rate of surgical site infections for FY24 (3.08) is unfavorable to target (2.42). Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. Initiatives launched the previous FY have resulted in a significant decrease of TKR infections. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures. (Timeline for improvement: We anticipate that our SSI rate will go down by Q2/Q3 or FY 2025.

This is a major focus for the organization and we will devote significant resources to understand and implement any changes needed)

FY 25: Unfavorable (4) to target of (2.5/month). We have identified an increase in infections in hysterectomies, Biliary and colon cases. We have instituted a task force with all stakeholders including physicians to address causes and institute specific solutions.

3. Risk Adjusted Readmission Index. Performance through May YTD (1.12) is unfavorable to target (1.0). El Camino Health remains committed to ensuring timely follow-up care for patients under SVMD primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital.

In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital.

Furthermore, we have introduced other initiatives to lower readmissions, including a philanthropy-sponsored program by the ECH Foundation. This program provides free Naltrexone (Vivitrol) Long-Acting Injectable (LAI), a drug that reduces patients' dependency on opioids and alcohol. This initiative targets substance-related readmissions and went live on April 10th. (Timeline for improvement: The new database vendor uses an observed readmission rate and we will be monitoring that)

4. **Risk Adjusted Mortality Index.** Performance for FY24 YTD (1.12) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. (Timeline for improvement: The mortality index should improve when we institute inpatient hospice during this quarter)

   FY 25: Unfavorable (1.1) to target of 1.

5. **Sepsis Mortality Index.** Performance for FY24 (1.22) is unfavorable to target (1.00). Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program. (Timeline for improvement: The GIP program is planned for go-Live in Q1 of FY25. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation. This alone, Palliative care consult" increases the expected risk of mortality 6-fold)

FY 25 Unfavorable (1.4) to target of 1. (We have implemented the new process described above to ensure compliance with the sepsis bundle. Instituting GIP would also improve our index)

6. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV**. FY24Q4 performance through June of 2024 (24.6%) is unfavorable to target of 23.9%. We have seen a decrease year over year in the metric from 26.4.% to 24.7%. This is a big reduction year over year and is attributed to our MCH team's focus and efforts. The MCH team shares data quarterly with the medical staff regarding individual physician NTSV rates. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: We did not achieve this target in FY 24, but showed significant improvement year over year).

   FY 25: No data for July 25

7. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24 performance (155 minutes) is favorable to the target of 165 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

   FY 25: Favorable (148 mins) to target of 160 mins.

8. **Inpatient HCAHPS Likelihood to Recommend**. For the month of June (84.7) and FY24 (81.9) performance has exceeded the target of 76.4..This holds true for both the LG and MV campuses. We continue to rank in the top decile in the Bay Area. These increases were due to strong scores in our Key Drivers, that is Nurse Communication and Staff Worked Together (teamwork). We are continuing to upgrade our RN call system on both campuses leading to better responsiveness. We are did exceed this target for FY24.

   FY25: Unfavorable (80.1) to target of 81.9

9. **Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** For June (82.8) and FY24 (82.0) performance exceeded target of 75. We continue to perform in the top decile in the Bay Area and 87% nationally. Our new facility in Mountain View has rave reviews from our patients and families.

   FY25: Unfavorable (73.8) to target of 82.

10. **ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** The overall ED top box score exceeded target (71.7) FY24 (75.5) and exceeding target (71.7) for fiscal year to date.

    FY25: Favorable (78) to target of 77.2

11. **El Camino Health Medical Network: Likelihood to Recommend Care Provider Top Box Rating of "Yes, Definitely likely to Recommend".** Our ECHMN Clinics exceeded target for the month of June (84.3) and YTD (81.3). FY 24 ended at (82.4%) achieving our goal.

    FY25: Unfavorable (82.9) to target of 83.4

Changes in EQD for FY 25:

- **HAC 2.0 index has been replaced.**

- **nvHAP has been retired. Reason: nvHAP does not have a standard definition, not being benchmarked or measured by CMS.**
- **Hand Hygiene Combined Compliance rate will be measured. Favorable (89.4%) to target of 85%.**
- **Percentage of Departments meeting targets will be measured.** Favorable (100%) to target of 80% **(Leapfrog Measure)**
- **Readmission index has been replaced by Observed readmission rate.** FY 25 readmission rate is Unfavorable (10.4%) to target of (<=9.8%). **(new vendor does not measure readmission index)**
- **Complications of Hip and Knee Replacement: Favorable (0%) to target of </= 3.5%. (CMS/Leapfrog measure)**

Attachments:

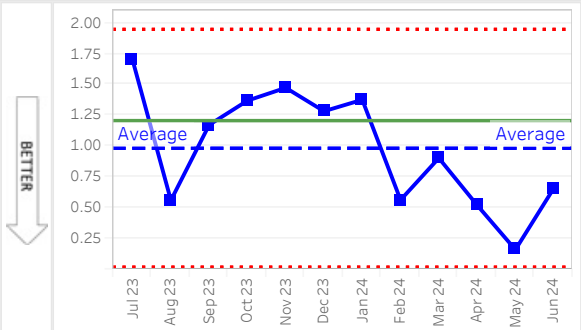
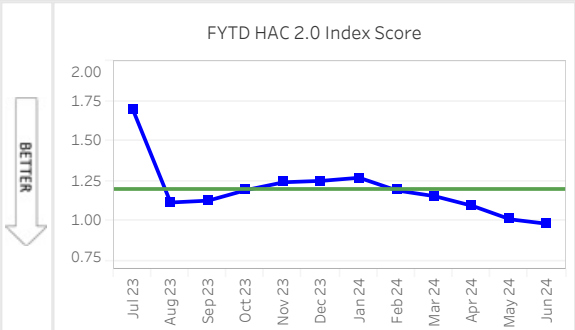
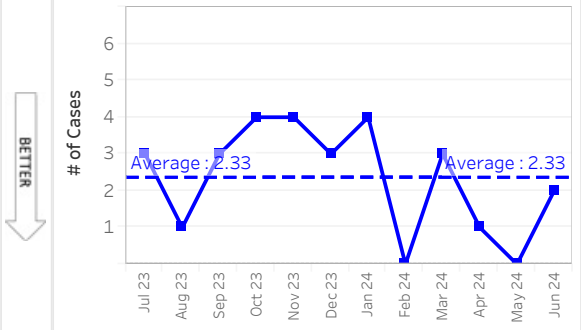
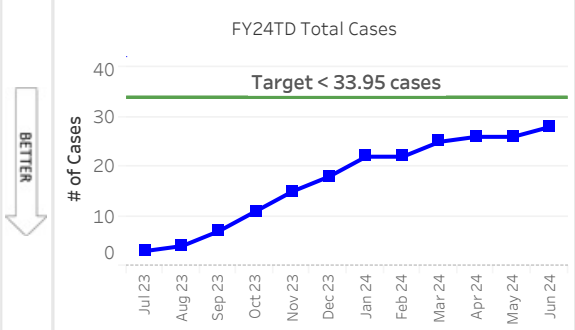
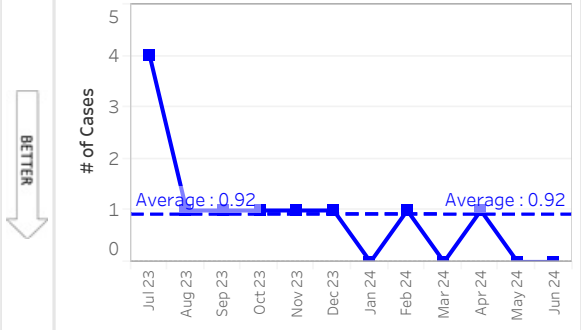
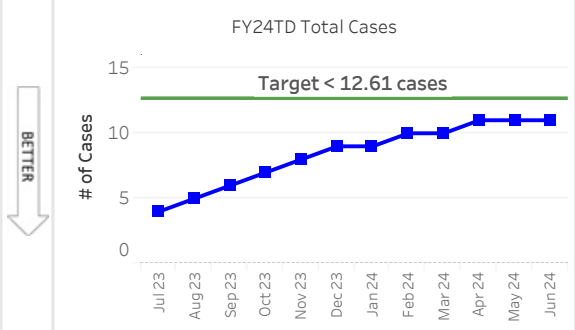
1. Enterprise Quality Dashboard FY 24 through June 2024
2. Enterprise Quality Dashboard FY 25 through July 2024 (unless otherwise noted)

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

June 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : June 2024	0.6584	0.9851	1.238	1.201 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : June 2024	2 cases	2.33 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : June 2024	0 cases	0.92 cases/mo	1.08 cases/mo	1.05 cases/mo		

Quality Department | Note : updated as of Aug 19, 2024

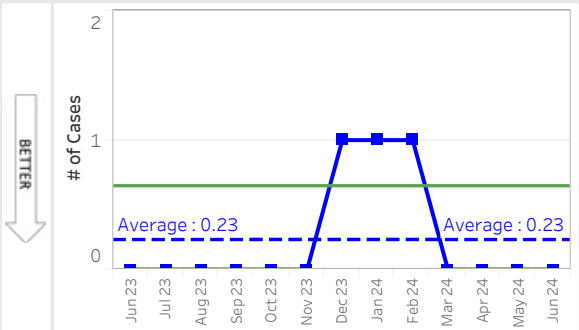
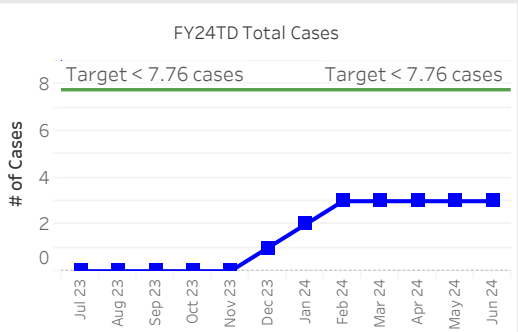
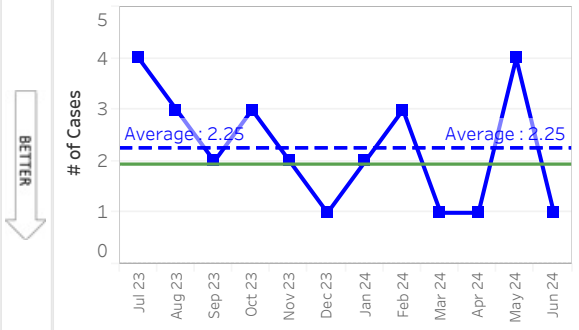
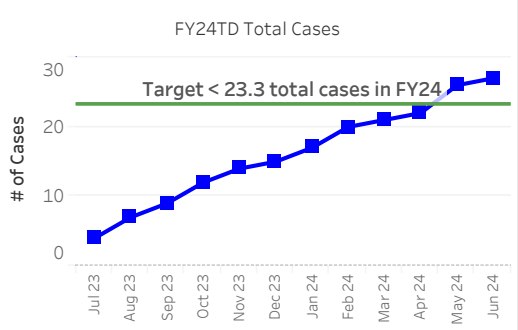
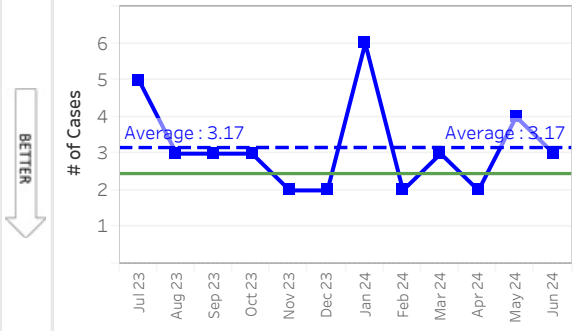
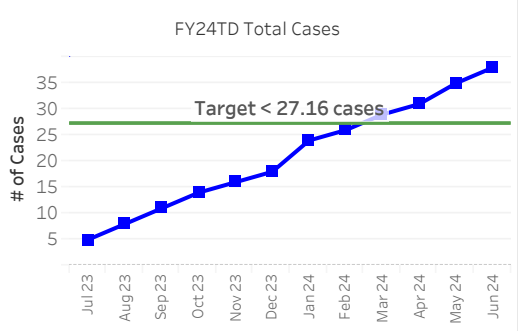
Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal HAC Index 2.0	H. Beeman, MD	For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%,Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%,	See below
HAC Component Clostridium Difficile Infections (C-Diff)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component Catheter Associated Urinary Tract Infection (CAUTI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

June 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : June 2024	0 cases	0.25 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : June 2024	1 cases	2.25 cases/mo	2.00 cases/mo	1.94 cases/mo		
Surgical Site Infections (SSI) Latest Month : June 2024	3 cases	3.17 cases/mo	2.50 cases/mo	2.42 cases/mo		

Quality Department | Note : updated as of Aug 19, 2024

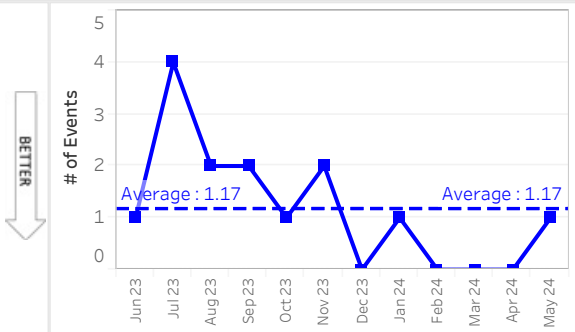
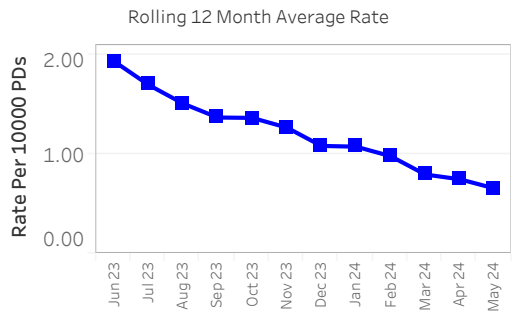
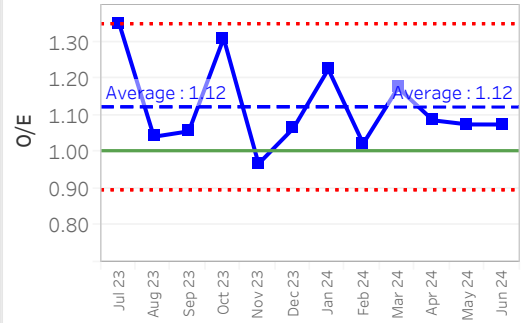
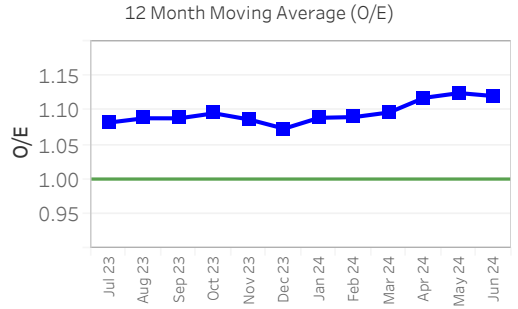
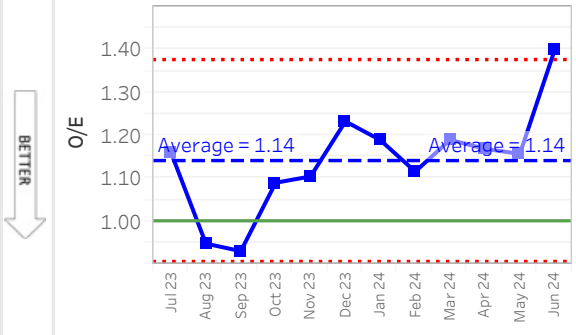
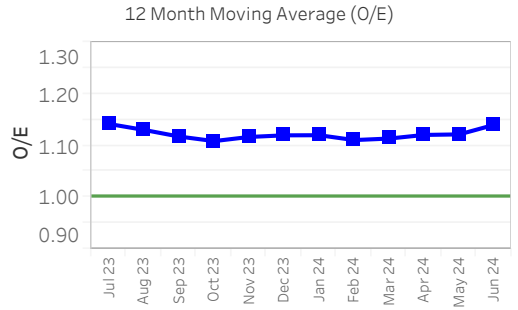
Measure	Definition Owner	Metric Definition	Data Source
HAC Component Central Line Associated Blood Stream Infection (CLABSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP)	C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; **Numerator** identified by nvHAP workgroup; **Denominator**: EPSi patient days nvHAP Tableau Dashboard maintained by: **Mohsina Shakir**
Surgical Site Infections (SSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	**Numerator:** Infection control Dept. **Denominator**: EPIC Report

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

June 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : May 2024	1 events	0.66 (13 / 196782)	1.93 (41 / 212460)	n/a		
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : June 2024	1.07 (8.90% / 8.28%)	1.12 (9.08% / 8.09%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : June 2024	1.40 (3.14% / 2.24%)	1.14 (2.20% / 1.93%)	1.13 (2.21% / 1.96%)	1.00		

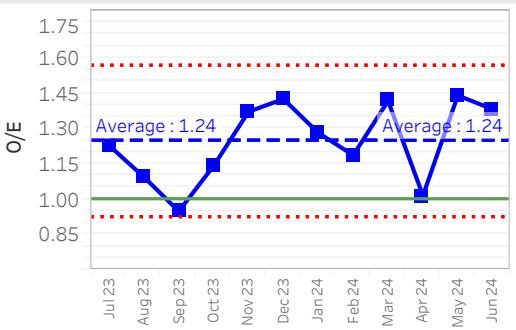
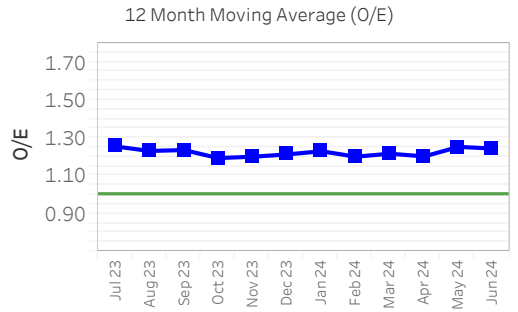
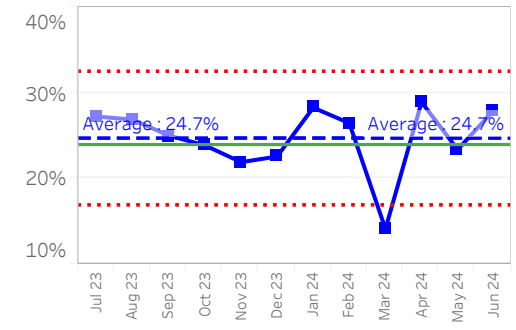
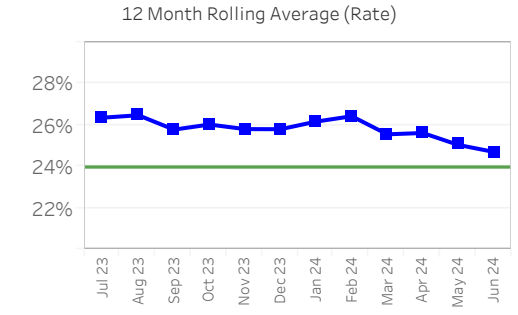
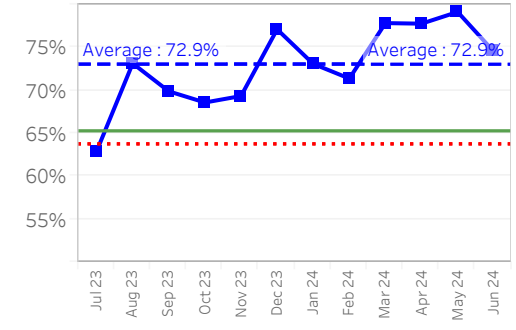
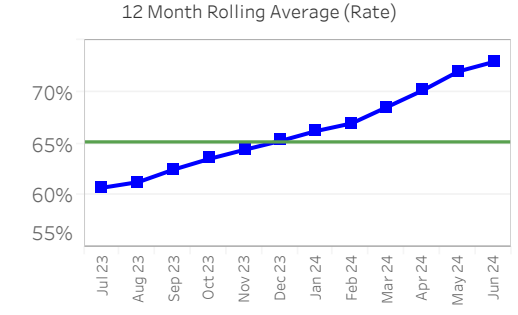
Quality Department | Note : updated as of Aug 19, 2024

Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems Safety Event Tableau Dashboard maintained by: **Michael Moa**
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA	H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D.	Premier Quality Advisor Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Premier Care Sciences Standard RA	H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor

FY24 Enterprise Quality, Safety and Experience Dashboard

June 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : June 2024	1.38 (16.55% / 11.99%)	1.24 (13.67% / 11.00%)	1.21 (14.07% / 11.59%)	1.00		
PC-02 : Cesarean Birth Latest Month : June 2024	MV : 27.9% (39 / 140)	MV : 25.3% (474 / 1875)	MV : 27.6% (516 / 1869)	23.9% (FY24 ENT Target)		
	LG : 28.6% (6 / 21)	LG : 20.7% (57 / 275)	LG : 19.4% (62 / 320)			
	ENT : 28.0% (45 / 161)	ENT : 24.7% (531 / 2150)	ENT : 26.4% (578 / 2189)			
PC-05 : Exclusive Breast Milk Feeding Latest Month : June 2024	MV : 72.6% (193 / 266)	MV : 71.0% (2458 / 3463)	MV : 58.1% (1998 / 3437)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 84.6% (44 / 52)	LG : 84.1% (476 / 566)	LG : 68.4% (428 / 626)			
	ENT : 74.5% (237 / 318)	ENT : 72.8% (2934 / 4029)	ENT : 59.7% (2426 / 4063)			

Quality Department | Note : updated as of Aug 19, 2024

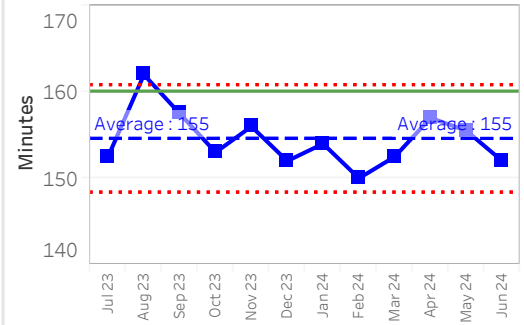
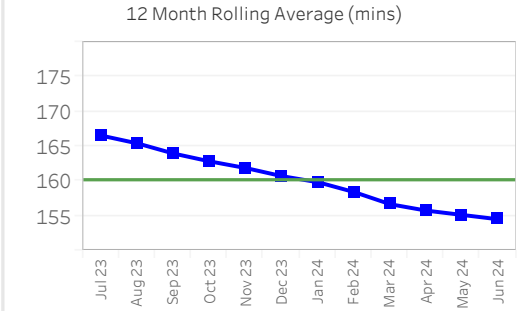
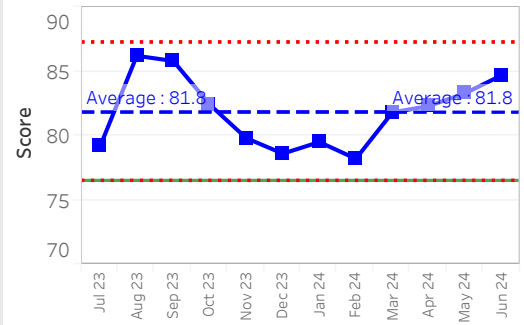
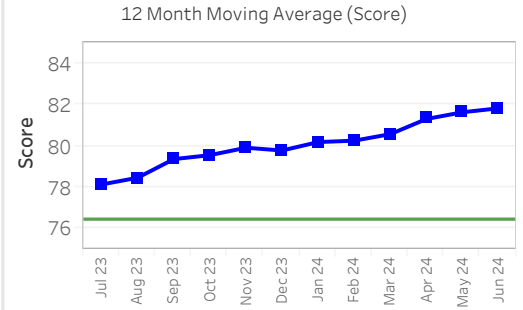
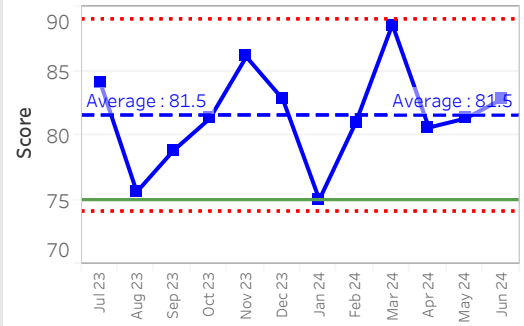
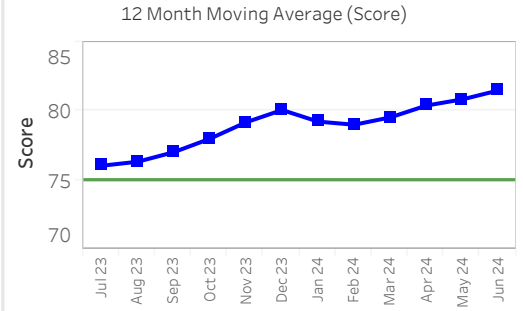
Measure	Definition Owner	Metric Definition	Data Source
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA	J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

June 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : June 2024	MV : 170 mins LG : 134 mins ENT : 152 mins	MV : 174 mins LG : 135 mins ENT : 155 mins	MV : 194 mins LG : 142 mins ENT : 168 mins	MV : 191 mins LG : 139 mins ENT : 165 mins		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : June 2024	84.7	81.9	78.5	76.4		
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : June 2024	82.8	82.0	75.0	75.0		

Quality Department | Note : updated as of Aug 19, 2024

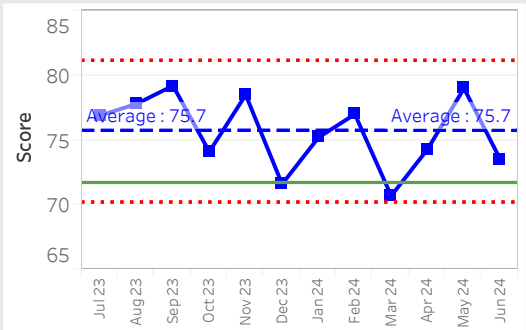
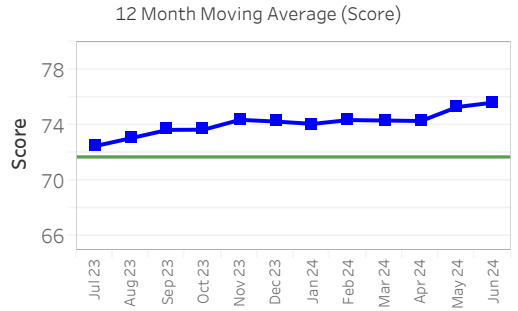
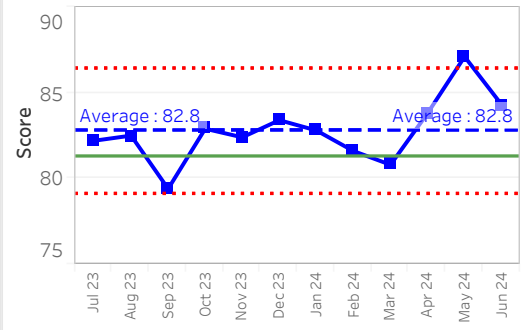
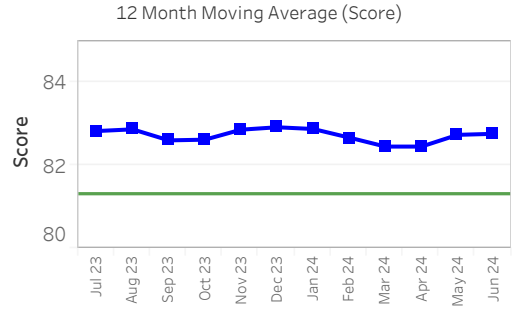
Measure	Definition Owner	Metric Definition	Data Source
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard ED Tableau Dashboard maintained by: **Hsiao-Lan (Dee) Shih**
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

June 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : June 2024	73.5	75.5	71.7	71.7		
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : June 2024	84.3	82.1	82.7	81.3		

Quality Department | Note : updated as of Aug 19, 2024

Measure	Definition Owner	Metric Definition	Data Source
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Final Notes:
1.) SSER through May 2024
2.) Readmissions through June 2024
3.) PC-02 & PC-05 through June 2024
4.) Updated as of 2024-08-19

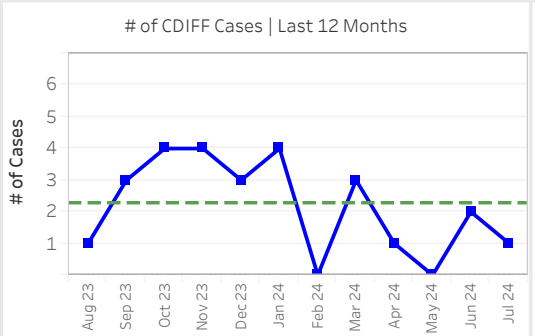
El Camino Health

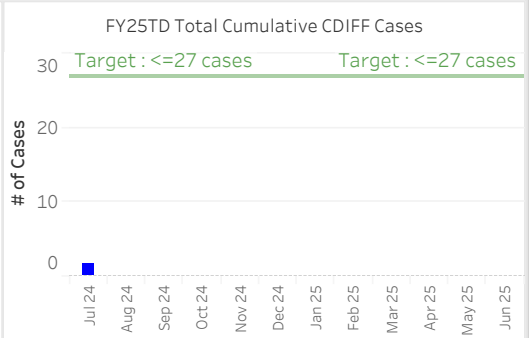
FY25 Enterprise Quality, Safety and Experience Dashboard

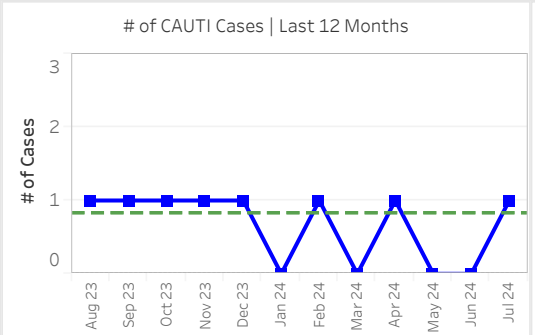
July 2024 (unless other specified)

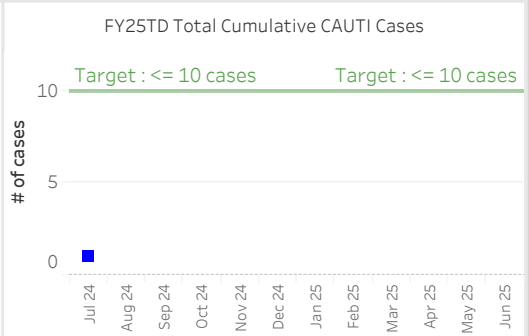
Month to Board Quality Committee : September 2024

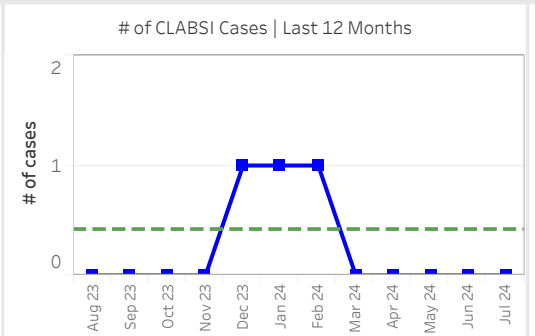
Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases Latest Month : July 2024	1 cases	1.00 cases/mo	2.33 cases/mo	2.25 cases/mo	BETTER	BETTER
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : July 2024	1 cases	1.00 cases/mo	0.92 cases/mo	0.83 cases/mo	BETTER	BETTER
Central Line Associated Blood Stream Infection (CLABSI) cases Latest Month : July 2024	0 cases	0.00 cases/mo	0.25 cases/mo	0.42 cases/mo	BETTER	BETTER

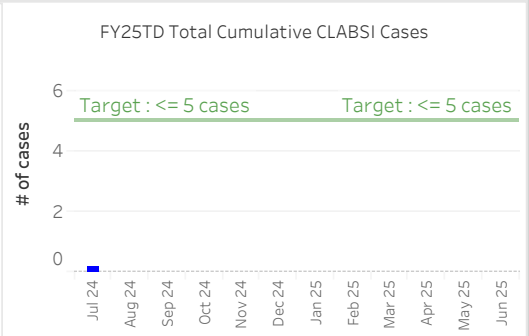












Quality Department | Note : updated as of Aug 15, 2024

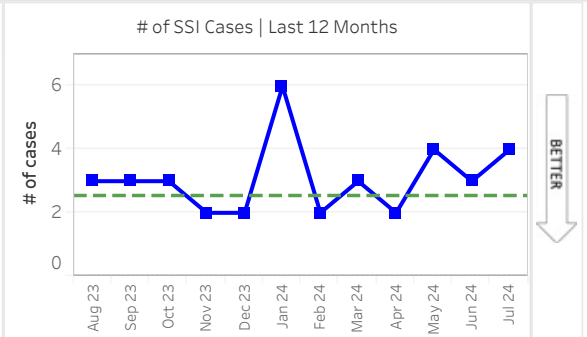
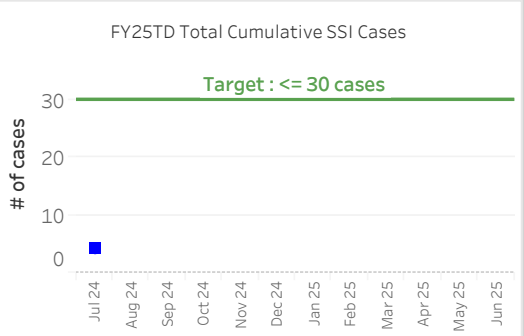
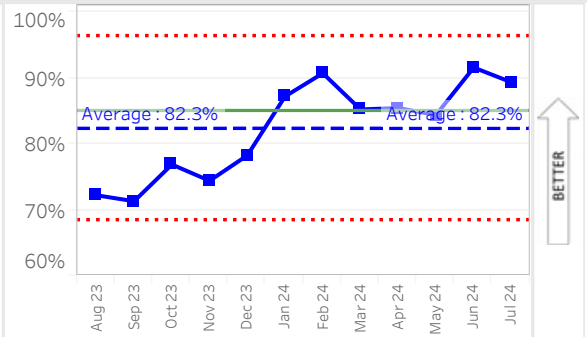
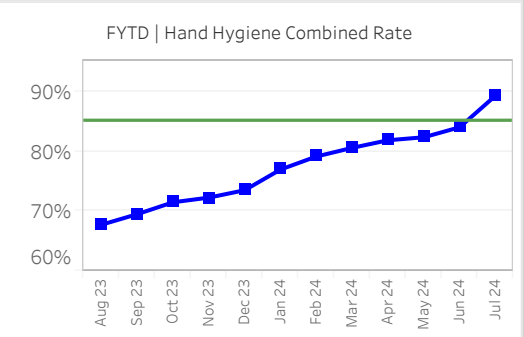
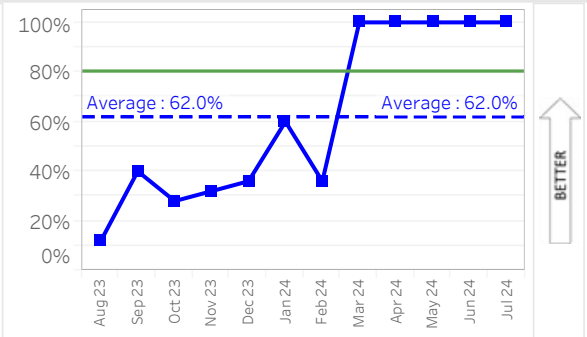
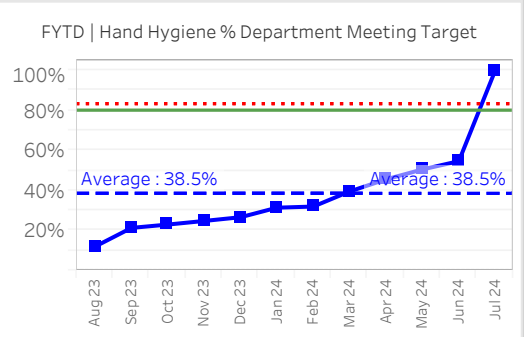
Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Central Line Associated Blood Stream Infection (CLABSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

July 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Surgical Site Infections (SSI) cases Latest Month : July 2024	4 cases	4.00 cases/mo	3.17 cases/mo	2.50 cases/mo		
Hand Hygiene Combined Compliance Rate Latest Month : July 2024	89.4% (9690 / 10840)	89.4% (9690 / 10840)	84.1% (64956 / 77245)	85%		
Hand Hygiene % of Departments Meeting Target Latest Month : July 2024	100.0% (25 / 25)	100.0% (25 / 25)	54.7% (164 / 300)	80% of units		

Quality Department | Note : updated as of Aug 15, 2024

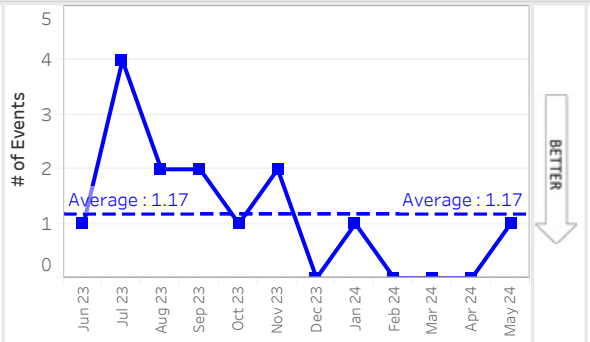
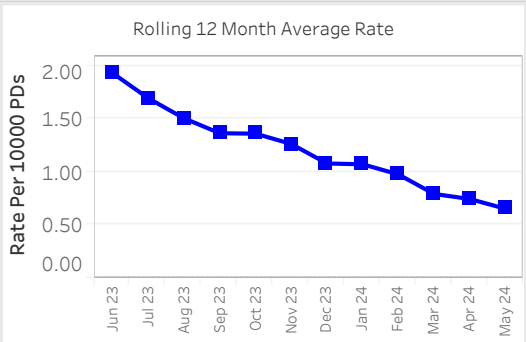
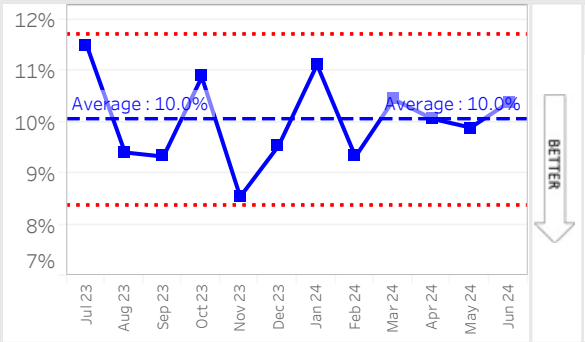
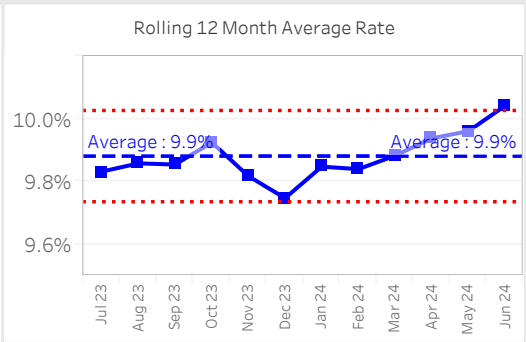
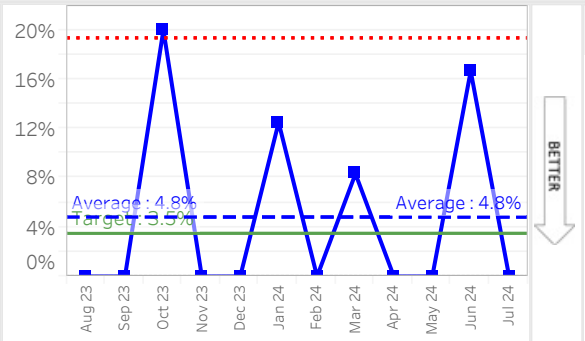
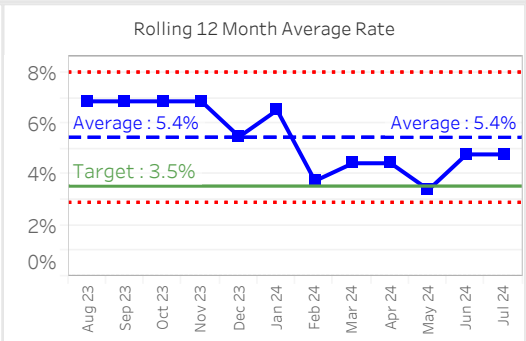
Measure	Definition Owner	Metric Definition	Data Source
Surgical Site Infections (SSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Hand Hygiene Combined Compliance Rate	S. Mallur, MD / Lyn Garrett	% of yes Cleaning Before Entering or Exit	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: **Hsiao-Lan Shih**
Hand Hygiene % of Departments Meeting Target	S. Mallur, MD / Lyn Garrett	Number of Unit done Audit according to their Target (Only Leapfrog units)	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: **Hsiao-Lan Shih**

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

July 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : May 2024	1 events	0.66 (13 / 196782)	1.93 (41 / 212460)	n/a		
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : June 2024	10.4% (132 / 1270)	10.0% (1602 / 15947)	9.8% (1519 / 15552)	<= 9.8%		
Complications - Hip & Knee Observed Rate Vizient Risk Model Latest Month : July 2024	0.0% (0 / 11)	0.0% (0 / 11)	5.9% (5 / 85)	<= 3.5%		

Quality Department | Note : updated as of Aug 15, 2024

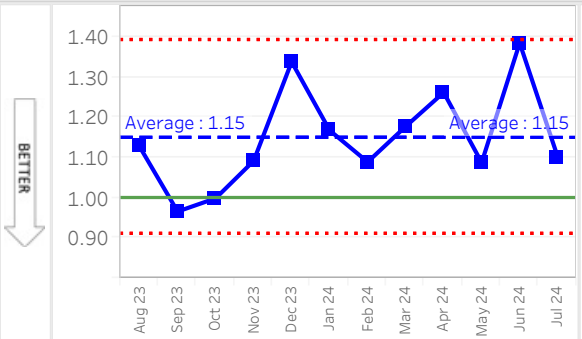
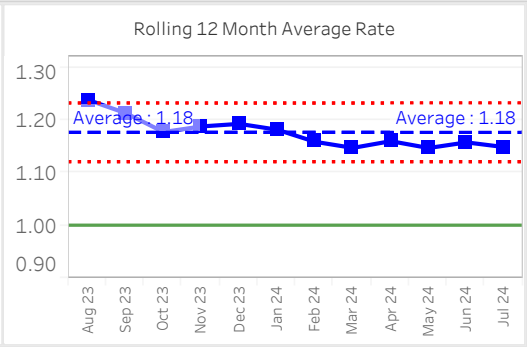
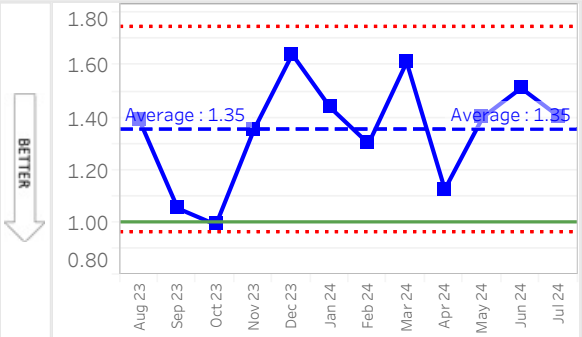
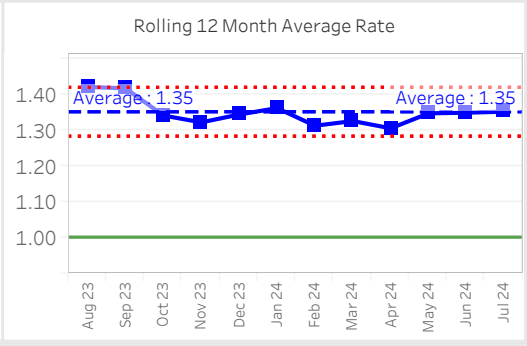
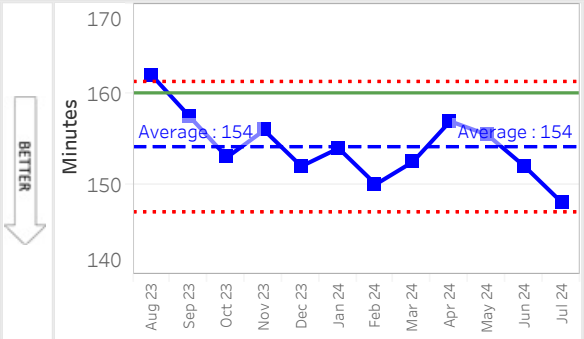
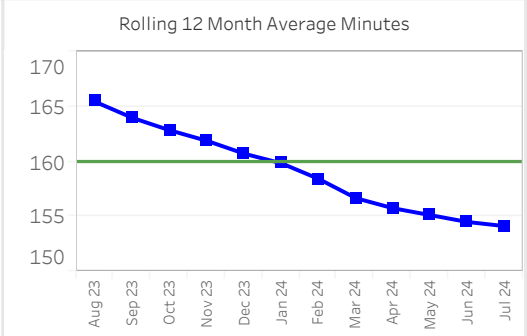
Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems Safety Event Tableau Dashboard maintained by: **Michael Moa**
30-Day Readmission Observed Rate Vizient Risk Model	S. Mallur, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Vizient Risk Model 2023 Community + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn	Vizient Clinical Database Readmission Tableau Dashboard maintained by: **Steven Sun**
Complications - Hip & Knee Observed Rate Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2023 Community + AHRQ Version 2023 2) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate & Normal Newborn	Vizient Clinical Database

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

July 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Mortality Index Observed / Expected Vizient Risk Model Latest Month : July 2024	1.10 (2.08% / 1.88%)	1.10 (2.08% / 1.88%)	1.16 (2.55% / 2.20%)	1.00		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : July 2024	1.40 (10.00% / 7.12%)	1.40 (10.00% / 7.12%)	1.35 (13.37% / 9.91%)	1.00		
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : July 2024	MV : 166 mins LG : 130 mins ENT : 148 mins	MV : 166 mins LG : 130 mins ENT : 148 mins	MV : 174 mins LG : 135 mins ENT : 155 mins	MV ED = 180 min LG ED = 140 min ENT = 160 min		

Quality Department | Note : updated as of Aug 15, 2024

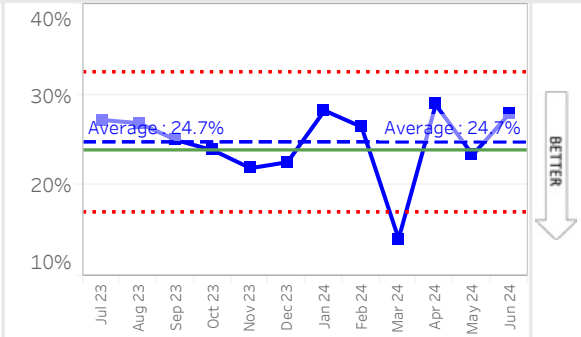
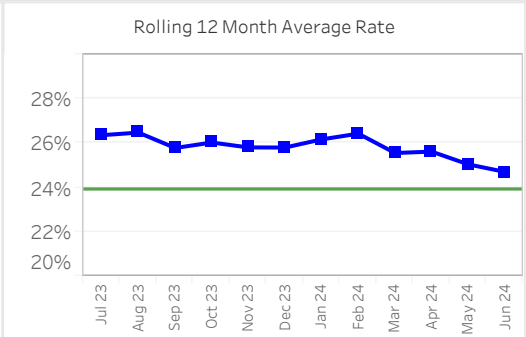
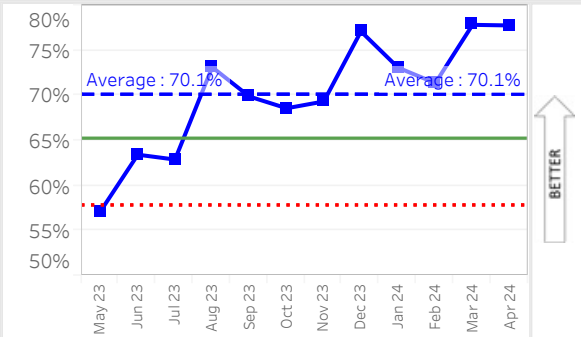
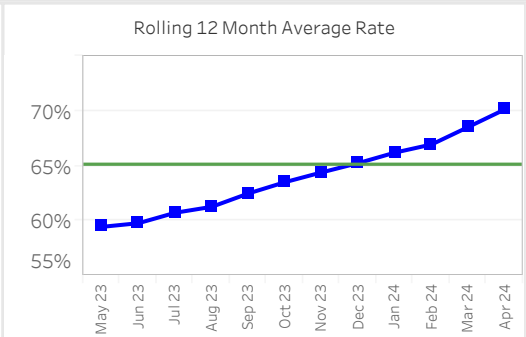
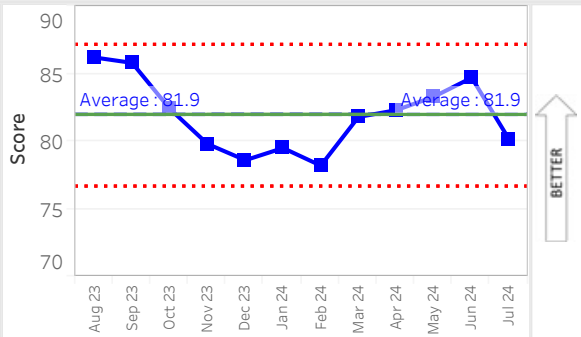
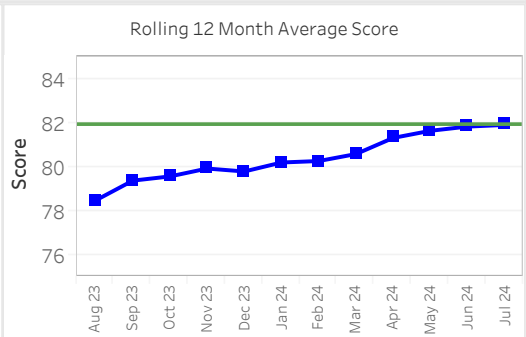
Measure	Definition Owner	Metric Definition	Data Source
Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2023 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Vizient Clinical Database
Sepsis Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD Maria Consunji	1) Numerator inclusions: Patient Type = Inpatient (exclude Rehab, Hospice, Nonviable Neonate & Normal Newborn + Behavioral Health (based on Vizient Service Line = Behavioral Health), Prin or 2nd diagnosis of sepsis (SEP-1 list of codes) & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Vizient Clinical Database
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard ED Tableau Dashboard maintained by: **Hsiao-Lan Shih**

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

July 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 27.9% (39 / 140)	MV : 25.3% (474 / 1875)	MV : 27.6% (516 / 1869)	23.9% (FY24 ENT Target)		
	LG : 28.6% (6 / 21)	LG : 20.7% (57 / 275)	LG : 19.4% (62 / 320)			
Latest Month : June 2024	ENT : 28.0% (45 / 161)	ENT : 24.7% (531 / 2150)	ENT : 26.4% (578 / 2189)			
PC-05 : Exclusive Breast Milk Feeding	MV : 76.4% (207 / 271)	MV : 71.0% (2458 / 3463)	MV : 58.1% (1998 / 3437)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 84.9% (45 / 53)	LG : 84.1% (476 / 566)	LG : 68.4% (428 / 626)			
Latest Month : June 2024	ENT : 77.8% (252 / 324)	ENT : 72.8% (2934 / 4029)	ENT : 59.7% (2426 / 4063)			
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	80.1	80.1	81.9	81.9		
Latest Month : July 2024						

Quality Department | Note : updated as of Aug 15, 2024

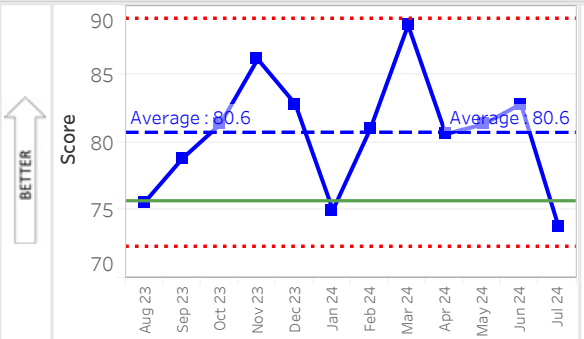
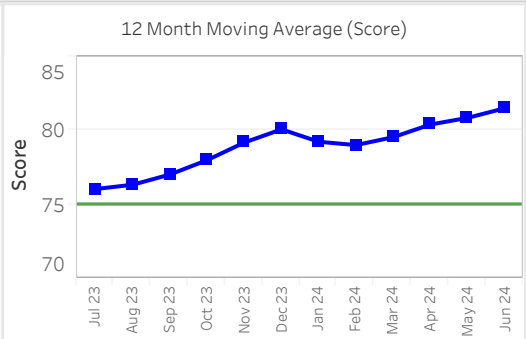
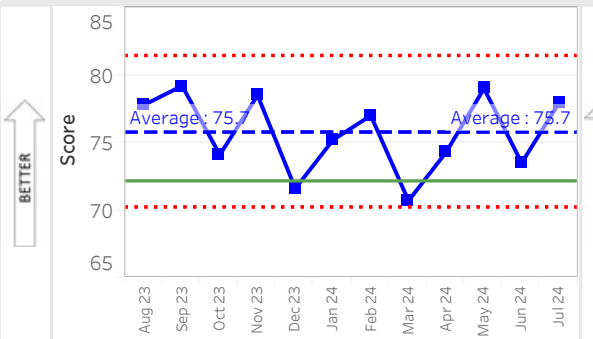
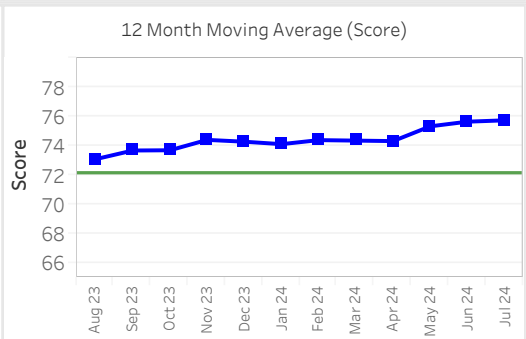
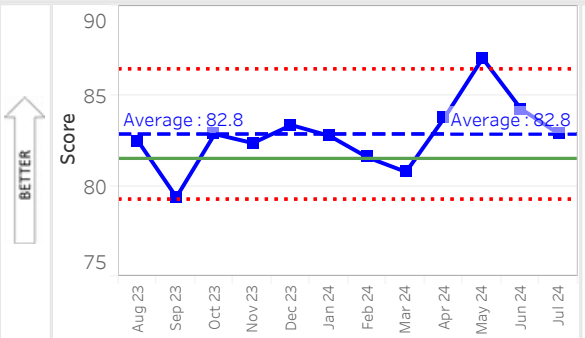
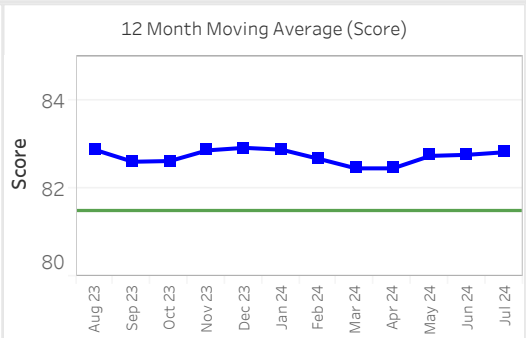
Measure	Definition Owner	Metric Definition	Data Source
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

July 2024 (unless other specified)

Month to Board Quality Committee : September 2024

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : July 2024	73.8	73.8	82.0	82.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : July 2024	78.0	78.0	75.5	77.2		
ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : July 2024	82.9	82.9	82.1	83.4		

Quality Department | Note : updated as of Aug 15, 2024

Measure	Definition Owner	Metric Definition	Data Source
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey