El Camino Health

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

Monday, November 4, 2024 – 5:30 pm

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

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: 974 4286 2038 # No participant code. Just press #.**

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

Please note that the live stream 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 (09/03/2024) b. FY25 Pacing Plan c. CDI Dashboard d. Core Measures	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:30 – 5:40**
6.	**COMMUNITY MEMBER RECRUITMENT – AD HOC COMMITTEE** a. Approve QC Resolution 2024-01	Carol Somersille, MD Quality Committee Chair	Discussion	**5:40 – 5:45**
7.	**COMMITTEE EXPERTISE REPORT**	Krutica Sharma, MD Quality Committee Member	Information	**5:45 – 5:55**
8.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Discussion	**5:55– 6:05**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
9.	**SAFETY REPORT FOR THE ENVIRONMENT OF CARE**	Ken King, Chief Administrative Services Officer	**Motion Required**	**6:05 – 6:20**
10.	**Q1 FY25 STEEEP DASHBOARD REVIEW / FY25 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:20 – 6:40**
11.	**EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Jaideep Iyengar, MD, FAAOS Peter Goll, Chief Administrative Officer, ECHMN Kirstan Smith, BSN, CPHQ, Director of Clinical Quality, ECHMN	Discussion	**6:40 – 7:00**
12.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:00 – 7:01**
13.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (09/04/2024) b. Quality Council Minutes (10/02/2024) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Carol Somersille, MD Quality Committee Chair	Information	**7:01– 7:11**
14.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (09/03/2024)** *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:11 – 7:16**
15.	**Q1 FY25 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**7:16 – 7:26**
16.	**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**	**7:26 – 7:36**
17.	**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	**7:36 – 7:41**
18.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:41 – 7:42**
19.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:42 – 7:43**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
20.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:43 – 7:49**
21.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:49 – 7:50**

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

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, September 3, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD, Chair	**Pancho Chang**	**Mark Adams,** MD**,** CMO
Melora Simon, Vice Chair *(at 5:48)*		**Christine Cunningham,** Chief Experience and Performance Improvement Officer
Shahram Gholami, MD *(at 5:40)*		**Theresa Fuentes**, CLO
Steven Xanthopoulos, MD		**Shreyas Mallur,** MD, CQO
Jack Po, MD		**Cheryl Reinking,** DPN, RN, CNO
Krutica Sharma, MD		**Tracey Lewis Taylor,** COO
John Zoglin		**Lyn Garrett,** Senior Director, Quality
	**via teleconference	**Sheetal Shah**, Senior Director, Risk Management and Patient Safety
		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 **5:37 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Pancho Chang was absent.	Call to order at **5:37 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 Items (a) Approve Minutes of the Open Session of the Quality Committee Meeting (08/05/2024), (c) Approve Quality Committee Charter as Reviewed and Recommended for Approval by the Governance Committee, and (e) Receive Progress Against FY25 Committee Goals were pulled for further discussion. Regarding item (a), Chair Somersille requested thorough additions to specific agenda items to capture the full discussions. Regarding item (c), the Committee had an in-depth discussion regarding the Hospital and Medical Network Organizational Structure and how this structure allows for the Committee to oversee and assess Quality across the Enterprise. Ms. Fuentes discussed the legal structure of the enterprise. She provided a flow chart of the overall structure to facilitate the discussion, specifically regarding the limits on oversight provided in the operating agreements with the affiliated entities. The Committee requested that the charter be brought back for approval at the next meeting, with the entire flow chart included for review. Regarding item (e), Director Zoglin asked for clarification on when there would be a report on AI. Dr. Mallur shared that this is currently paced for the December meeting. **Motion**: To approve the consent calendar except item (c) Quality Committee Charter as Reviewed and Recommended for Approval by the Governance Committee **Approval**: (a) Minutes of the Open Session of the Quality Committee Meeting (08/05/2024), (b) Minutes of the Closed Session of the Quality Committee Meeting (08/05/2024), (c) Quality Committee Charter as Reviewed and Recommended for Approval by the Governance Committee **Received**: (d) Committee Governance Policy, (e) Progress Against FY25 Committee Goals, (f) FY25 Pacing Plan **Movant**: Po **Second**: Zoglin **Ayes**: Somersille, Gholami, Po, Sharma, Simon Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang **Recused**: None	***Consent Calendar Approved*** *The Quality Committee Charter will be brought back to the Committee with the Hospital and Medical Network Organizational Structure Flowchart for approval at the next meeting.*
6. VERBAL CHAIR'S REPORT	Chair Somersille did not provide a verbal Chair's report.	

7. PATIENT STORY	Ms. Reinking presented the Patient's Story to the Committee. She shared the patient's concerns regarding their late discharge due to waiting for the hospitalist to confer with the cardiologist. The Patient shared positive remarks about the overall care received but said that the delay in discharge was disappointing. Ms. Reinking shared that the implementation of revised comprehensive multidisciplinary rounds should lower the length of stay times, as observed in the pilot units. The Committee suggested using scripts for hospitalists to utilize during discharges to reduce the length of stay times.	
8. PATIENT EXPERIENCE REPORT	Ms. Cunningham provided the Patient Experience Report to the Committee. Ms. Cunningham presented the ECH data vs the National Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Ms. Cunningham added that ECH outperforms the Press Ganey market year-over-year. Ms. Cunningham continued to present the FY24 ECH Likelihood to Recommend metrics, reporting exceeded performance above the Press Ganey market data month over month. Ms. Cunningham presented the FY25 LTR Goal-Setting Methodologies and Targets to maintain continuous improvement across the Enterprise and achieve or exceed the 75th percentile. The Committee inquired about El Camino's local performance. Ms. Cunningham shared that El Camino performs even higher in the local comparisons for the same measures.	
9. Q4 FY24 / FY25 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur provided the Q4 FY24 / FY25 Enterprise Quality Dashboard to update the Quality, Patient Care, and Patient Experience Committee on quality, safety, and experience measure performance through June 2024 (unless otherwise noted) and July FY25. The data provided described performance for the end of FY 2024 and changes to the FY 2025 Dashboard. Dr. Mallur highlighted specific changes to the Enterprise Quality Dashboard for FY25, including: • The HAC 2.0 Index has been replaced. • nvHAP (non-ventilator hospital-acquired pneumonia) has been retired since nvHAP does not have a standard definition and is not being benchmarked or measured by CMS. • The Hand Hygiene Combined Compliance rate will be measured. It is currently favorable (89.4%) to the target of 85%. • The percentage of Departments meeting targets will be measured. It is currently favorable (100%) to the target of 80%, which is a Leapfrog measure. • The observed readmission rate has replaced the readmission index. FY 25 readmission rate is Unfavorable (10.4%) to the target of (<=9.8%).	

	• Complications of Hip and Knee Replacement: Favorable (0%) to target of </= 3.5%, which is a CMS/Leapfrog measure.	
10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 6:47 pm **Movant**: Po **Second**: Simon **Ayes**: Somersille, Gholami, Po, Sharma, Simon Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang **Recused**: None	***Recessed to Closed Session at 6:47 PM***
11. AGENDA ITEM 17: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee unanimously approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors.	***Reconvened Open Session at 7:38 PM***
12. AGENDA ITEM 18: COMMITTEE ANNOUNCEMENTS	The Committee did not have any announcements.	
13. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:39 p.m. **Movant**: Po **Second**: Gholami **Ayes**: Somersille, Gholami, Po, Sharma, Simon Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent**: Chang **Recused**: None	***Adjourned at 7:39 PM.***

Attest as to the approval of the preceding 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: Carol Somersille, MD, Quality Committee Chair; Theresa Fuentes, Chief Legal Officer; Tracy Fowler, Director of Governance Services

APPROVED BY QC
05/06/2024

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 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 Improvement & Patient Safety Plan (QIPS)								✓				
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
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Cornel Delogramatic, MD, MBA
Director, Health Equity and Clinical Integrity
Date: November 4th, 2024
Subject: Clinical Documentation Integrity Dashboard FY 2024 - 2025

Purpose: To provide a semi-annual update on the Clinical Documentation Integrity Department activity.

Summary:

1. Situation: From a clinical perspective, CDI ensures accurate descriptions of health conditions and creates electronic documents for every step of the patient's treatment and services, which translates into quality outcomes (mortality score, readmission score, complication score, etc.), patient safety measures (PSI rate, HAC rate), and utilization outcomes (expected LOS, denial rate, clean claim rate, RAF scores, CMI, etc.).

2. Authority: The board's quality Committee is responsible for overseeing the Clinical Documentation Integrity Department.

3. Background: The Clinical Documentation Integrity (CDI) department is critical to a hospital because it ensures that clinical documentation accurately tells the patient's story and that the records of each patient and their medical history are maintained for future use. CDI programs can aid in the documentation of diagnoses that are specific and consistent throughout the medical record, which leads to accurate code assignment, better understanding of patient complexity, and improved safety and quality scores. Additionally, a well-trained clinical documentation integrity team will use consistent processes to promote accurate claims, which will reliably result in full reimbursement for rendered care services, reduce denials and improved appeal processes for the organization.

4. Assessment: Each medical record is reviewed by a clinical documentation specialist (CDS) who identifies documentation deficiencies or opportunities and uses a communication tool named "clinical documentation query" to communicate with the physicians to correct the deficiencies or to validate the diagnoses/procedures clinically. The CDI team is also responsible for educating the providers on documentation compliance requirements or newly emerged diagnostic guidelines, clinical classifications, and risk adjustment methodologies. Each query is stored within EMR as a part of the legal medical record.

In this dashboard, each metric that is higher is better and is highlighted in green.

5. Outcomes:

- **A.** CDI review coverage rate – Inpatient population; (process measure)
- **B.** CDI review coverage rate – Outpatient population; (process measure)
- **C.** CDI query volumes and provider meaningful responses; (process and engagement measure)
- **D.** PSI/HAC exclusion rates; (outcome measure)

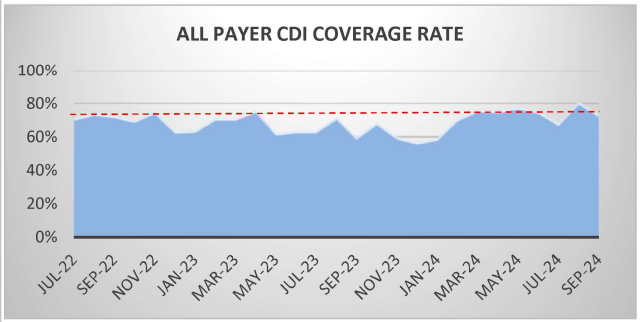
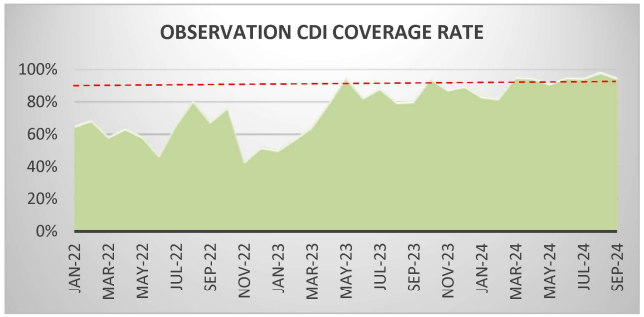
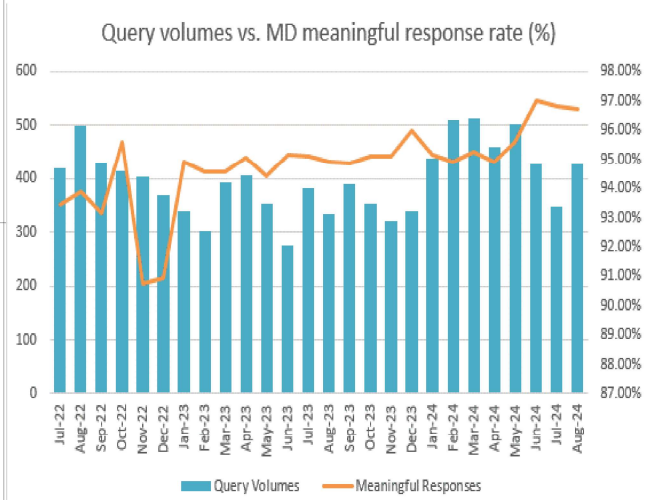
E. Nv-HAP exclusion rates; (outcome measure) – retired fir FY 2025

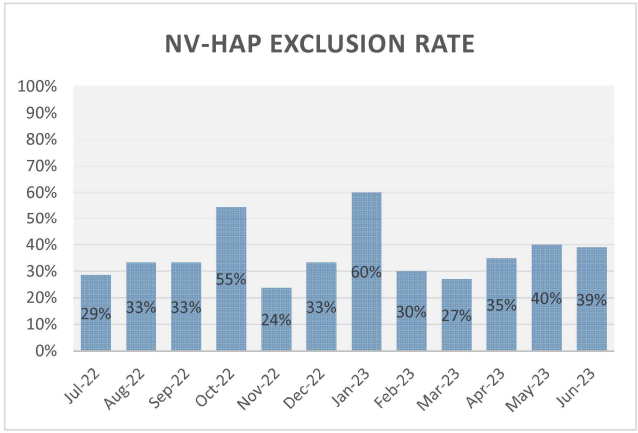
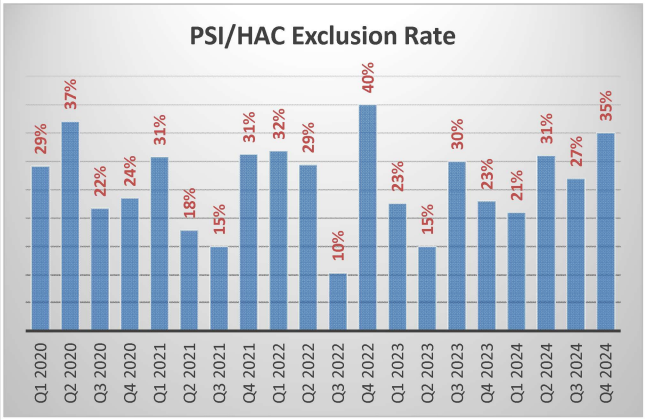
List of Attachments:

1. CDI Dashboard FY24 – FY25.

El Camino Health — Clinical Documentation Integrity Dashboard (Monthly/ all adult, acute care, non-OB inpatient population)

As of Oct 17, 2024

		Performance		Baseline	FY25 Goal	Trend	Comments
	CDI Coverage			FY2024	FY2025 goal		
1	**All Payer CDI coverage rate** **Source: iCare CDI Productivity report*	**Sep 2024** **73%**	**FYTD** **74%**	68%	70%		The all-payer coverage highlights the CDI Team's effectiveness, with our 4.5 FTEs currently covering all adult non-OB patients across both campuses, amounting to approximately 1,300 to 1,500 patients per month. We remain committed to enhancing our productivity by implementing new technologies throughout FY 2025.
2	**Observation CDI Coverage Rate** **Source: iCare CDI Productivity report*	**Sep 2024** 95%	**FYTD** **95%**	87%	90%		Reviewing observations is crucial for various organizational functions. Engaging clinical documentation specialists in this process ensures that the medical record accurately reflects the medical necessity and that all comorbidities are properly coded and clinically validated.
	Physician engagement	Performance		FY2024	FY 2025 goal		
3	**Query volumes** **Source: iCare CDI Query report*	**Sept 2024** **427**	**FYTD** **388**	414	430		This metric aims to evaluate physician engagement in our health system's CDI efforts by measuring the rate of meaningful responses relative to the total number of queries. Over the past four years, our CDI program has demonstrated significant improvement, with the response rate rising from 67% in FY 2019 to 97% year-to-date. This upward trend is largely driven by robust collaboration between CDI teams and physicians, as well as ongoing education on the value of high-quality clinical documentation for the organization.
4	**Meaningful Response Rate** **Source: iCare CDI Query report*	**Sep 2024** **97%**	**FYTD** **96%**	87%	90%		

CDI Quality Outcomes		Performance		FY2024	FY 2025 goal		
#							
5	**nv-HAP exclusion rate** **Source: CDI nv-HAP dashboard*	**June 2024** **39%**	**FYTD Avg.** **36%**	**30%**	**Retired for FY 2025**		Nv-HAPs play a critical role in the HAC Quality Index. The CDI team supports this effort by thoroughly reviewing each pneumonia case to identify any documentation issues before final coding and data submission. This meticulous approach is just one of the many advantages that a skilled CDI team brings to enhancing the organization's quality and safety of care. Achieving a high exclusion rate for inaccurately labeled hospital-acquired pneumonia cases significantly improves our HAC Index.
6	**PSI/HAC exclusion rate** *Source: CDI PSI/HAC Dashboard	**Q4 2024** **35%**	**FYTD Avg.** **29%**	**23%**	**30%**		CDI also plays a crucial role in enhancing the quality of care and ensuring accurate public reporting by reviewing cases involving PSIs and HACs. The team collaborates with physicians to identify any exclusion factors that may account for these safety events. Through ongoing monitoring, the CDI team helps ensure that our data is accurately reported to federal agencies and third-party organizations that publish hospital ratings. Maintaining a high rate of exclusions for inaccurately documented complications not only improves patient care but also strengthens the public's perception of our institution.

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: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: November 4, 2024
Subject: Fiscal Year 2024 Core Measure Dashboard

Purpose:

To update the Quality, Patient Care, and Patient Experience Committee on FY 2024 Core Measure Dashboard, Non-Hospital-based Inpatient Psychiatric Services Non-HBIP and Hospital-based Inpatient Psychiatric Services (HBIPS).

Summary: As required under section 1890A(a)(6) of the Social Security Act, Centers for Medicare and Medicaid Services (CMS) assesses the quality and efficiency of care provided to patients through establishing quality standards and programs to improve health care for beneficiaries and all who receive care in the United States. Core measures are designed to be meaningful to patients, consumers, and physicians. CMS uses core measure performance to inform how we are graded in various quality initiatives such as pay for reporting, value-based pay, and public reporting on Care Compare (https://www.medicare.gov/care-compare/) previously known as Hospital Compare.

1. Authority: The Quality, Patient Care, and Patient Experience Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on compliance with CMS measurements of clinical quality.

2. Background: There are no new revisions for FY 2024 by CMS or the Joint Commission (TJC) to the core measures. Some metrics are measured as eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program. Sepsis (SEP-1) Core Measure is reported as its own dashboard. These measures only reflect Inpatient Quality Reporting (IQR) and some Outpatient Quality Reporting (OQR) Program Measures.

3. Assessment: CMS has two sets of Core Measures relevant to El Camino Health acute care: one covers acute hospitals (Non-HBIPS) and the second only applies to acute hospitals with inpatient behavioral health units, which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

A. Non-HBIPS Core Measures (Non**-** Hospital-based Inpatient Psychiatric Services**)**

i. **PC01- Elective Delivery (EED)** Prior to 39 weeks gestation- Percent of mothers with elective vaginal deliveries or elective cesarean births at >=37 and < 39 weeks gestation completed. This measure shows the percentage of pregnant individuals who had elective deliveries 1-2 weeks early (either vaginally or by C-section) whose early deliveries were not medically necessary. Higher numbers may indicate that hospitals aren't doing enough to discourage this unsafe practice. FY2024 ECH Target = <2%, FY 2024 Performance: 2.9% (8/279). Hospital Compare reporting period Q12023-Q42023 PC-01 - ECH 2%; national 3% and state 2%. We are currently in the sustainment phase with this measure.

ii. **PC02- Cesarean Birth**- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of less than 23.9%; FY 2024 Performance is 24.9% (536/2156). Leapfrog is following Healthy People 2020 NTSV cesarean birth rate target of 23.9% and 23.6% or less by 2030. OB Task Force is working to identify where we can make system improvements to reduce unnecessary NTSV. MCH leadership team has worked with independent OBs and OB groups to identify practice patterns and opportunities for improvement. Their data is showing steady progress. The following are actions taken by MCH Service Line:

- Quarterly unblinded data to OBs
- Data distributed to RNs.
- Support for outlier OBs provided
- Implemented CMQCC NTSV checklist
- Provided OB and RN education (positioning)
- Developed class for S. Asian pts (largest population with high rate)
- Bi-weekly interdisciplinary team NTSV case review process

iii. **PC05- Exclusive Breast Milk Feeding**- Newborns that were fed breast milk only since birth during the entire hospitalization. ECH Target goal is >50% (CMQCC 50th percentile). FY 2024 Performance: 75.7% (626/827) which is above TJC's rate of 50%. Below are the actions taken by MCH Service Line, Normal Newborn

- Baby friendly education in MV / received Baby friendly redesignation in LG.
- Continue with the interdisciplinary Baby Friendly Designation process in MV including training of staff and providers, updating the infant feeding policy, and expanding prenatal breastfeeding education. Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, The Ten Steps to Successful Breastfeeding adopt baby friendly 10 steps to successful breastfeeding.
- Refine the banked donor milk for term infants rollout to improve nursing and MD workflow, increasing use of donor milk instead of formula if supplementation needed or requested.

iv. **PC06- Unexpected Complications in Term Newborns**- this measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. ECH Target goal is 0%; FY 2024 Performance: 2.5% (99/3988) compared to TJC's 3%. This measure is not publicly reported yet. The cases that failed the measures are forwarded to peer review for further assessment. All cases of sever UNC are reviewed in detail and changes implemented if opportunities identified.

v. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients**-Median time (in minutes) patients spent in the emergency department before leaving from the visit. ECH Target goal is 168 minutes or less; FY 2024 rate is ENT:162 minutes. Latest Hospital Compare - ECH 169

minutes, California 186 minutes, and National average-163 minutes with reporting period Q12023-Q42023.

vi. **OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke**- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. ECH Target goal is 100%; FY 2024 performance is 25% (2/8). This measure has a very low volume. The number of patients/cases is too few as reported on Medicare Care Compare website. CY24 data (Jan-Jun) 66.7% (4/6) met metric compliance. Total Patient Population: 23 Stroke Observed/ED patients. 17 excluded. Feb follow up: Provider group educated regarding use of CT Stroke order when indicated. Other 17 patient encounters excluded due to: Last Known Well Time Unknown or >120 minutes, Left AMA

B. **HBIPS Core Measures (**Hospital-based Inpatient Psychiatric Services)

i. **IMM-2 Influenza Immunization** - Patients assessed and given influenza vaccination. ECH Target goal is 86.3%; FY 2024 rate is 91.1% (367/403) FY 2024 compliance dropped compared to FY 2023 r/t Influenza vaccine not given-no justification documented. MHAS team is now receiving daily epic emails to notify them of patients who need a vaccination. Latest Hospital Compare - IMM-2 Influenza ECH is 96% California rate 83%; National 77% with reporting period 4Q2022-1Q2023.

ii. **HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification**. RETIRED

iii. **PC-TOB Perfect Care - Tobacco Use**- ECH Target goal is 19.4% FY 2024 rate is 50%. Patients are not receiving all components of practical counseling prior to discharge AND referral for outpatient tobacco cessation counseling not offered at D/C. Quality team began monthly meetings with the MHAS team in November 2023. Great discussion on barriers and challenges they face. There is now a better understanding of requirements for each subsection measure.

iv. **PC-SUB Perfect Care - Substance Abuse**- This measure shows the percentage of patients hospitalized in an inpatient psychiatric facility aged 18 years and older with alcohol or drug use disorder who, when discharged, received or refused medications to treat their alcohol or drug use OR who received or were offered a referral for addiction treatment. ECH Target goal is 55% FY 2024 rate is 61.5%. MHAS team is engaging providers to better understand the measure and the workflow to increase compliance.

v. **TR-1 Transition Record with Specified Elements Received by Discharged Patients.** ECH Target goal is 51.3% FY 2024 rate is 82.8%.

vi. **MET-1 Screening for Metabolic Disorders** - Comprehensive screening currently defined to include: Body mass index, A1C or glucose test, Blood pressure, Lipid panel, Total cholesterol Low density lipoprotein, High density lipoprotein, Triglycerides. ECH Target goal is 64.2%; FY 2024 rate is 95.4%.

vii. **HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours)** lower is better. ECH Target goal is 0.0001; FY 2024 rate is 0.0002.

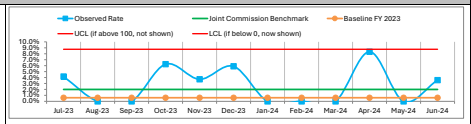
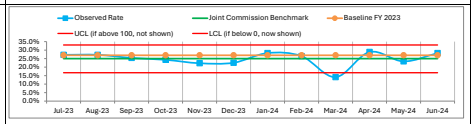
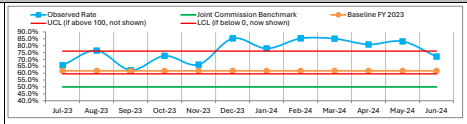
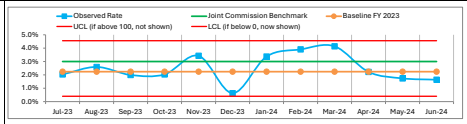
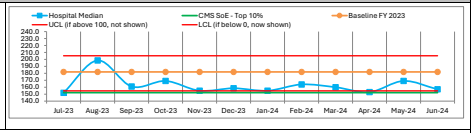
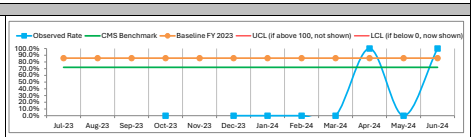
viii. **HBIPS-3 Hours of Seclusion Use (per 1000 patient hours**) lower is better ECH Target goal is 0.0003; FY 2024 rate is 0.0004.

List of Attachments:

- Attachment 1: FY 2024 Core Measure Report Non-HBIPS for GB
- Attachment 2: FY 2024 Core Measure Report HBIPS for GB

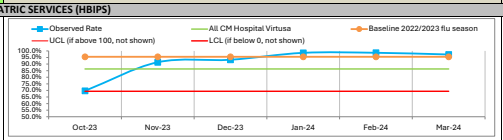
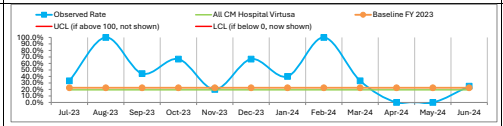
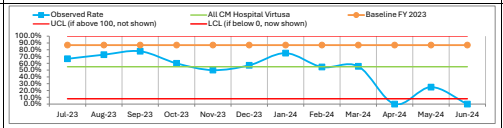
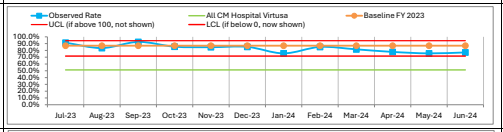
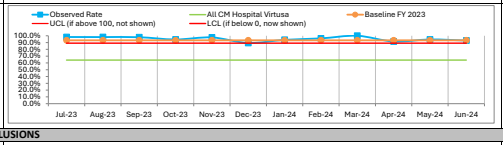
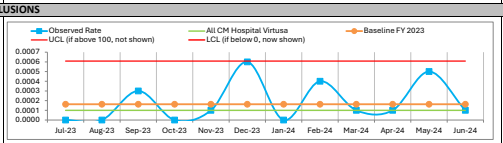
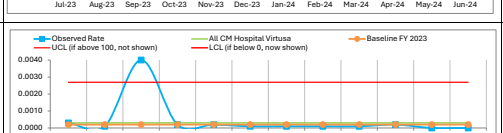
El Camino Health

FY 2024 Performance Core Measures Dashboard (Enterprise, unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2024 Performance	FY 2023 Baseline	Target	Trend Graph	Comments	FY 2024 Definition	Definition Owner	Work Group	Source
PERINATAL CARE MOTHER										
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: June 2024	ENT: 3.6% (1/28) MV: 5.6% (1/18) LG: 0.0% (0/10)	ENT: 2.9% (8/279) MV: 2.6% (6/227) LG: 3.8% (2/52)	ENT: 0.6% (2/330) MV: 0.8% (2/260) LG: 0.0% (0/70)	< 2% (Joint Commission Benchmark)		PC01- Elective Delivery Prior to 39 weeks gestation- Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Also known as Early Elective Delivery (EED) Target goal is 0%; FY 2024 Performance: 2.9% Statistically topped out national 2% and state 2% and was recently removed from Value Based Purchasing Program. MCH has an EED tracking system and reach out to providers to reschedule as needed. EED is tracked and closely monitored to avoid unindicated cases.	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to peer review coordinator	Virtusa CareDiscovery Quality Measures
PC-02 Cesarean Birth (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: June 2024	ENT: 28.2% (46/163) MV: 27.9% (39/140) LG: 30.4% (7/23)	ENT: 24.9% (536/2156) MV: 25.5% (478/1878) LG: 20.9% (58/278)	ENT: 27.0% (595/2207) MV: 28.1% (530/1884) LG: 20.1% (65/323)	< 25% (Joint Commission Benchmark)		PC02- Cesarean Birth- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CY 2024 Performance is 24.9% The providers get their score card generally every quarter so they can see how they are doing along with their peers;OB Task Force has been evaluating where they can make system improvements to reduce unnecessary NTSV.	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Virtusa CareDiscovery Quality Measures
PERINATAL CARE BABIES										
PC-05 Exclusive Breast Milk Feeding **FINALIZED** Data Source : Virtusa Latest Data Month: June 2024	ENT: 72.1% (49/68) MV: 74.5% (41/55) LG: 61.5% (8/13)	ENT: 75.7% (626/827) MV: 75.3% (536/712) LG: 78.3% (90/115)	ENT: 61.7% (514/833) MV: 61.1% (436/714) LG: 65.5% (90/115)	< 50% (Joint Commission Benchmark)		PC05- Exclusive Breast Milk Feeding- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; FY 2024 Performance: 75.7% Our target compliance rate of 70%- this gives us 30% allowance for cases with maternal /infant indicators to supplement with formula feeding. Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration. • Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, The Ten Steps to Successful Breastfeeding adopt baby friendly 10 steps to successful breastfeeding	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	TJC	Quarterly meeting/emails with L&D nursing leadership	Virtusa CareDiscovery Quality Measures
PC-06 Unexpected Complications in Term Newborns (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: June 2024	ENT: 1.6% (5/305) MV: 1.2% (3/252) LG: 3.8% (2/53)	ENT: 2.5% (99/3988) MV: 2.1% (71/3393) LG: 4.7% (28/595)	ENT: 2.2% (91/4062) MV: 2.1% (73/3410) LG: 2.8% (18/652)	< 3% (Joint Commission Benchmark)		PC06- Unexpected Complications in Term Newborns- TJC's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; FY 2024 Performance: 2.5% This measure is intended to track moderate to severe adverse outcomes of healthy infants without pre-existing conditions. Failed cases are referred to peer review coordinators/ nurses for further investigation.	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Virtusa CareDiscovery Quality Measures
ED THROUGHPUT										
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) **FINALIZED** Data Source : Virtusa Latest Data Month: June 2024	ENT: 152.2 Minutes	ENT: 162 Minutes	ENT: 182 Minutes	160 min ECH Goal		OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients-Median time patients spent in the emergency department before leaving from the visit. Target goal is 160 minutes or less; FY 2024 rate is ENT:162 mins	"Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department"	Hospital OQR Specifications Manual		Virtusa CareDiscovery Quality Measures
OUTPATIENT MEASURES										
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke **FINALIZED** Data Source : Virtusa Latest Data Month: June 2024	ENT: 100.0% (1/1) MV: 100.0% (1/1) LG: - no cases	ENT: 25.0% (2/8) MV: 25.0% (2/8) LG: - no cases	ENT: 85.7% (6/7) MV: 100.0% (5/5) LG: 50.0% (1/2)	100% (CMS Standard of Excellence - Top 10% of Hospitals)		OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival.Target goal is 100%; FY 2024 25.0% The metric only includes patients who arrive within 2 hours of last known well explaining the low denominator . Currently, we are a Thrombectomy-capable Stroke Center in MV and Primary Stroke Center in LG so we continue to transfer certain cases to align with insurance and/or for higher level of care (primarily SAH cases in MV, and possible thrombectomy cases in LG.)	Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)	Virtusa CareDiscovery Quality Measures

El Camino Health

FY 2024 Performance - Core Measures (HBIPS) - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2024 Performance	FY 2023 Baseline	All Core Measures Hospitals FY 2024 Benchmark	Trend Graph	Comments	FY 2024 Definition	Definition Owner	Work Group	Source
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)										
IMM-2 Influenza Immunization FINALIZED *Data Source : Virtusa* *Latest Data Month: March 2024* ***Data only captured for: Jan-Mar, Oct-Dec months***	97.3% (72/74)	91.1% (367/403)	95.5% (429/449) (2022/2023 flu season)	86.3%		IMM-2 Influenza Immunization Patients assessed and given influenza vaccination. Target goal is 100%; FY 2024 rate is 91.1%	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	CMS/TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures
PC-TOB Perfect Care - Tobacco Use FINALIZED *Data Source : Virtusa* *Latest Data Month: June 2024*	25% (1/4)	50% (23/46)	23% (14/62)	19.4%		PC-TOB Perfect Care - Tobacco Use-Target goal FY 2024 19.4% rate is 50% Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of FDA approved tobacco cessation drugs while inpatient and upon discharge. . Daily monitoring to identify current tobacco users to ensure proper interventions are implemented- quality collaborating with MHAS asst. clinical managers and hospital supervisors.	No tob 1 , same Tob 2 and 3	TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures
PC-SUB Perfect Care - Substance Abuse FINALIZED *Data Source : Virtusa* *Latest Data Month: June 2024*	- (0/0)	61.5% (59/96)	86.8% (112/129)	55.0%		PC-SUB Perfect Care - Substance Abuse- Target goal FY 2024 IS 55%, rate is 61.5%	No Sub 1, same SUB 2 and 3	TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures
TR-1 Transition Record with Specified Elements Received by Discharged Patients FINALIZED Data Source : Virtusa Latest Data Month: June 2024	77% (57/74)	82.8% (735/888)	87% (760/874)	51.3%		TR-1 Transition Record with Specified Elements Received by Discharged Patients Target goal is FY 2024 IS 51.3%, rate is 82.8%	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	CMS/TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures
MET-1 Screening for Metabolic Disorders FINALIZED Data Source : Virtusa Latest Data Month: July 2024	93% (53/57)	95.4% (597/626)	93.3% (558/598)	64.2%		MET-1 Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal FY 2024 IS 64.2% rate is 95.4%	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	CMS/TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures
RESTRAINTS AND SECLUSIONS										
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower = better) FINALIZED Data Source : Virtusa Latest Data Month: June 2024 *Event measures are calculated by event occurrence date	0.0001	0.0002	0.0002	0.0001		HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours) Target goal is 0.0001; FY 2024 rate is 0.0002	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower = better) FINALIZED Data Source : Virtusa Latest Data Month: June 2024 *Event measures are calculated by event occurrence date	0.0000	0.0004	0.0002	0.0003		HBIPS-3 Hours of Seclusion Use (per 1000 patient hours) Target goal is 0.0003; FY 2024 rate is 0.0003	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	TJC	quarterly meeting/email to BHS team	Virtusa CareDiscovery Quality Measures

EL CAMINO HOSPITAL
QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
RESOLUTION 2024-01
APPOINTMENT OF SPECIAL ADVISORY COMMITTEE FOR LIMITED PURPOSE AND LIMITED DURATION

WHEREAS, the El Camino Hospital Quality, Patient Care, and Patient Experience Committee (the "QC") has determined it is necessary to carefully consider and make recommendations regarding recruitment of one or more community members to the QC; and

WHEREAS, such work can be undertaken by an ad hoc temporary advisory committee for presentation to and consideration by the QC at a future meeting.

NOW, THEREFORE, BE IT RESOLVED, that an ad hoc temporary advisory committee (the "QC Recruitment Ad Hoc Committee"), consisting of three members of the QC is hereby established pursuant to Article VII, Section 7.6 of the Bylaws of the El Camino Hospital and paragraph 3 of the QC Charter, to carefully consider and make recommendations regarding the recruitment of one or more community members to the QC; and

BE IT FURTHER RESOLVED, that the members of the QC Recruitment Ad Hoc Committee shall determine the time, place, date, and frequency of such committee meetings; and

BE IT FURTHER RESOLVED, that _____ is appointed as Chair of the QC Recruitment Ad Hoc Committee; and

BE IT FURTHER RESOLVED, that _____ and _____ are appointed as members of the QC Recruitment Ad Hoc Committee.

DULY PASSED AND ADOPTED at a regular meeting of the QC held on November 4, 2024, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
Carol Somersille, MD, Chair
El Camino Hospital Quality, Patient Care, and
Patient Experience Committee

Corporate Integrity Agreements (CIA) in Healthcare - Focus on Quality-of-Care CIA

Quality, Patient Care, And Patient Experience Committee

Krutica Sharma, MD, Committee Member

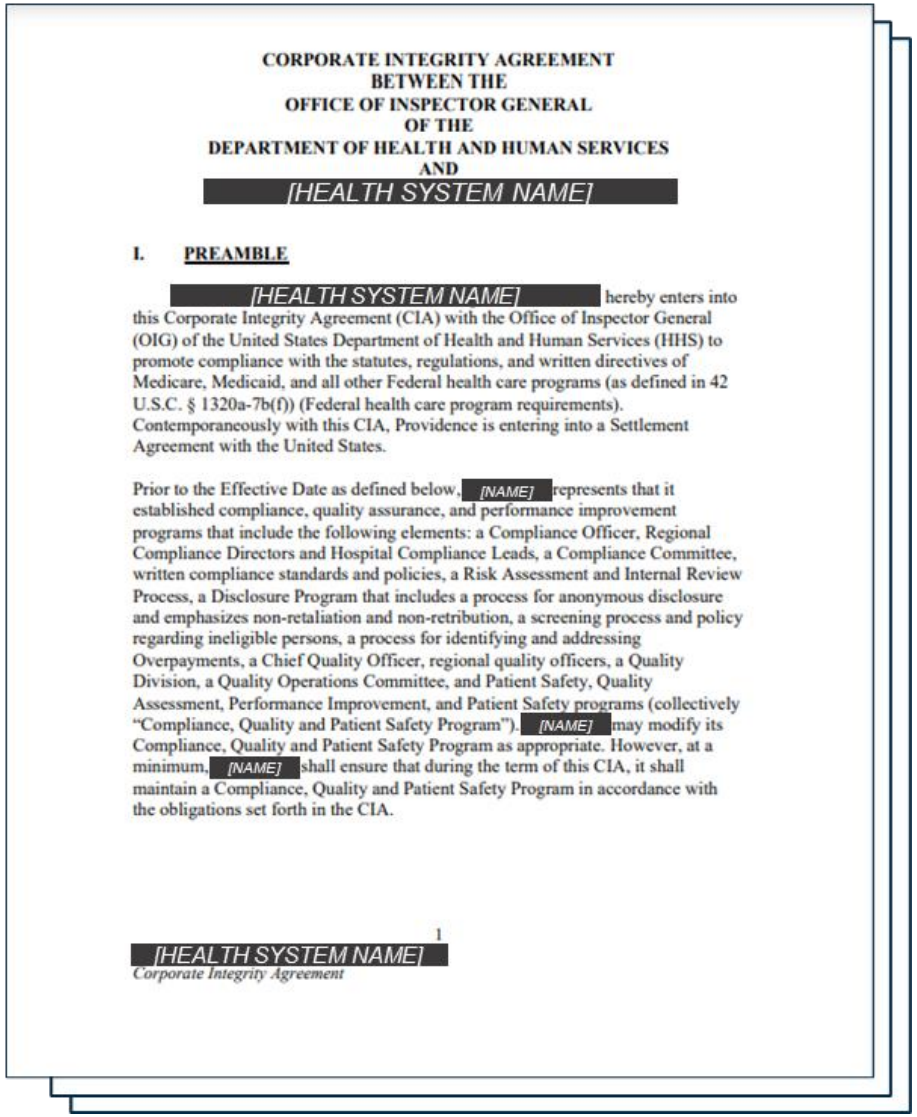
November 4th, 2024

Before We Dive In…

Fidelity with acronyms/initialisms!

El Camino Health

What is a CIA? Why does it occur?



CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
[HEALTH SYSTEM NAME]

I. PREAMBLE

[HEALTH SYSTEM NAME] hereby enters into this Corporate Integrity Agreement (CIA) with the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) (Federal health care program requirements). Contemporaneously with this CIA, Providence is entering into a Settlement Agreement with the United States.

Prior to the Effective Date as defined below, [NAME] represents that it established compliance, quality assurance, and performance improvement programs that include the following elements: a Compliance Officer, Regional Compliance Directors and Hospital Compliance Leads, a Compliance Committee, written compliance standards and policies, a Risk Assessment and Internal Review Process, a Disclosure Program that includes a process for anonymous disclosure and emphasizes non-retaliation and non-retribution, a screening process and policy regarding ineligible persons, a process for identifying and addressing Overpayments, a Chief Quality Officer, regional quality officers, a Quality Division, a Quality Operations Committee, and Patient Safety, Quality Assessment, Performance Improvement, and Patient Safety programs (collectively "Compliance, Quality and Patient Safety Program"). [NAME] may modify its Compliance, Quality and Patient Safety Program as appropriate. However, at a minimum, [NAME] shall ensure that during the term of this CIA, it shall maintain a Compliance, Quality and Patient Safety Program in accordance with the obligations set forth in the CIA.

1
[HEALTH SYSTEM NAME]
Corporate Integrity Agreement

- A Corporate Integrity Agreement (CIA) is typically a five-year agreement entered into by an entity as part of a settlement with the DOJ. The oversight of the CIA is conducted by the Office of the Inspector General.

CIAs are an effective enforcement tool used by the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), and the Department of Justice (DOJ) to fight healthcare **fraud, waste, and abuse.**

OIG negotiates corporate integrity agreements (CIA) with healthcare providers and other entities as part of the **settlement of Federal health care program investigations** arising under a variety of **civil false claims statutes**.

Providers or entities agree to the obligations, and in exchange, OIG agrees not to seek their **exclusion from participation** in Medicare, Medicaid, or other Federal health care programs.

El Camino Health

Types of CIAs

- CIAs require the covered entity to be monitored by either an Independent Review Organization (IRO) or Quality Review Organization (QRO) depending on the details of the settlement. Both the IRO and QRO must pass the independence test.

Independent Review Organization (IRO)

- Can be selected by the entity
- Must be accepted by the OIG
- Scope focused on billing review and medical necessity reviews
- In some instances, an IRO may conduct a more in-depth systems review

Quality Review Organization (QRO)

- Selected by the OIG
- Scope focused on Board and Governance, Executive Leadership, Medical Staff Infrastructure and Oversight, Quality/Safety Function and QAPI, Clinical Care
- More involved with the covered entity than an IRO and functions as a hybrid monitor / advisor

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Quality of Care CIAs

- The OIG has utilized CIAs as an enforcement tool since 1994. While CIAs are fairly common, Quality of Care CIAs are less common and typically used in Post-Acute Facilities; Quality CIAs involving hospitals / health systems are very rare.

Examples of Hospitals & Health Systems with History of Quality CIA:

Tenet Health	Tenet Healthcare, Co. - 2003
Parkland	Parkland Health and Hospital System - 2013
UHS	Universal Health Services, Inc. - 2020
Providence	Providence Health System - 2022

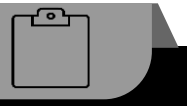
Common Elements of a Quality CIA

- *CIAs have certain common elements, but each one is tailored to address the specific facts of the case and may incorporate elements of a preexisting Quality program.*

A Quality CIA typically lasts five years.

Common elements include:

- Designate a Chief Quality Officer under the CIA responsible for oversight of quality, physician credentialing and peer review, and utilization management
- Establish CIA Governance and Operations Committees to provide oversight for Quality of Care and CIA Compliance
- Implement standards of conduct and comprehensive policies and procedures focused on Quality and Safety
- Implement a comprehensive Quality and Safety focused training program for all employees, medical staff, contractors, and governing members
- Retain a Quality Review Organization to conduct clinical quality systems and monitor quality and safety events and handling of the same
- Establish a process to identify and investigate Reportable Quality Events
- Report overpayments, Reportable Events, and ongoing investigations / legal proceedings
- Submit annual reports to OIG on status of the entity's Quality activities and compliance with the requirements of the CIA, including Board resolution and Management certifications



Surveyor

- Typically represents regulatory/licensing bodies – CMS, DOH, TJC, DNV
- Assesses the entity as snapshots in time via on-site survey – periodic or complaint based
- Generally, provides a summary of findings only

VS.

QRO

- Selected by the OIG
- More involved with the covered entity than an IRO. Functions as a hybrid monitor/advisor.
- Assesses the entity on a rolling basis through a five-year term typically

El Camino Health

QRO Responsibilities under a Quality CIA

Effectiveness, reliability, and thoroughness of the entities' **Quality Management Infrastructure and Systems**[1]

The health systems' efforts to achieve **compliance** with its Clinical Quality P&Ps, Medicare CoPs, and other standards of patient care services

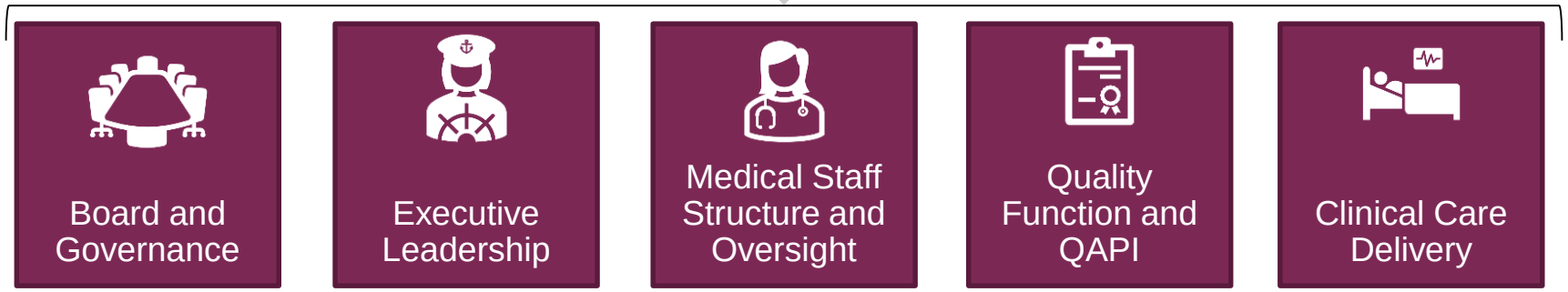
The health systems' **proactive** efforts to ensure each patient receives care in accordance with **recognized standards** of healthcare

The health systems' response to **quality-of-care issues**[1]

The health systems' processes for identification and response to **Reportable Quality Events (RQEs)**

Additionally, the QRO is required to submit an annual report to the OIG with the QRO's findings and recommendations based on the Clinical Quality Systems Review

To fulfill this role the QRO evaluates the effectiveness of:



El Camino Health

Evaluation of Systems Effectiveness

Evaluation of quality management infrastructure includes but is not limited to an assessment of:

1. The accuracy of the entity's internal reports, data, and assessments required by the Clinical Quality Policies and Procedures
2. The entity's ability to analyze outcome measures and other data
3. The extent to which reviews under The entity's Quality of Care and Patient Safety Program and other reviews are occurring to identify and address quality management issues at Providence;
4. The entity's compliance with the Clinical Quality Training requirements, Clinical Quality Policies and Procedures, and performance standards of Section III.B of the CIA;
5. The extent to which the entity's Clinical Quality Training program is effective, thorough, and competency-based;
6. The extent to which the entity's communication systems are effective and results of decisions are transmitted to the proper individuals in a timely fashion;
7. The extent to which the entity has implemented an effective Quality of Care and Patient Safety Program as required under Section III.A.5 of this CIA
8. The extent to which the entity's credentialing and privileging process is effective and thorough;
9. The extent to which the entity monitors practitioners with current privileges by the review of clinical practice patterns, ongoing case review, proctoring, and discussion with other individuals involved in the care of patients; and
10. The entity's implementation and monitoring of medical staff peer review.

Evaluation of response to quality of care issues, including an assessment of:

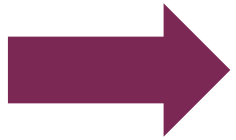
1. The entity's ability to identify the problem;
2. The entity's ability to determine the scope of the problem (e.g., systemic or isolated);
3. The entity's ability to conduct a root cause analysis;
4. The entity's ability to create a corrective action plan to respond to the problem;
5. The entity's ability to execute the corrective action plan;
6. The entity's ability to operate in a timely and effective manner; and
7. The entity's ability to monitor and evaluate whether the assessment, corrective action plan, and execution of that plan were effective, reliable, thorough, and maintained.

High Level Summary of QRO's Activities

The QRO role requires ongoing knowledge of the healthcare systems' quality systems and mechanisms for identifying and investigating adverse safety events.

In order to conduct the Quality Systems Review, a typical workplan includes:

- Attendance at key Quality, Patient Safety, Medical Staff, and Committee meetings
- Review of key quality and patient safety data and metrics on a regular basis
- Onsite observations, audits, and interviews focused on 1) Governance, 2) Executive Leadership, 3) Quality Management Infrastructure, 4) Medical Staff Oversight, and 5) Clinical Quality
- Observe adverse event investigation meetings, including RCAs/ACAs
- Review all Reportable Quality Events (RQE) notifications and any plans of correction
- Regularly meet with key Quality and Patient Safety, Compliance and Risk, Medical Staff, and Executive leadership, and members of the governing bodies



Provide an annual report to the OIG and client that includes a full analysis of our findings and prudent recommendations for improving clinical care delivery and oversight as required under the CIA.

Questions/Discussion

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: November 4, 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:

1. Situation: This patient was transferred to a Skilled Nursing Facility (SNF) from the hospital and the patient was unhappy because all the necessary information from the inpatient stay was not transferred to the SNF.

2. Authority: To provide insight into the experience our patients and families have while being provided care at El Camino Health.

3. Background: This patient's post-acute provider did not receive the accurate medication list from the hospital when transferred to the SNF. Transfer of the medication list is completed through the orders written by the physicians through the electronic health record. If the medication list is not correct, the SNF will not have the medications prepared for the patient transferring into the facility.

4. Assessment: If not checked carefully, the medication list transferred to the SNF may be inaccurate. Hospitalists most often prepare the medication list that is transferred electronically to the SNF. The process can be complicated and with new hospitalists onboard, the hospital will review the process with the new hospitalists to ensure they know the process. In addition, the SNF physicians are allowed to join the Epic Secure Chat Platform so there is easy access to our hospitalist physicians for questions regarding follow up treatment including medication prescribing changes.

5. Other Reviews: None

6. Outcomes: While the ECH social worker, Gabby was able to assist the patient to get an accurate medication list at the SNF, the patient left the hospital with a negative opinion of the discharge process. We believe the new communication avenue will assist in direct communication between the ECH physicians and the SNF physicians.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What process is used to transfer the information between the hospital and SNF?

2. Who checks the information to assure it is correct?

Patient Story

“Discharge procedures given to patients is not very thorough compared to other hospital. For example, medication lists were not transferred to nursing facilities (May 2024). Some medications are very critical to patients & must be taken Immediately. However, pharmacy was not prepared there due to lack of communication from hospital. Fortunately, Social worker Gabby was extremely helpful and caring. With her guidance, able to navigate the difficult situations after discharge to nursing facility (May 2024). Gabby was our life saver & the best.”

El Camino Health

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CAO
Date: November 4th, 2024
Subject: FY-24 Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): The Safety Committee and the Emergency Management Committee of the Hospital recommend that the Board Quality Committee approve the Annual Report, Evaluation of the Environment of Care & Emergency Management for FY-24.

Summary:

1. Situation: The management of the environment of care, the safety program with all its elements and the emergency management plan produced mixed results in FY-25. Results include:

   a) **Employee Safety:** The rate of OSHA Recordable Injuries decreased 15% in 2023, however they have increased 35% in 2024. The lost work time rate decreased 50% in 2023 but increased 17% in 2024. These rate increases from the prior year were due to an increased number of Patient Lift Transfer Injuries, and Bloodborne Pathogen Exposures. Note however that we remain below national and state rates for OSHA Recordable Injuries. Improvement strategies have been implemented to reduce the number of injuries.

   b) **Security:** The number of OSHA reportable Workplace Violence incidents increased 45% from the prior year with a total of 45 WPV incidents in 2024. The increase was due in large part to confused and dementia patients acting out.

   c) **Hazardous Materials:** There were no Reportable Hazardous Material Incidents or Wastewater Discharge violations.

   d) **Fire Safety:** There were no Fire Incidents at any El Camino Health facilities in FY-24.

   e) **Medical Equipment:** The planned maintenance for high-risk medical equipment was maintained at 99.42% completion rates, a slight improvement over the prior year.

   f) **Utilities: There** were four PG&E electrical power outages during FY-24, two in Los Gatos and two in Mountain View. This is a reduction from the prior year which had nine power outages. All emergency power systems functioned as designed and there were no negative outcomes.

   g) **Emergency Management:** There were no incidents during FY-24 that prompted the activation of the Command Center and activation of the HICS (Hospital Incident Command System) protocols. However, the organization did participate in three Drills which provided valuable training and education for our emergency preparedness.

1. Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.

2. Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

3. Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement.

4. Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.

5. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-24.

List of Attachments:

1. Full Report – FY-24 Evaluation of the Environment of Care & Emergency Management

Fiscal Year 2024 Evaluation of the Environment of Care And Emergency Management

Prepared by:

Matt Scannell
Director, Safety and Security

Bryan Plett
Manager, Environmental Health and Safety

Created: 09/13/2024

Table of Contents

Program Overview

The Joint Commission standards provide the framework for the Safety Program for managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer (Ken King Chief Administrative Officer) develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing, Safety / Security and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends. The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for the Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2024. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

Executive Summary

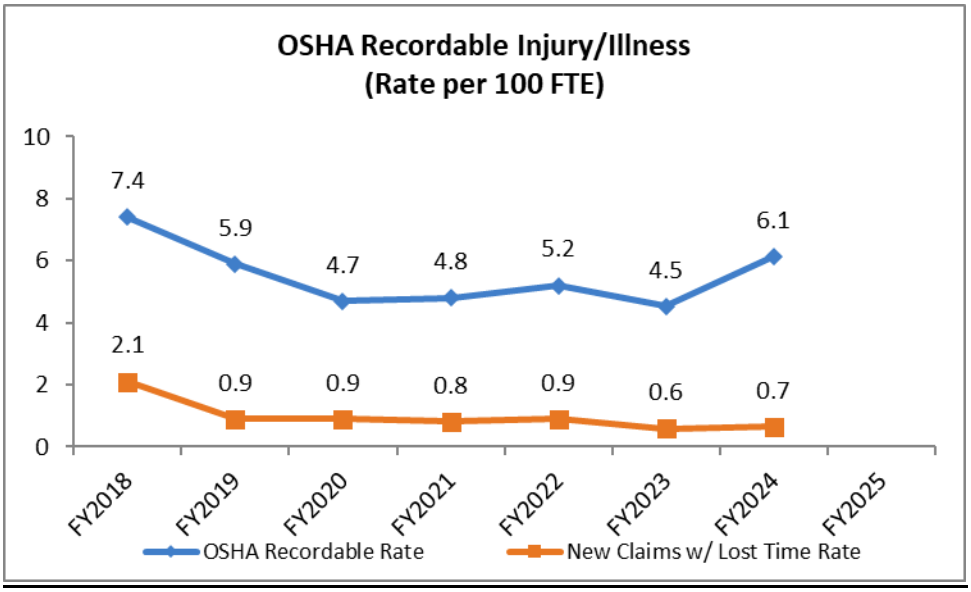
Safety Management

Performance

Performance indicators offer the opportunity to objectively assess areas of focus and identify potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-24. This includes data from both the Mountain View and Los Gatos campuses.

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 Full Time Equivalent employees (FTE) increased in FY-24 to 6.1 as compared to 4.5 in FY-23. The change is directly attributed to increased reporting of injuries that do not involve lost time or job transfer. Contributing factors to this increase include increased departmental outreach and education at Tier 1 daily huddles, Management Team attention and sharing lessons learned at Enterprise Huddle, and a focus on prompt employee reporting of bloodborne pathogen exposures (needlesticks). The rate of claims with lost time per 100 FTE remained stable at 0.7 in FY-24 compared to 0.6 in FY-23. Thus, although overall injury reporting is increasing, injuries of consequence remain stable.



Analysis

- In FY-24, the rate of OSHA recordable injuries increased 35% compared to FY-23 and the loss time rate observed an absolute increase of 0.1 (17%) compared to FY-23.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were strains and sprains at 42%, blood and bodily fluid exposures (e.g. needlesticks and other exposures to blood) at 20%, and contusions

at 16%. There were 12 (6%) Cal/OSHA recordable injuries due to patient agitation (e.g. workplace violence).

- In FY-24 bloodborne pathogen exposures due to needle sticks increased to 28 injuries compared to 22 injuries in FY-23. An overall increase in exposures such as splashes of bodily fluids to the eyes was noted. Improvement strategies will be explained in the bloodborne pathogen exposures section below.

Effectiveness

Key indicators were identified to establish goals for FY-24 with opportunities to improve Safety Management within the Environment of Care.

FY 24 Goals

1) Reduce employee bloodborne pathogen exposures.

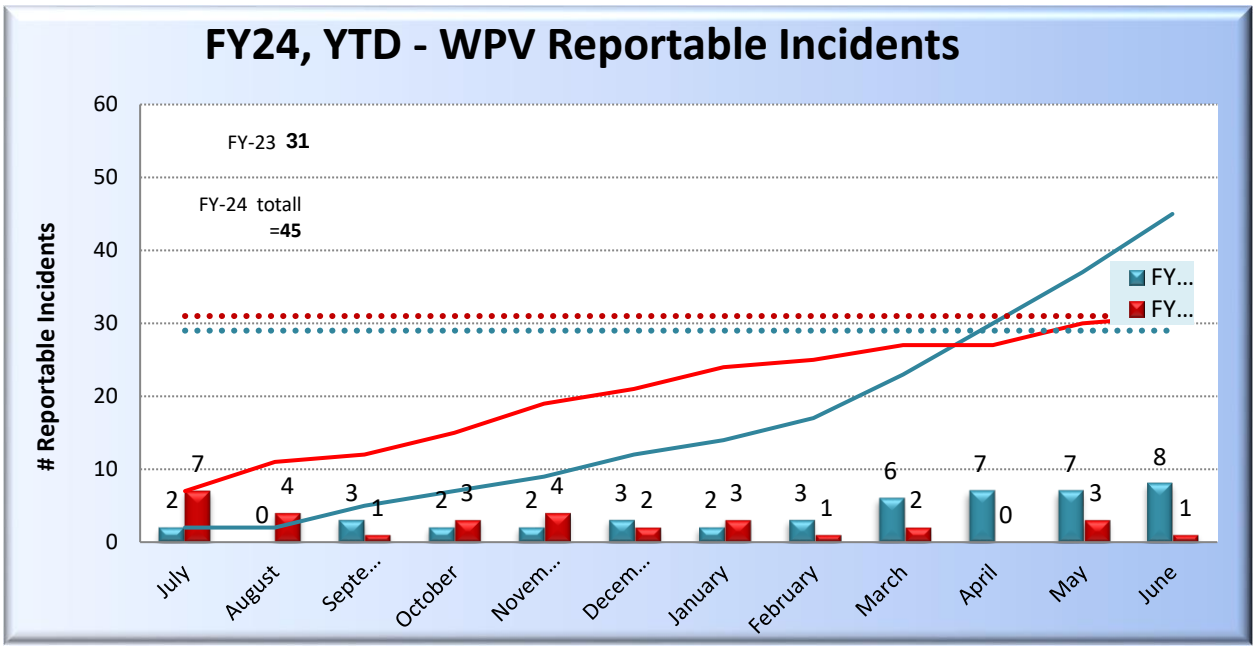
EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Decrease the rate of bloodborne pathogen exposures from 1.20 to 1.08	EWHS /EH&S	**Goal not met.** Rate increased to 2.7 in FY-24 compared to 1.2 in FY-23.

- **Measurement of success**: This goal was not met. Organization incidence of bloodborne pathogen exposures returned to increased levels observed prior to FY-20. In response, EWHS initiated:
  - Joining tier 1 huddles across the enterprise emphasizing the importance of BBPE prevention to meet employees where they are at the start of their shifts.
  - Established focus departments for further training or intervention when observed rates exceeded historical data norms.
  - Analyzed patterns of injuries to partner with Clinical Education in targeted prevention education efforts.
  - Examined ways to improve employee safety such as partnering with clinical leadership, Supply Chain Management, and Security to examine eyewash station placement for future enterprise-wide rollout for facial splash exposures to blood, bodily fluids, and other hazards.

Security Management

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY24. The data includes activity from both campuses.



Review of the FY24 WPV incidents showed:

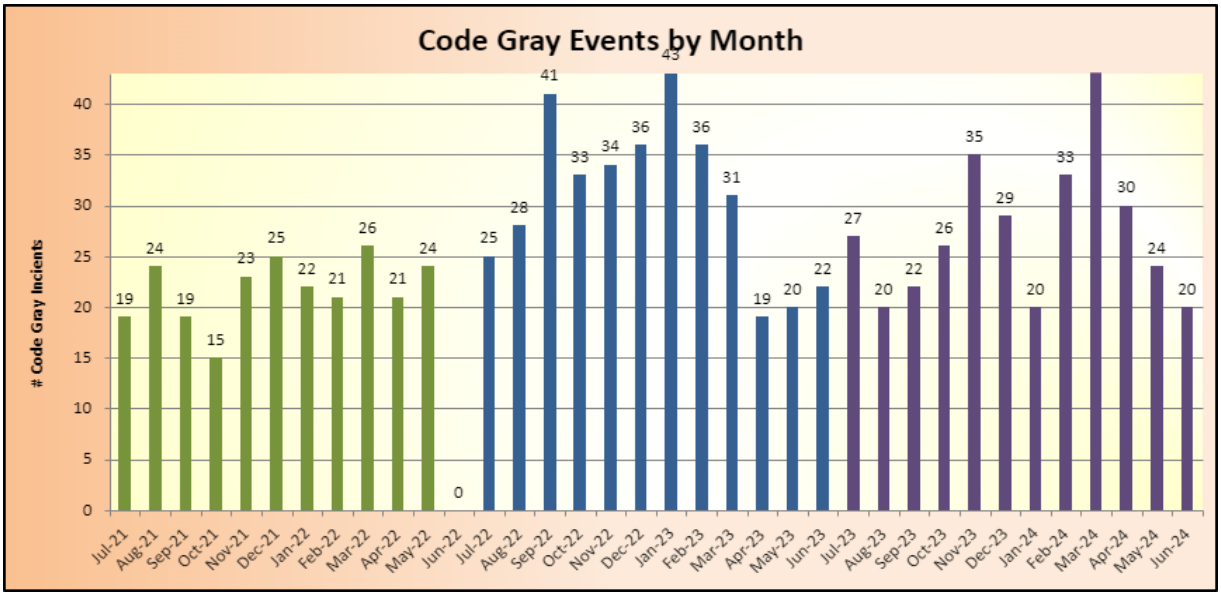
There were 45 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 24. This is a 45% increase from FY23.

- Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:

1. **A significant increase in the number of WPV events related to confused or dementia patients.**
2. **A moderate increase in the number of WPV events related to behavioral health patients.**

- **Code Gray Responses:**

  Code Gray responses decreased (11%) in both MV and LG. The total number of incidents in FY24 was 327 compared to 368 in FY23. The decrease in code greys is largely due to the implementation of the CALM (Collaborative Aid through Listening and Motivation) team in M.V. and the activation of the portable panic button program in Los Gatos in March 2024.



Effectiveness

Key performance indicators were identified in FY24 to improve Security Management within the Environment of Care.

1) 5% reduction in number of reportable workplace violence incidents- In FY24 there was a 45% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

This goal was not met.

2. 10 % reduction in the number of Code Greys over FY 2023. In FY 24 there were a total of 327 code greys. This is a 11% reduction in the number of code greys.

This goal was met.

Hazardous Material Management

Effectiveness

- In FY 24 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation compliance:
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors

- Monthly Safety Rounds that include observation of waste segregation practices
- Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.
- Working with Outside vendor on Code Orange Response process and procedures.
- Regular Hazardous Materials Work Group Meetings with the goal for discussion with high risk hazardous materials and waste departments.

FY-24 Goals:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
   - Measurement of success :> 95%. **This goal was accomplished.**
2. Staff can describe the process for accessing a safety data sheet.
   - Measurement of Success: >95%. This goal was accomplished.

Fire Safety Management

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY24.

A. Fire Incidents

There was no fire incident in Mountain View or Los Gatos in FY24.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated for potential opportunities for improvement.

The total number of events in FY24 (47) was slightly higher than FY23 (45). There were 45 events in Mountain View and 2 in Los Gatos. This increase was mostly related to significant construction activities at both hospitals during FY24.

D. Effectiveness

Based on opportunities for improvement identified in the FY23 annual EOC evaluation the FY24 performance improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY25 due to staff performance in FY24.

Medical Equipment

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-24.

A. Reports to the FDA –

There were 6? reports through the Medwatch[1] system in FY-24. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 93% for FY-24. A 6% improvement from FY-23. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought up the completion rate to 96%.
- All high risk, life safety equipment was maintained at 98.99% completion rate. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.42%. Only two devices(external pacemakers) could not be located for 100% completed maintenance.

C. Product Recalls Percentage Closed / Received

For FY-24, there were 465 recorded equipment recalls: 44 still open.

Effectiveness

[1] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

FY24 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

Raise the percentage of the total database completed that is currently at 96.77% to 98%. This will confirm that 98% of all inventoried medical devices received a completed maintenance within the last 12 months.

Goal was met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 98.82%.

Reduce open ECRI recall/alerts by 80%. Currently at 331 open ECRI alerts.

Goal was not met. Reduced all ECRI alert/recalls by 75% or 88 open ECRI alerts.

Utility Systems

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-24.

A. Utility Reportable Incidents

There were four incidents in FY-24. All were electrical outages or voltage fluctuations.

- Los Gatos had a temporary loss of electrical utility to the campus on February 4th, 2024, at 05:00. Los Gatos experienced a power fluctuation that tripped the breaker to the MRI trailer. There was no impact to patient safety related to this event. On April 15th, 2024, the Los Gatos Rehabilitation building loss PG&E supplied power at 18:15 due to an offsite power disruption. This outage lasted until 19:10. The emergency generator number 3 which supplies the Rehabilitation building supplied emergency power for 55 minutes. There was no impact to patient safety related to this event.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates,2/4/24, 2/9/24. These events were weather related disruptions, and the emergency generators ran and functioned as designed:

Effectiveness

Key indicators were targeted to establish goals for FY-24. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**88% Goal was not met**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**93%- Goal was met**

Note: Data is collected through fire drills and environment of care rounds.

Emergency Management

Performance

- Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant, events are presented to the Central Safety Committee for their review. The following Emergency Management indicators were reported in FY24.

A. Activation of Hospital Incident Command System (HICS)

- There were no recorded events and/or emergencies during FY24 requiring activation of HICS and opening of the Hospital Command Center (HCC).
- **FY24 Goals**

1. Expand the use of the El Camino Health mass notification system (Everbridge) to all employees (continued from FY23)
    - **Measurement of Success**
    - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
    - Evaluate and set up logical groups and rules for notifications. **In progress**
    - Train key staff to be able to use/send alerts.
    - **This *goal was accomplished.***
    - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
    - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
    - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
2. Implement additional layers of communication redundancy to include:
    - **Measurement of Success**

- Transition cellular service from AT&T to FirstNet which allows for the use of deployable satellite assets during a communication failure.
- Train and provide resources to an internal amateur radio team.
    - **This *goal was accomplished.***
- Partnered with Supply Chain to create a contract with FirstNet and ensure a smooth transition of services.
- Hosted several internal and community wide amateur radio certification and licensure courses in M.V. and L.G.

EC 1.0 - Safety Management

Work Group Chair: ***Michael Rea***

Scope

Safety Management is the responsibility of health system leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

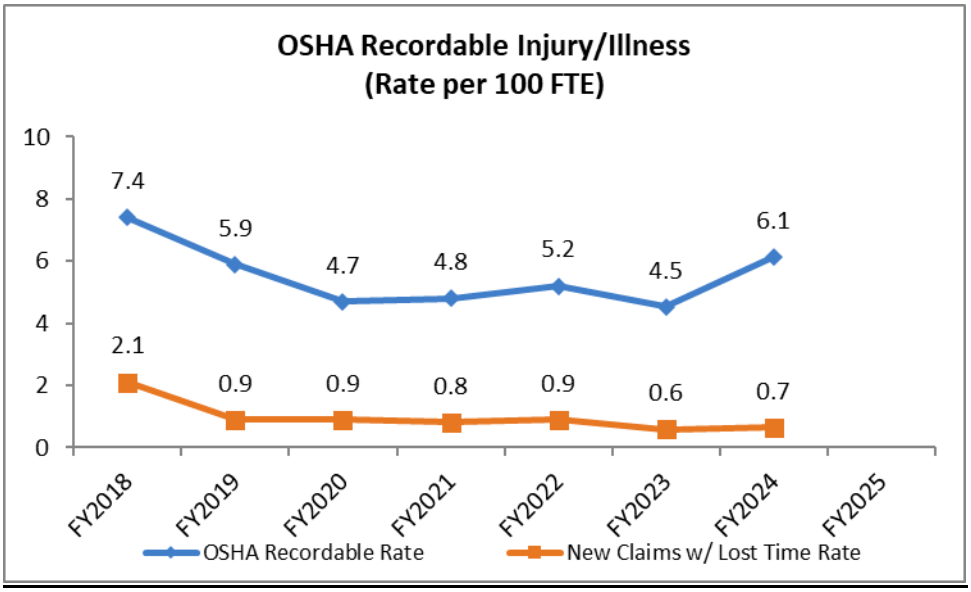
- Employee Wellness & Health Services
    - Education Services
    - Quality and Patient Safety
    - Infection Prevention
    - Security Management
    - Environmental Services
    - Facilities Services
    - Patient Care Services
    - Human Resources
    - Radiation Safety

Performance

Performance indicators offer the opportunity to objectively assess areas of focus and identify potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-24. This includes data from both the Mountain View and Los Gatos campuses.

B. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 Full Time Equivalent employees (FTE) increased in FY-24 to 6.1 as compared to 4.5 in FY-23. The change is directly attributed to increased reporting of injuries that do not involve lost time or job transfer. Contributing factors to this increase include increased departmental outreach and education at Tier 1 daily huddles, Management Team attention and sharing lessons learned at Enterprise Huddle, and a focus on prompt employee reporting of bloodborne pathogen exposures (needlesticks). The rate of claims with lost time per 100 FTE remained stable at 0.7 in FY-24 compared to 0.6 in FY-23. Thus, although overall injury reporting is increasing, injuries of consequence remain stable.



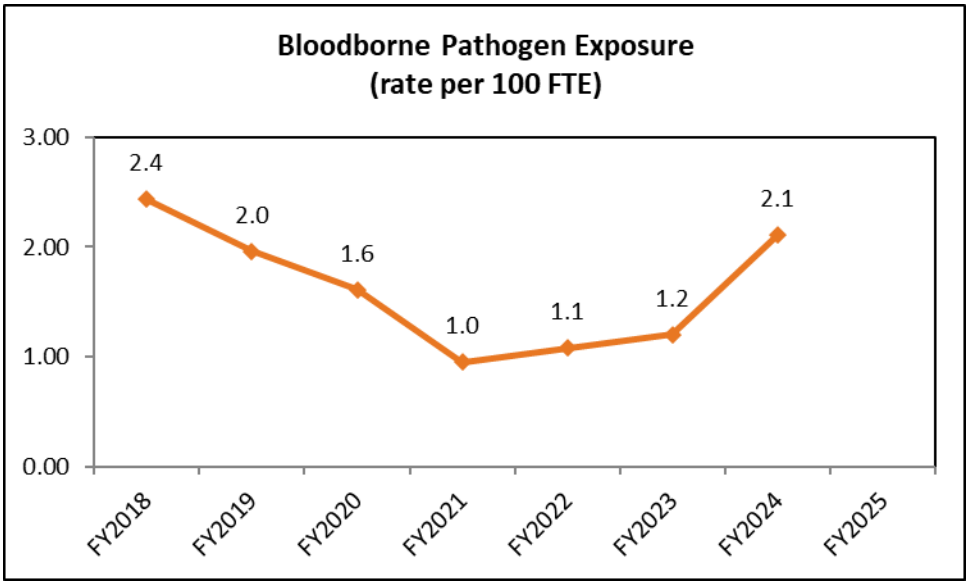
The lost workday rate for reported injuries (per 100 FTEs) increased to 0.7 in FY-24 compared to 0.6 in FY-23.

Analysis

- In FY-24, the rate of OSHA recordable injuries increased 35% compared to FY-23 and the loss time rate observed an absolute increase of 0.1 (17%) compared to FY-23.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were strains and sprains at 42%, blood and bodily fluid exposures (e.g. needlesticks and other exposures to blood) at 20%, and contusions at 16%. There were 12 (6%) Cal/OSHA recordable injuries due to patient agitation (e.g. workplace violence).
- In FY-24 bloodborne pathogen exposures due to needle sticks increased to 28 injuries compared to 22 injuries in FY-23. An overall increase in exposures such as splashes of bodily fluids to the eyes was noted. Improvement strategies will be explained in the bloodborne pathogen exposures section below.

Improvement Strategies:

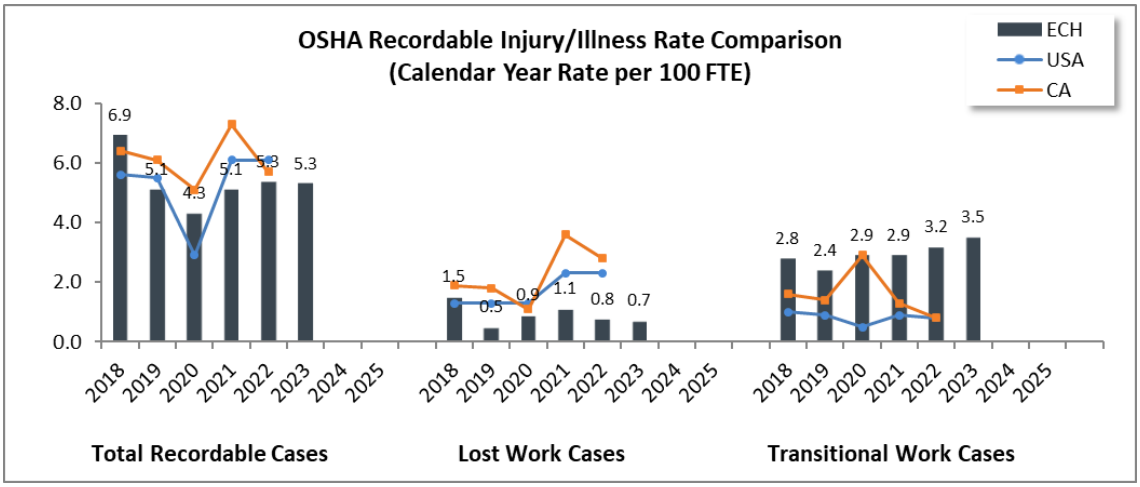
The OSHA recordable rate of bloodborne pathogen exposures increased in FY 24 returning to before COVID-19 pandemic incidence levels. That is, the improvement observed in FY 21, FY 22, and FY 23 was not sustained. More information is contained in the bloodborne pathogen exposure section below.



Slips, trips, and falls among employees continued the overall net decrease in FY 24 compared to the baseline period in FY 17. More information is contained in the slips, trips, and falls section below.

C. OSHA Recordable Injury/Illness Rates as Compared to US & CA Hospitals

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[2].



The ECH injury/illness rate in ***calendar year 2023*** was 5.3, which is comparable to the California state and national averages in 2022 (6.1 and 5.7, respectively where 2022 is the most recent year available from the BLS). The ECH lost work cases rate was 0.7,

[2]The BLS data is calculated by calendar year. 2022 is the most recent calendar year of injury and illness data available as of August 20, 2024.

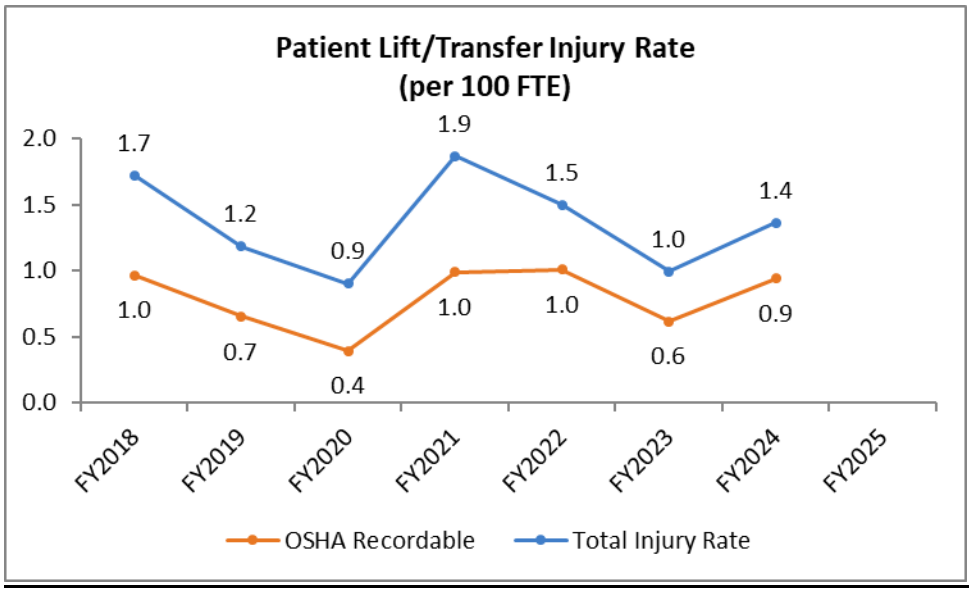
which is below both the state and national average. The lower rate in lost time incidents is due to overall prevention efforts departmental outreach.

El Camino Health's robust Transitional Work Assignment Program shows a commitment to keeping employees safely working and engaged through an injury or illness. This innovative program accounts for the nearly three-fold increase in transitional work cases (3.5) relative to the state and national rates of Cases with job transfer or restriction (0.8 and 0.8, respectively).

D. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **increased in FY-24, from 0.6 in FY-23 to 0.9 in FY-24.**
- **Total Injuries**: The overall number of SPHM injuries (42) and those that are OSHA recordable (29) represent an increase compared to FY 23 but still within program performance norms observed since FY 18.



SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 18-21)

SPHM Injuries	2017	2018	2019	2020	2021	2022	2023	2024
Total Reported	44	41	29	23	50	37	29	42
OSHA-recordable	29	23	16	10	26	28	18	29
% OSHA	66%	56%	55%	43%	52%	76%	62%	69%

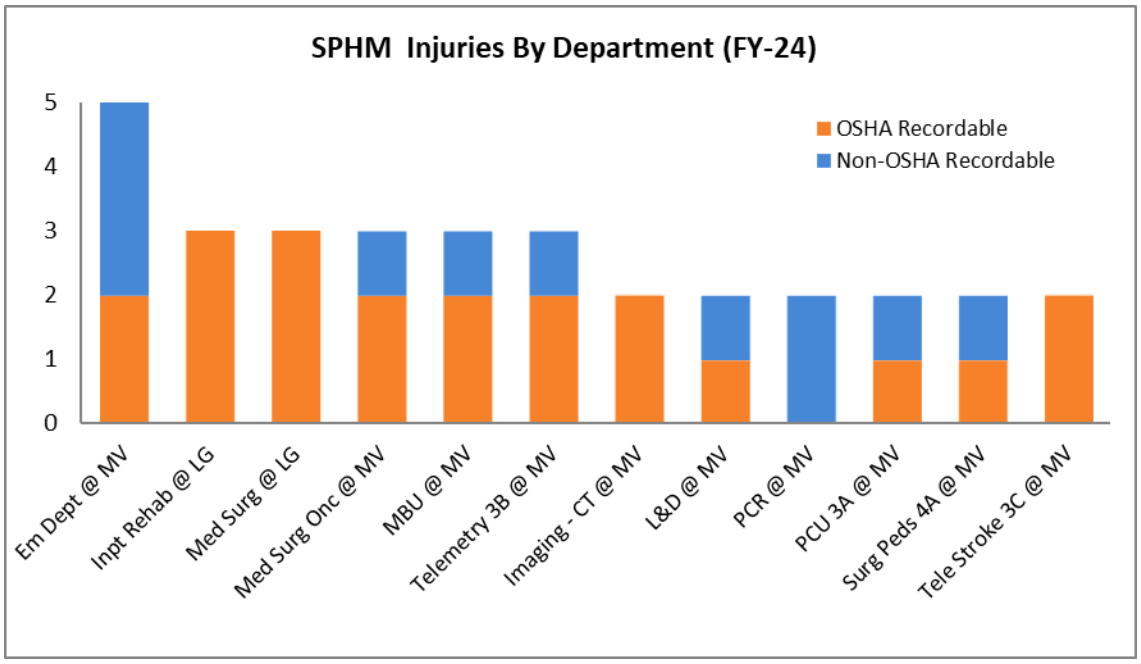
- **Lost/Restricted Days due to SPHM Injuries:** Of the 29 OSHA-recordable injuries, 8 resulted in lost days.

SPHM Injuries by Type, Fiscal Years 17 – 23

Activity	2017	2018	2019	2020	2021	2022	2023	2024
Combined Transfer	6	5	5	2	3	1	4	1
Cumulative Pt Handling	5	4	0	1	2	5	1	2
Lateral Transfer	8	1	5	3	9	4	3	4
Patient fall/prevention	5	9	8	8	10	3	9	4
Car extraction	0	0	0	1	2	1	0	0
Pt Holding	2	3	2	1	5	0	1	4
Turning/Pulling	12	16	5	6	17	11	9	18
Vertical Transfer	5	3	4	1	2	3	1	4

- Turning/pulling persists as the top category of SPHM injuries.

- **Injuries by Department**



- Inpatient Rehabilitation @ LG observed 3 OSHA Recordable SPHM injuries in FY 24 compared to 3 OSHA Recordable and 1 non-OSHA Recordable injuries in FY 23.

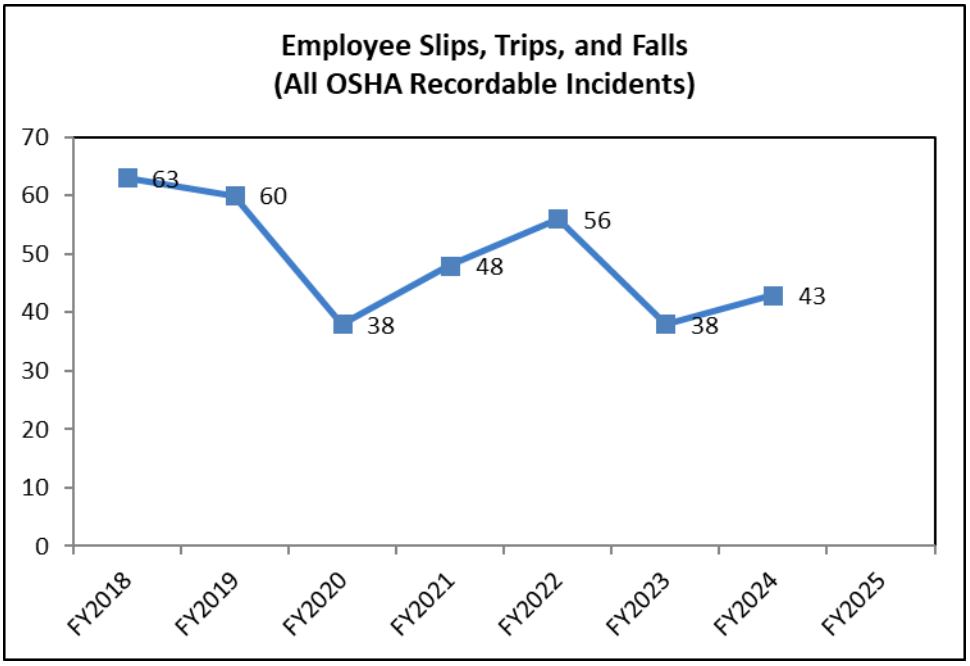
- Medical Surgical @ LG observed 3 OSHA Recordable SPHM injuries in FY 24 compared to 2 OSHA Recordable and 2 Non-OSHA Recordable SPHM injuries in FY 23.

- Patient Care Resources @ MV observed a decline in SPHM injuries noting 2 Non-OSHA Recordable SPHM injuries in FY 24 versus 2 OSHA Recordable and 2 Non-OSHA Recordable SPHM injuries in FY 23.

- Mother Baby Unit @ MV and Medical 2C @ MV represent two departments with consistent OSHA Recordable SPHM injuries.

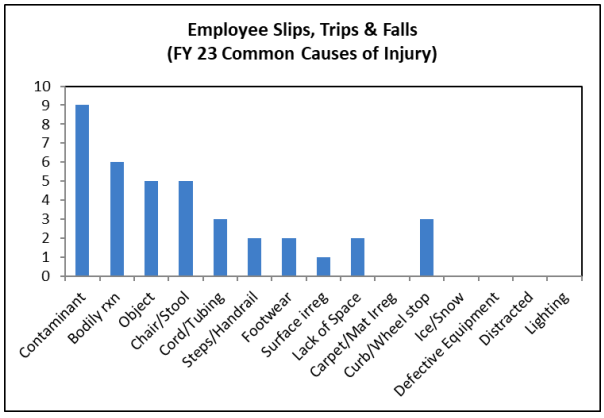
- EWHS partnered with the Mother Baby Unit @ MV to conduct a worksite evaluation of the newly renovated patient rooms and propose strategies to mitigate the risk of SPHM injury.

E. Slips, Trips, Falls Injuries



Analysis:

- **Injury Incidence**: Targeted interventions to reduce Slip, Trip, and Fall (STF) injuries were initiated in FY-17 due to the consistently rising incidence. The decrease in STF injuries was sustained in FY 24 with 43 STFs.
- The number of OSHA-recordable STFs was 8.
- **Injury Types:**
  - Employees who reported distraction as the root cause of the slip, trip, and fall were the leading category (n=7). Of note, contaminants/slippery floor is no longer a leading cause of slips, trips, and falls (n=3); a substantial reduction from a high of 20 in FY-22.



  - Bodily reaction, or "I just fell" (n=4) was the second most common cause.

An employee sustained a serious injury requiring hospitalization from a STF in April 2024. The employee sustained a slip, trip, and fall over parked equipment in a Main

Operating Room passageway. The injury was reported to CAL/OSHA who conducted a site visit on 04/18/2024.

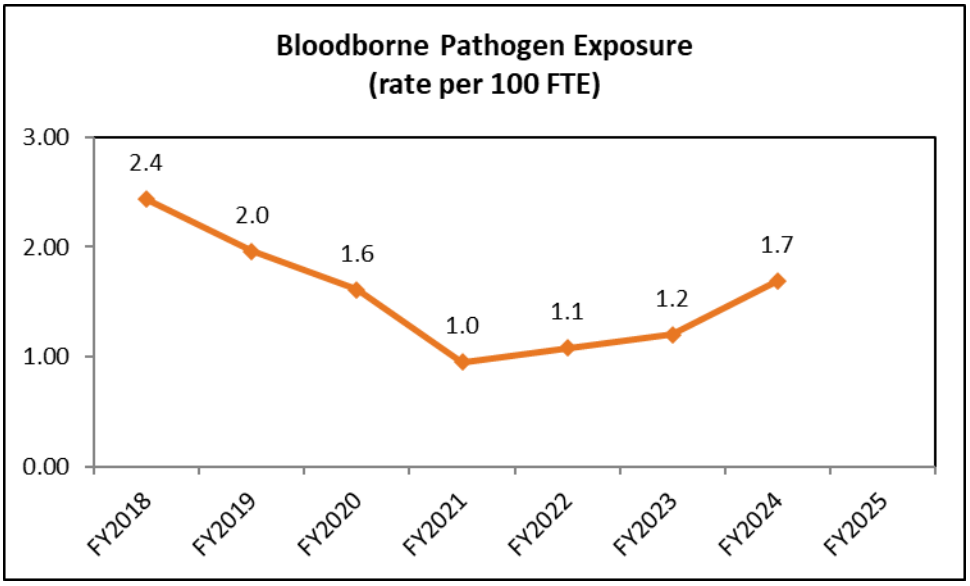
Improvement Strategies:

- EWHS and Management continue to partner with Facilities to identify and mitigate hazards to ensure the same injury does not occur twice.
- Increased focus on floor contaminants (e.g. wet surfaces) and a major decline from n=9 slips, trips, and falls in FY-23 to n=3 in FY-24.

  Adding report-outs to OSHA Recordable incidents at Enterprise Huddle to share lessons learned related to universal skills.

F. Bloodborne Pathogen (BBP) Exposures

The rate of bloodborne pathogen exposures per 100 FTE **increased to 1.7 in FY-24 compared to 1.2 in FY-23.** The total number of exposures for both campuses increased to 52 exposures in FY-24 compared to 35 in FY-23. Of the 52 exposures in FY 24, 35 were percutaneous exposures and 17 were bodily fluid exposures due to splashes.



Analysis:

- The number of sharp injuries decreased in FY-24 to 6 compared to 7 in FY23:
- The number of needlesticks increased to 28 in FY 24 compared to 22 in FY 23.

G. TB Conversions

There were no known occupational exposure conversions during FY-23.

H. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-

based training is required for all employees. All employees complete new employee orientation upon hire. Annual regulatory review courses are required for all employees and are provided as online modules. The topics include fire, evacuation, hazardous materials, and other safety topics. The compliance rates for FY--24 are:

- New employee orientation: 100% (Target: 100%)
- Annual Regulatory Clinical Review: 93% (Target: 95%)
- Annual Regulatory Non-Clinical Review: 96% (Target: 95%)

Effectiveness

Key indicators were identified to establish goals for FY-24 with opportunities to improve Safety Management within the Environment of Care.

FY 24 Goals

2) Reduce employee bloodborne pathogen exposures.

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Decrease the rate of bloodborne pathogen exposures from 1.20 to 1.08	EWHS /EH&S	**Goal not met.** Rate increased to 2.7 in FY-24 compared to 1.2 in FY-23.

- **Measurement of success**: This goal was not met. Organization incidence of bloodborne pathogen exposures returned to increased levels observed prior to FY-20. In response, EWHS initiated:
    - Joining tier 1 huddles across the enterprise emphasizing the importance of BBPE prevention to meet employees where they are at the start of their shifts.
    - Established focus departments for further training or intervention when observed rates exceeded historical data norms.
    - Analyzed patterns of injuries to partner with Clinical Education in targeted prevention education efforts.
    - Examined ways to improve employee safety such as partnering with clinical leadership, Supply Chain Management, and Security to examine eyewash station placement for future enterprise-wide rollout for facial splash exposures to blood, bodily fluids, and other hazards.

EC 2.0 - Security Management

Work Group Chair: ***Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

The Workplace Violence Prevention Plan is required by Cal-OSHA (Section 3342 of Title 8 of the California Code of Regulations). This plan is specifically for healthcare workers. The WPVP program at El Camino Health is overseen by the Workplace Violence Prevention Committee. There are four required elements to the plan:

1. Written Plan: The plan is reviewed and updated annually.
2. Response: The plan includes a comprehensive violent incident investigation process.
3. Training: The hospital has developed two levels of training.
    - **AVADE** – Computer based training module assigned annually to most staff.
    - **Nonviolent Crisis Intervention (NCI) training** – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
        - Behavioral Health
        - Emergency Department
        - Security
        - Assistant Hospital Managers (Hospital Supervisors)

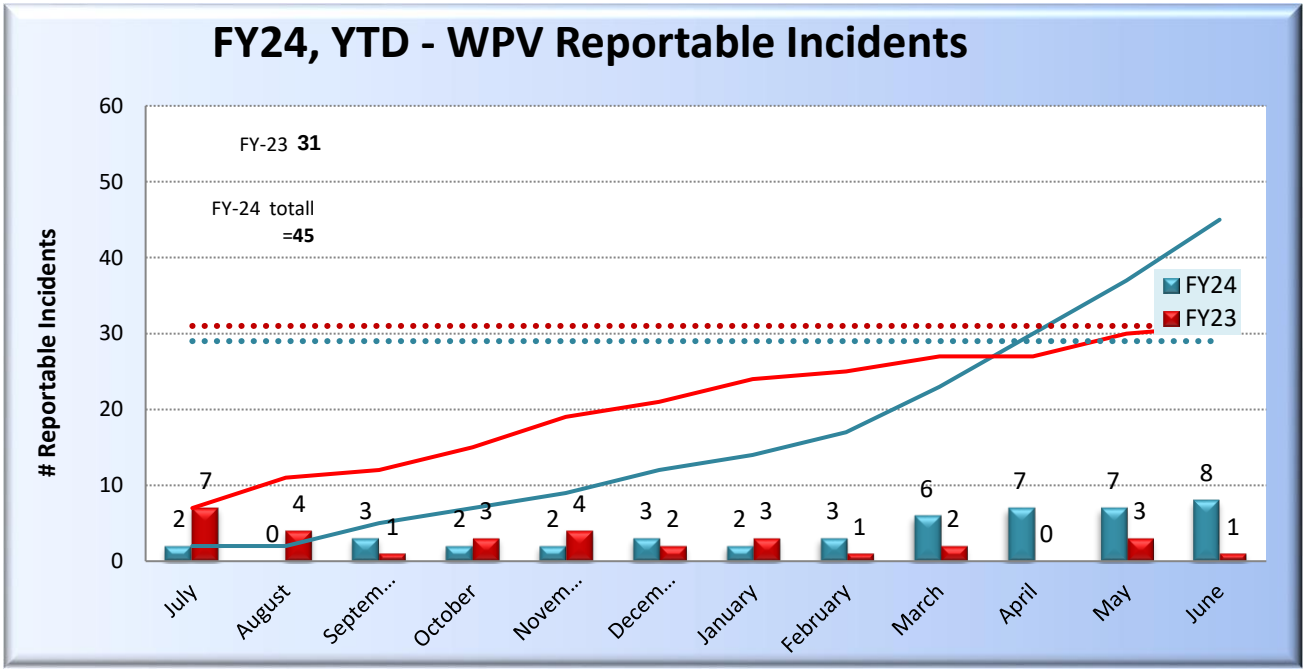
      Note- The hands-on portion of the class was restarted in February of 2023. This training was revised to include a three-hour mental health component.
4. Reporting: An ongoing WPV reporting team ensures reporting is completed as required.
    - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
    - In FY24, 45 incidents reported to the CAL-OSHA WPV website. There were no major WPV related injuries reported to the CAL-OSHA district office.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY24. The data includes activity from both campuses.

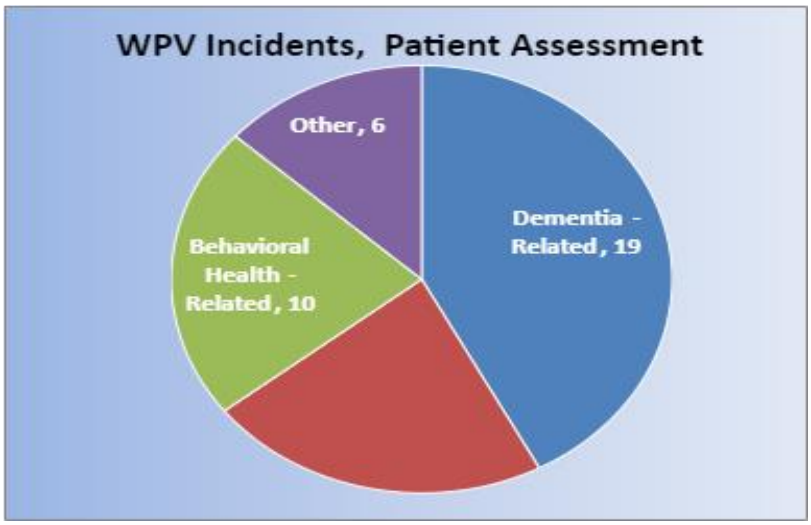
Review of the FY24 WPV incidents showed:

- There were 45 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 24. This is a 45% increase from FY23.



- Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:

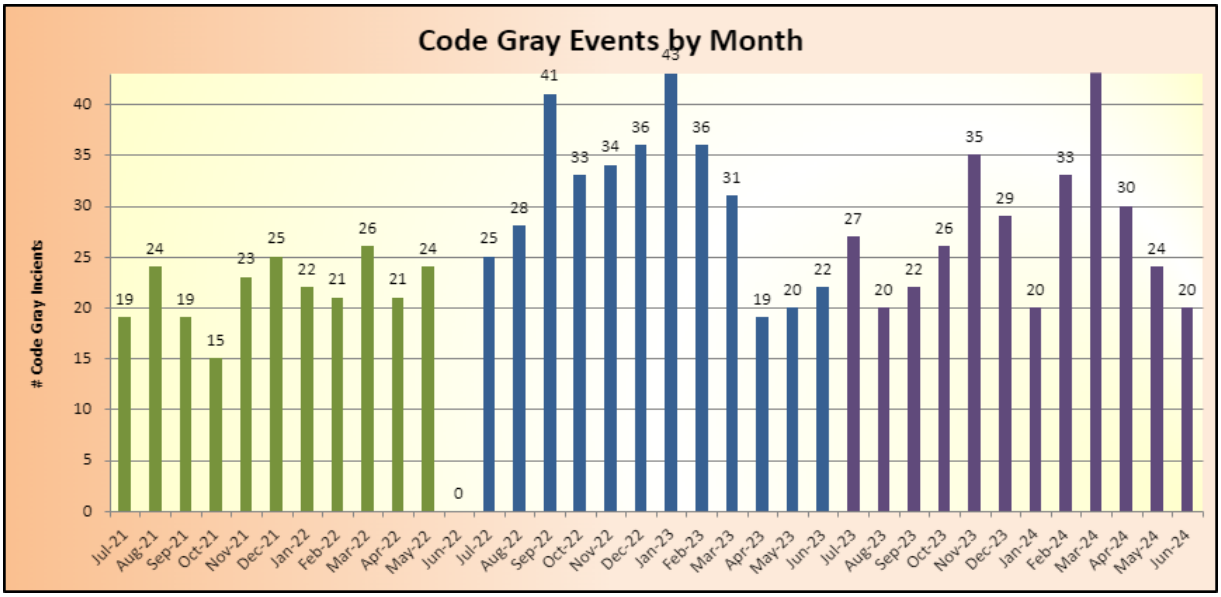
1. A significant increase in the number of WPV events related to confused or dementia patients.
2. A moderate increase in the number of WPV events related to behavioral health patients.



Note – A focus on managing our dementia related patient population will occur in FY 25.

A. Code Gray Responses

Code Gray responses decreased (11%) in both MV and LG. The total number of incidents in FY24 was 327 compared to 368 in FY23. The decrease in code greys is largely due to the implementation of the CALM (Collaborative Aid through Listening and Motivation) team in M.V. and the activation of the portable panic button program in Los Gatos in March 2024.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- **MV Emergency Dept. (ED) – 36%**
- **Medical Unit (4A)- 13%**
- **MV Medical Unit (3C) – 11%**
- **Medical Unit (3B)- 8%**

Responses are tracked through the Code Gray security shift report form and monitored to help identify possible improvements to the process.

B. Security Incidents

There was a total of 567 reported security incidents for FY24 requiring a security response. This is a slight increase from FY23 of 547.

C. Bulletins, Alerts & Presentations

Security Services issued six personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

D. Patient Belongings

Security Officers performed 6,365 chain-of-custody transactions involving patient's belongings in FY 24. This was slight increase over FY 23.

E. Fire Drills / Fire Watches

Security Officers conducted 96 fire drills and 6 fire watches were performed in FY24.

F. ID Badges

Security Badging Services issued approximately 3,500 El Camino Health badges in FY 24, which was an increase of approximately 1,000 Photo ID Badges (mostly related to removing RN's last name as part of the nursing contract). This provides access and barcoding technology to staff, physicians, auxiliary, contractors, and students. Additionally, in FY 24 approximately 350 temporary badges were issued to staff who forgot, or temporality lost their badges.

G. Investigations & Audits

Security Services performed 129 investigations and audits including, but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

H. Lost and Found

Security Officers performed 496 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

I. Inspections

Security Services performed a total of 84,423 inspections (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

J. Loitering

Security Officers responded to 327 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

K. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 93 vehicle-related services including jump-starts, door unlocks and tows. 865 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

L. Police Activity

Law enforcement agencies were on-site 141 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

M. Effectiveness

Key performance indicators were identified in FY24 to improve Security Management within the Environment of Care.

FY24 Goals

2) 5% reduction in number of reportable workplace violence incidents- In FY24 there was a 45% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

This goal was not met.

2. 10 % reduction in the number of Code Greys over FY 2023. In FY 24 there were a total of 327 code greys. This is a 11% reduction in the number of code greys.

This goal was met.

EC 3.0 - Hazardous Materials & Waste Management

Work Group Chair: ***Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Health. The work group chair serves as the central contact point for the reporting and documentation for the work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

A. Hazardous Material Incidents

The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

Recordable Hazardous Material Incidents:

1) 9-18-23 Nitroglycerin/Dextrose Pharmacy Mix leaking through 1 box – Loading Dock – Fedex offloaded box that was leaking. Container was shipped in a failed container and was not noticed immediately due to volume of shipments being received at the same time. Gap identified with incomplete Code Orange Response Team presence. Education to staff to not to accept leaking boxes, place immediately in secondary containment immediately, and safety. Cleanup was handled safely.
2) 1-8-24 Perjeta 250ml spill – Cancer Center, Oak Pavilion – RN did not re-attach the Primary IV line to the patient. Reviewed/educated RN staff to double check all connections prior to administration. Cleanup was handled safely.
3) 2-9-24 Oxytocin 50-100 ml spill - MV Mother Baby Unit – IV bag leaking from the hose connection. Education to staff to double check all connections prior to administration. Cleanup was handled safely.
4) 4-3-24 /Chemo Drug 30-50 ml spill – Cancer Center, Oak Pavilion – IV bag leaking from the hose connection. Education to staff to double check all connections prior to administration. Cleanup was handled safely.
5) 4-12-24 Taxol/Chemo Drug 234 ml spill – Cancer Center, Los Gatos – IV bag leaking from white port hose connection. Full Code Orange Response Team present. White port accessed and no malfunction identified. Education to staff to double check all connections prior to administration. Cleanup was handled safely.
6) 6-8-24 Doxorubicin, Etoposide, Vincristine/Chemo 1000 ml Spill - 3C 3323 Nurse was planning to start infusion of a new bag of chemotherapy when the patient needed to use the bathroom. Patient used IV pole for support when walking, but the IV pole fell over and the IV bag of chemotherapy hit the floor and ruptured.. 4B chemo nurses took initiative to clean spill on their own. Reinforced Safety, Isolate, Notify (SIN). Education on code orange process moving forward. Hot wash Conducted 6-20-24. Gaps and Opportunities identified. Working with consultant on Code orange revision, spill response

training/drills. During the interim, call vendor for all spills until code orange response is where it needs to be

- Reportable Hazardous Material Incidents – There were no reportable spills in FY 24.

B. Waste Water Discharge Violations:

- There were no wastewater discharge violations in FY 24.

C. Monitoring and Inspections

- Hazardous Waste Inspections – There were no hazardous materials and or waste inspections in FY 24.
- Santa Clara County Annual Medical Waste Inspections – There were no medical waste inspections in FY 24.
    - In FY 24 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation compliance:
    - Annual Waste Management education for staff
    - Daily rounds by EVS supervisors
    - Monthly Safety Rounds that include observation of waste segregation practices
    - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.
    - Working with Outside vendor on Code Orange Response process and procedures.
    - Regular Hazardous Materials Work Group Meetings with the goal for discussion with high-risk hazardous materials and waste departments.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly at the Central Safety Committee.

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[3] training course.

Key indicators were targeted to establish goals for FY-24. The following goals presented opportunities to improve hazardous materials & waste management.

[3] HAZWOPER: Hazardous Waste Operations and Emergency Response

FY-24 Goals:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
    - Measurement of success :> 95%. **This goal was accomplished.**
2. Staff can describe the process for accessing a safety data sheet.
    - Measurement of Success: >95%. This goal was accomplished.

EC 4.0 – Fire Life Safety Management

Work Group Chair: *John Folk*

Scope

The Fire Life Safety Management Plan is designed to assure appropriate, effective response to a fire emergency that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY24.

C. Fire Incidents

There was no fire incident in Mountain View or Los Gatos in FY24.

D. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated for potential opportunities for improvement.

The total number of events in FY24 (47) was slightly higher than FY23 (45). There were 45 events in Mountain View and 2 in Los Gatos. This increase was mostly related to significant construction activities at both hospitals during FY24.

C. Fire Drills Completed / Scheduled

All required fire drills were completed in FY24. All opportunities for improvement are corrected on the spot, through facility work orders or with further education by the dept. Manager.

E. Effectiveness

Based on opportunities for improvement identified in the FY23 annual EOC evaluation the FY24 performance improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY25 due to staff performance in FY24.

EC 5.0 - Medical Equipment Management

Work Group Chair: ***Jeff Hayes***

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment

Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-24.

D. Reports to the FDA –

There were **X** reports through the Medwatch[4] system in FY-24. There were no patient deaths associated with any of the reports.

E. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 93% for FY-24. A 6% improvement from FY-23. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought up the completion rate to 96%.
- All high risk, life safety equipment was maintained at 98.99% completion rate. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.42%. Only two devices(external pacemakers) could not be located for 100% completed maintenance.

F. Product Recalls Percentage Closed / Received

For FY-24, there were 465 recorded equipment recalls: 44 still open.

Effectiveness

[4] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

FY24 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

Raise the percentage of the total database completed that is currently at 96.77% to 98%. This will confirm that 98% of all inventoried medical devices received a completed maintenance within the last 12 months.

Goal was met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 98.82%.

Reduce open ECRI recall/alerts by 80%. Currently at 331 open ECRI alerts.

Goal was not met. Reduced all ECRI alert/recalls by 75% or 88 open ECRI alerts.

EC 6.0 - Utilities Management

Work Group Chair: John Thompson

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-24.

B. Utility Reportable Incidents

There were four incidents in FY-24. All were electrical outages or voltage fluctuations.

- Los Gatos had a temporary loss of electrical utility to the campus on February 4th, 2024, at 05:00. Los Gatos experienced a power fluctuation that tripped the breaker to the MRI trailer. There was no impact to patient safety related to this event. On April 15th, 2024, the Los Gatos Rehabilitation building loss PG&E supplied power at 18:15 due to an offsite power disruption. This outage lasted until 19:10. The emergency generator number 3 which supplies the Rehabilitation building supplied emergency power for 55 minutes. There was no impact to patient safety related to this event.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates,2/4/24, 2/9/24. These events were weather related disruptions, and the emergency generators ran and functioned as designed:

C. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was **95%,** meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

D. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

Effectiveness

Key indicators were targeted to establish goals for FY-24. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**88% Goal was not met**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**93%- Goal was met**

Note: Data is collected through fire drills and environment of care rounds.

EM – Emergency Management

Committee Chair: Bryan Plett

Scope

El Camino Health's Emergency Operations Plan (EOP) addresses all non-fire-related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee is responsible for ensuring a effective response to these emergencies. The hospital collaborates with state and local emergency management organizations to coordinate community planning and response efforts. Although Emergency Management is a distinct chapter under The Joint Commission, annual reporting is integrated with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant events are presented to the Central Safety Committee for review. For FY24, the following Emergency Management indicators were noted:

B. Activation of Hospital Incident Command System (HICS)

There were no recorded events and/or emergencies during FY24 requiring the activation of HICS and opening of the Hospital Command Center (HCC).

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY24, this was met through separate planned exercises at both campuses (see below). The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

- 10/19/2023 – El Camino Health / Great Shakeout Earthquake functional exercise. This exercise tested Situational Assessment, Operational Communications, Public Warning, and Public Health
- 3/28/2024 – Mass Casualty Incident functional exercise. This exercise tested El Camino Health's ability to respond to a Mass Casualty Incident. The exercise specifically tested Bi Lateral Communication, Triage, Treatment, and Transportation, Family Assistance, and Internal Communications.
- 6/19/2024 – Statewide Medical Response and Surge Tabletop Exercise. This exercise was conducted in partnership with Santa Clara Valley Emergency

Preparedness Health Care Coalition and other hospitals throughout the county. This exercise specifically looked at Intelligence and Information Sharing, Operational Communications, Operational Coordination, and Public Health and Medical Services.

D. Emergency Management Training

- New Hire and New Manager Orientation: Emergency management training was provided to all incoming new staff members.
- Safety Coordinator Meetings: Held both in-person and via Zoom, consisting of various aspects of emergency management related training.
- CHA Disaster Preparedness Conference: The annual conference, hosted by the California Hospital Association in September, was well-attended by El Camino Health representatives. This year's conference was held in September.

E. Community Involvement

El Camino Hospital remains actively involved in the Santa Clara County Hospital Emergency Preparedness Program (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives from all county hospitals and EMS to develop a collaborative emergency response and disaster plan. Additionally, the group organizes county-wide disaster exercises in which the hospital actively participates.

The EPHC extends similar emergency preparedness initiatives to all healthcare facilities in the county, including clinics and skilled-nursing facilities. The group meets quarterly to share information and provide training.

The Hospital conducts an annual Hazard Vulnerability Assessment (HVA) to evaluate the risk of various emergency situations. Separate HVAs are performed for the Los Gatos and Mountain View campuses to account for site-specific differences. Efforts are then directed towards mitigating the highest risks identified for the fiscal year.

- There were minimal changes to the top five HVAs at both campuses in FY24 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	**(1) Earthquake**
(2) Patient Surge	**(2) Utility Failure**
(3) Utility Failure	**(3) Patient Surge**
(4) IT System Outage	**(4) IT System Outage**
(5) Fire - External	**(5) Fire - External**

F. Effectiveness

Key indicators were targeted to establish goals for FY24. The following goals presented opportunities to improve emergency management.

FY24 Goals

1. Expand the use of the El Camino Health mass notification system (Everbridge) to all employees (continued from FY23)
    - **Measurement of Success**
    - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
    - Evaluate and set up logical groups and rules for notifications. **In progress**
    - Train key staff to be able to use/send alerts.
    - **This *goal was accomplished.***
    - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
    - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
    - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
2. Implement additional layers of communication redundancy to include:
    - **Measurement of Success**

- Transition cellular service from AT&T to FirstNet which allows for the use of deployable satellite assets during a communication failure.
- Train and provide resources to an internal amateur radio team.
    - **This *goal was accomplished.***
- Partnered with Supply Chain to create a contract with FristNet and ensure a smooth transition of services.
- Hosted several internal and community wide amateur radio certification and licensure courses in M.V. and L.G.

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: November 4th, 2024
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through September 2024

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through September 2024 (unless otherwise noted). This memo will describe the performance of both the STEEEP and Enterprise Quality Dashboards.

Summary:

Situation: The FY 25 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks eighteen quality measures. The STEEEP dashboard is updated each quarter and contains twenty measures. The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter. Most measures are tracked on both the Enterprise monthly and STEEEP quarterly dashboards.

Assessment:

Safe Care

a. **C. Difficile Infection:** There have been 6 (2 cases per month) (Goal: </= 27 infections FY 2025 or less than 2.25 cases/month) Hospital Acquired C=Diff infections in Q1 FY2025. Areas of focus to decrease C. Diff are three-fold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program has been implemented. Third, a robust antibiotic stewardship program is in place. (Timeline for improvement: We are on track to meet the goal)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been three CAUTI in Q1 FY2025 with a goal to have less than ten for the fiscal year. Q1 FY25 we are at (1.00) versus a target of (0.83/month).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. (Timeline for improvement: We are close to target and we will be reinforcing following existing processes)

c. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for the end of Q1 FY2025 year to date (0.0) is favorable to target (0.42 cases per month). Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. (Timeline for improvement: We are on track to meet target)

1. **Surgical Site Infection**. The number of cases/month of surgical site infections for Q1 FY2025 (4.67) is unfavorable to target (2.5). Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. A taskforce including SPD, OR staff, physicians has been instituted to reinforce best practices, enforce normothermia, timing of preoperative antibiotics and clean closure tray utilization in the OR and perioperative areas. (Timeline for improvement: We anticipate that our SSI rate will go down by Q2/Q3 of FY 2025. This is a major focus for the organization, and we have devoted significant resources to understand and implement any changes needed)

2. **Hand Hygiene Combined Compliance rate:** Performance for Q1 FY2025 is favorable (85.3) to target of 85%. (Timeline for improvement: We are on track to meet this target).

3. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for Q1 FY2025 is favorable (100%) to target of 80% of units.

B. Timely

1. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q1 (74%) is unfavorable to target (84%). The root cause of the delays relates to multiple factors, primary being radiology staffing issues experienced by the contracted vendor. In addition, there have been issues with the transfer of images and interface with our system which are being worked on. The vendor is hiring more radiologists to their team to expedite reading of images. (Timeline for improvement: Realistically, we anticipate improvement in the Turnaround times by Q3 2025)

C. Effective

1. **30 Day Readmission Observed Rate:** Performance through Q1 FY2025 (8.3%) is favorable to target (</=9.8%). El Camino Health remains committed to ensuring timely follow-up care for patients under 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. (Timeline for improvement: We are on track to achieve target for FY 2025)

2. **Risk Adjusted Mortality Index.** Performance for Q1 FY25 (0.88) is favorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. Though we are on track for this metric, we will be closely monitoring this since the system changes introduced in documentation integrity, reduction in clinical variation and institution of earlier hospice and GIP are just in the initial phases of implementation. (Timeline for improvement: We are on track to achieve this target for FY 2025)

3. **Sepsis Mortality Index.** Performance for Q1 FY2025 (1.06) 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 Q2/Q3 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)

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV). FY25 performance through August of 2024 (21.7) is unfavorable to target of 23.9%.The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. 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 are on track with this metric, however, we are closely watching this to ensure that the improvement is sustainable)

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD is (1.07) is unfavorable to target of (1.02). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams are optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place.
   - Within Epic a centralized care plan was created that pulls together important information about the patients care plan. This tool increased efficiency and allows

the care team to obtain pertinent information in a timely way. Additionally, interdisciplinary team members can track internal and external delays which will offer insight into the primary reasons for delays in patient throughput.

- Since the initiation of Multidisciplinary rounds (MDR) in December 2023, there have been significant improvements in LOS within the pilot program for patients who stay in nursing unit 2C. The data indicates a noteworthy decrease of -1.1 days in LOS (as of 04/24/2024) for these patients. Given the successful demonstration, the MDR process was expanded to the nursing unit on 3C. In addition, the plan is to roll out the MDR process to 3 additional units in Q1 2025.
- We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements. (Timeline for improvement: We anticipate improvement due to the changes implemented by Q3 of 2025)

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY25 Q1 performance (151 minutes) is favorable to the target of < 160 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).

E. Equitable

1. Social Drivers of Health Screening rate: FY 25 performance YTD is (4%) is unfavorable to target of 50%. This is a new measure and steps taken to improve our screening rate includes creating a new tool for staff to document required elements of the metric. Our team including care coordinators, nurses and informatics teams are working to implement this tool in the next few months. (We expect significant improvement in this metric by Q3 2025 once the new tool is deployed and adopted)

2. Voyce Interpretation Minutes Used: FY 2025 performance (173,776 minutes). We are in the process of establishing a target for this metric. This is the first year that we are using this metric, hence there is no benchmark either locally or nationally. We believe that this metric is an important proxy for communication with patients who do not have English as their primary language.

F. Patient Centered

1. **1. Inpatient HCAHPS Likelihood to Recommend**. For the month of March (83.4) and FY25 (80.7) performance is unfavorable to target of 81.9. We are continuing to focus on our Key Drivers of Nurse Communication, Hourly Rounding, and Responsiveness. We continue to upgrade our RN call system on both campuses leading to better responsiveness. (Timeline for improvement: We should see improvement in this metric in Q2/Q3 2025)

2. **2. Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** FY 2025 YTD (82.8.4) is

favorable to target of 82.0. 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.

3. **ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** The overall ED top box score exceeded target (78.9) Q1 FY2025 is favorable to target of (77.2)

3. **El Camino Health Medical Network: Likelihood to Recommend Care Provider Top Box Rating of "Yes, Definitely likely to Recommend".** Performance for Q1 FY2025 is unfavorable (80.9) to target of (83.4). 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.
4.

Attachments:

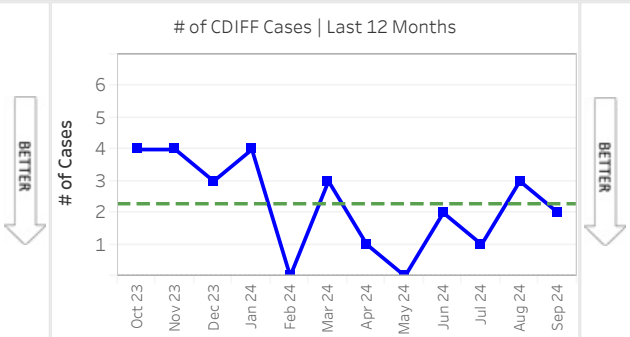
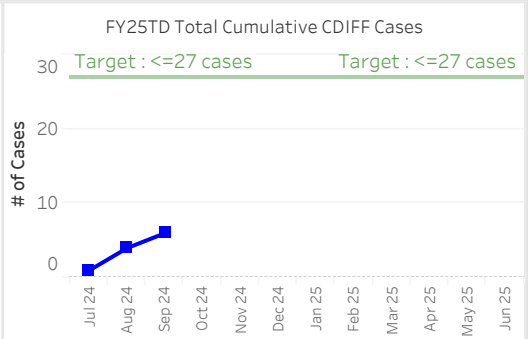
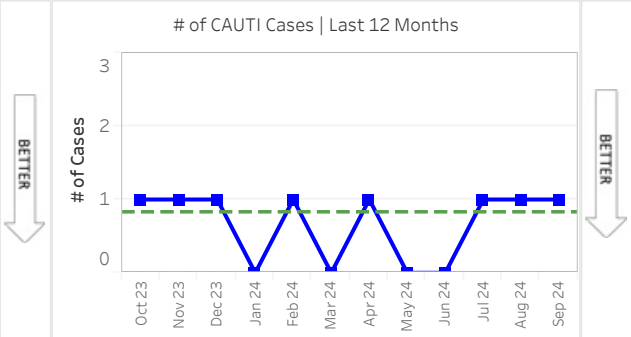
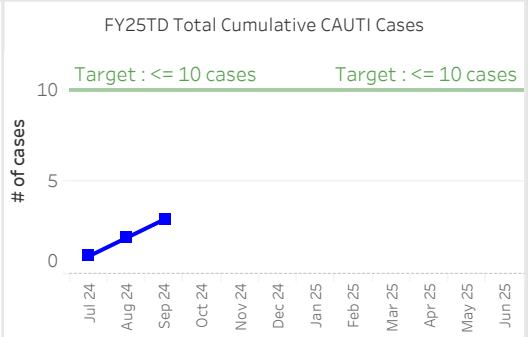
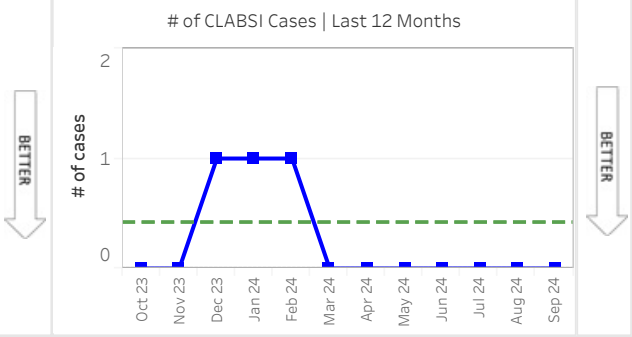
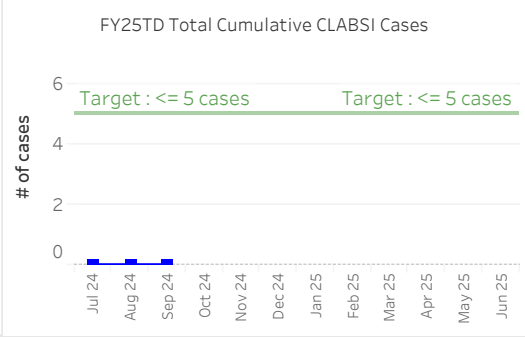
1. Enterprise Quality Dashboard through September of 2024
2. STEEEP Dashboard through September of 2024.

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

September 2024 (unless other specified)

Month to Board Quality Committee : November 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 : September 2024	2 cases	2.00 cases/mo	2.33 cases/mo	2.25 cases/mo		
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : September 2024	1 cases	1.00 cases/mo	0.92 cases/mo	0.83 cases/mo		
Central Line Associated Blood Stream Infection (CLABSI) cases Latest Month : September 2024	0 cases	0.00 cases/mo	0.25 cases/mo	0.42 cases/mo		

Quality Department | Note : updated as of Oct 16, 2024

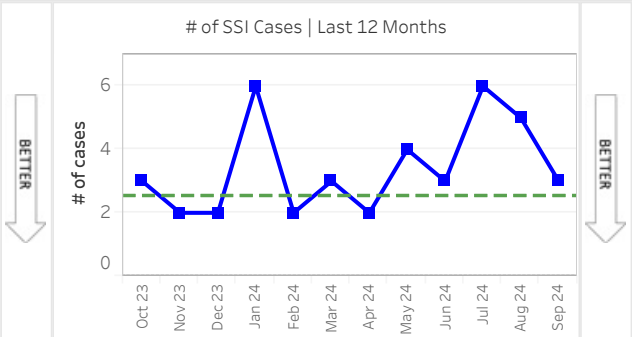
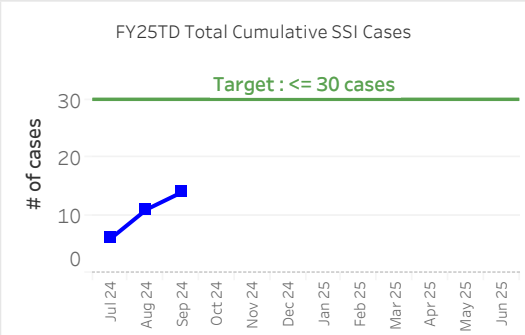
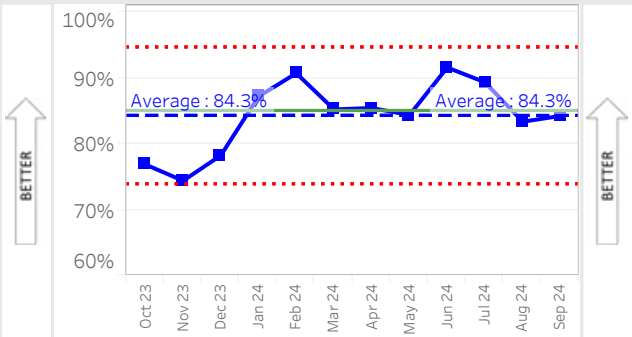
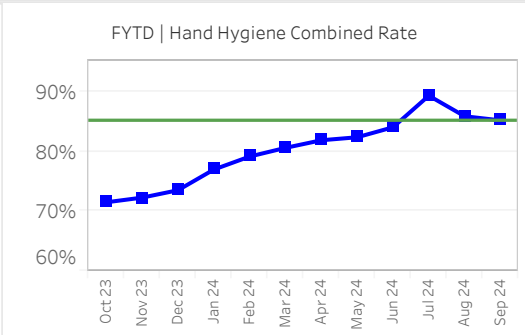
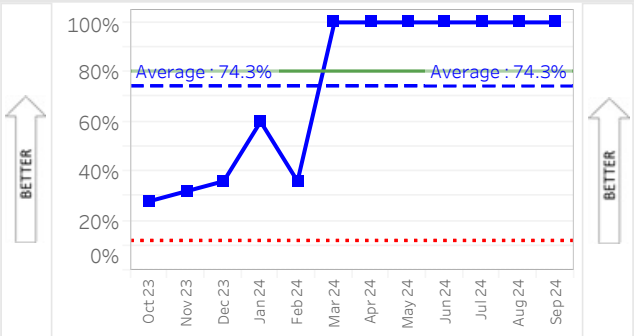
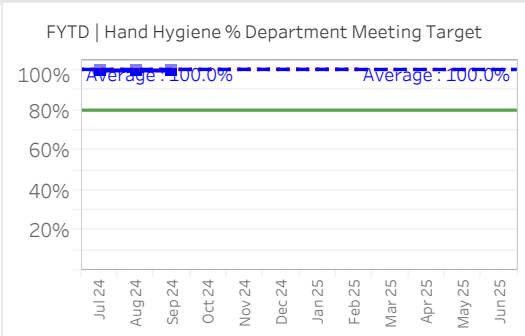
Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Catheter Associated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

September 2024 (unless other specified)

Month to Board Quality Committee : November 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 : September 2024	3 cases	4.67 cases/mo	4.67 cases/mo	2.50 cases/mo		
Hand Hygiene Compliance Rate (Entry and Exit Combined) Latest Month : September 2024	84.3% (15405 / 18277)	85.3% (37424 / 43899)	84.1% (64956 / 77245)	85%		
Hand Hygiene % of Departments Meeting Target Latest Month : September 2024	100.0% (25 / 25)	100.0% (75 / 75)	54.7% (164 / 300)	80% of units		

Quality Department | Note : updated as of Oct 16, 2024

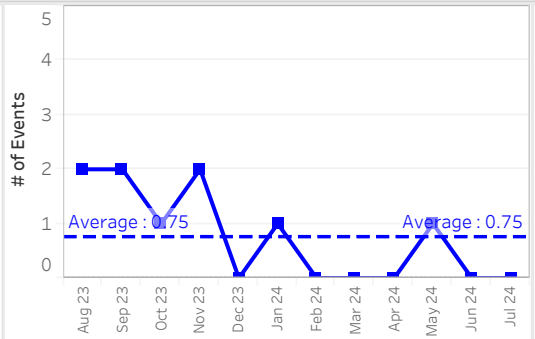
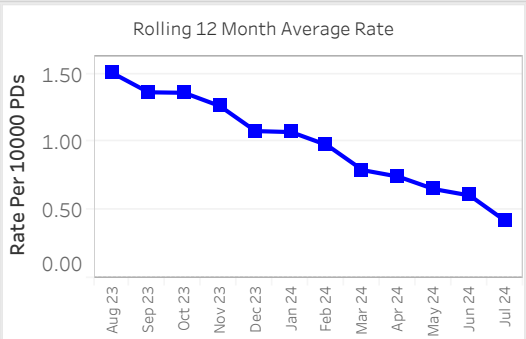
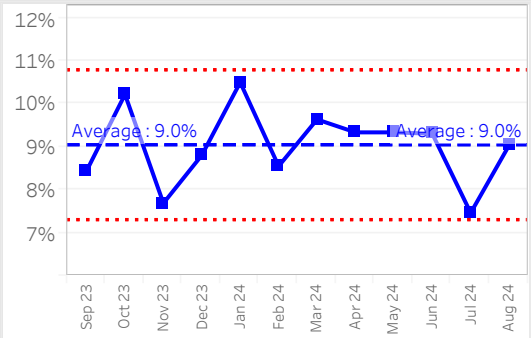
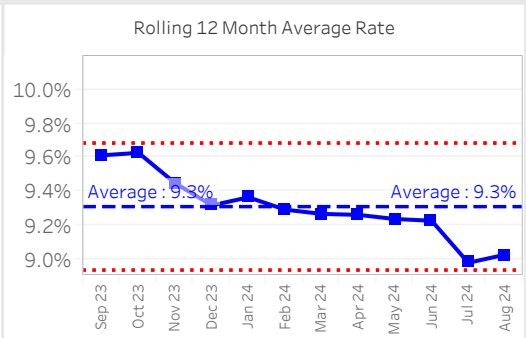
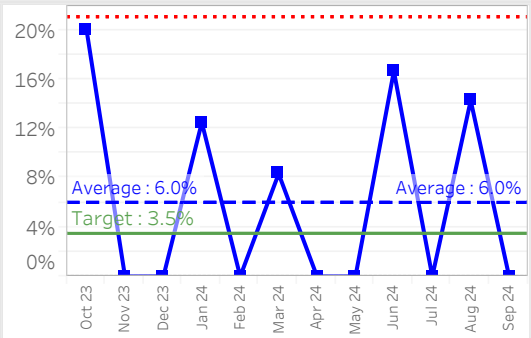
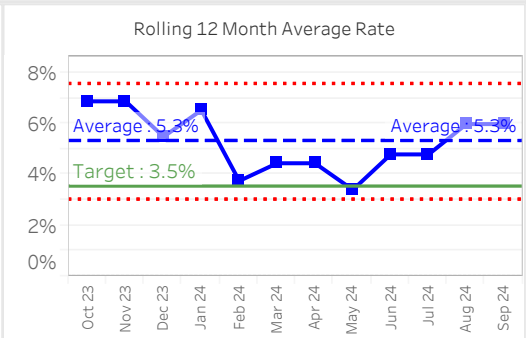
Measure	Definition Owner	Metric Definition	Data Source
Surgical Site Infections (SSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "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

September 2024 (unless other specified)

Month to Board Quality Committee : November 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 : July 2024	0 events	0.00 (0 / 17566)	1.93 (41 / 212460)	n/a		
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : August 2024	9.0% (130 / 1439)	8.3% (235 / 2846)	9.8% (1519 / 15552)	<= 9.8%		
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : September 2024	0.0% (0 / 12)	3.3% (1 / 30)	5.9% (5 / 85)	<= 3.5%		

Quality Department | Note : updated as of Oct 16, 2024

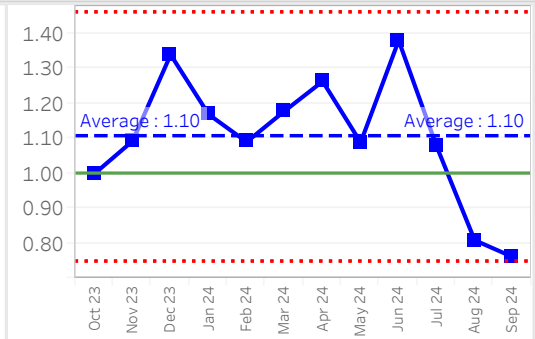
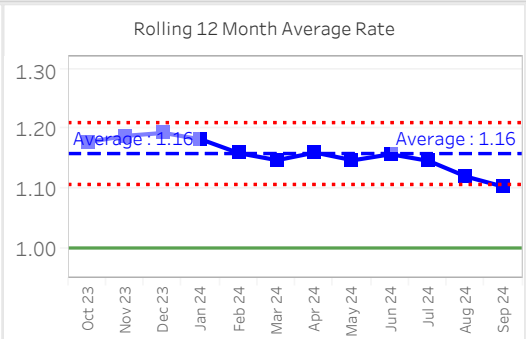
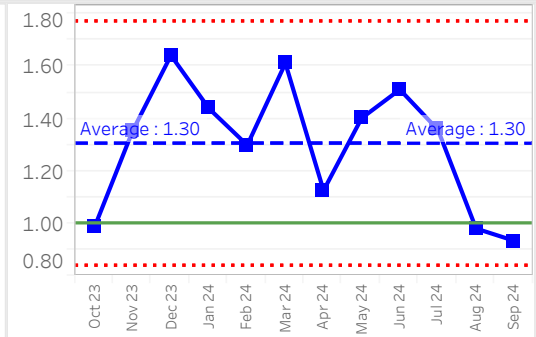
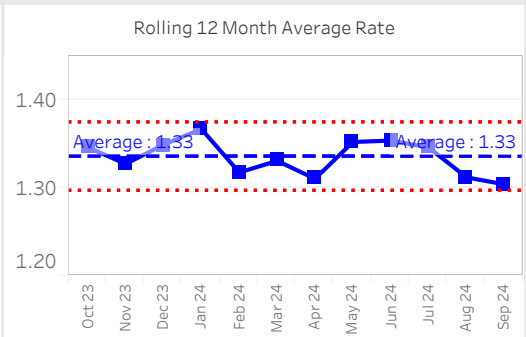
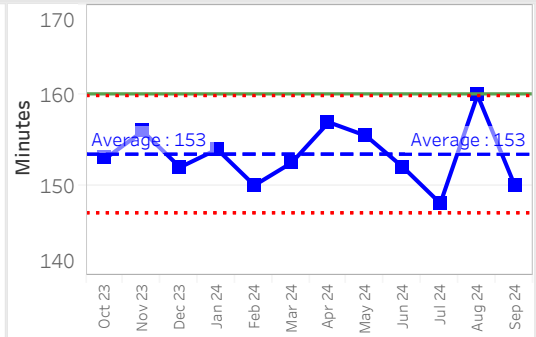
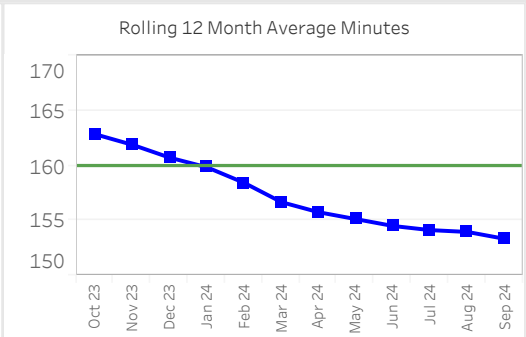
Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events 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	Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthoplasty (THA), total knee arthoplasty (TKA) procedure. Numerator : Distinct count of patients having complications / Total Cases. Patients with complications are counted in the numerator only once, regardless of the number or type of complication. Denominator : Eligible index admissions who are at least 65 years of age who have undergone a qualifying elective primary THA or TKA procedure. 2.) Based upon Vizient Risk Model 2023 Community + AHRQ Version 2023 3) 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

September 2024 (unless other specified)

Month to Board Quality Committee : November 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 : September 2024	0.76 (1.51% / 1.98%)	0.88 (1.79% / 2.03%)	1.16 (2.55% / 2.20%)	1.00		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : September 2024	0.93 (9.20% / 9.86%)	1.06 (9.77% / 9.18%)	1.35 (13.37% / 9.91%)	1.00		
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : September 2024	MV : 164 mins LG : 136 mins ENT : 150 mins	MV : 169 mins LG : 135 mins ENT : 152 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 Oct 16, 2024

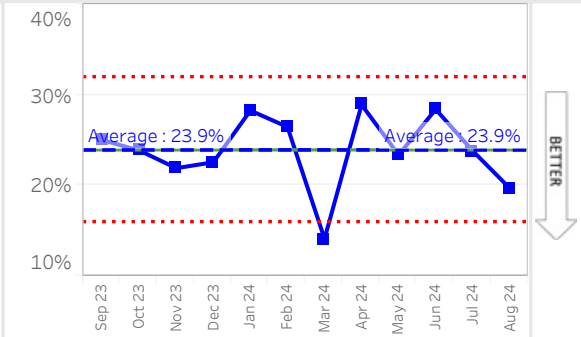
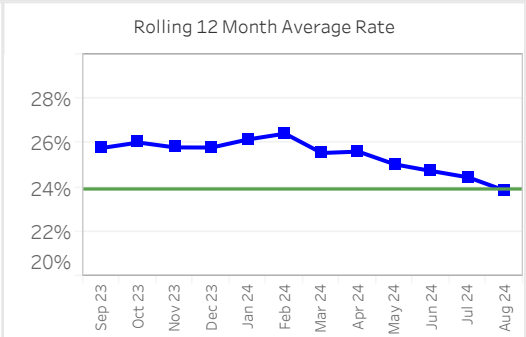
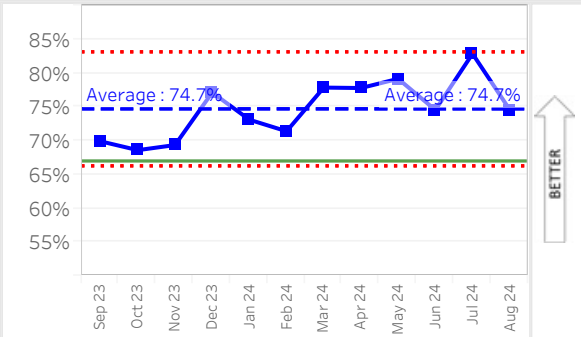
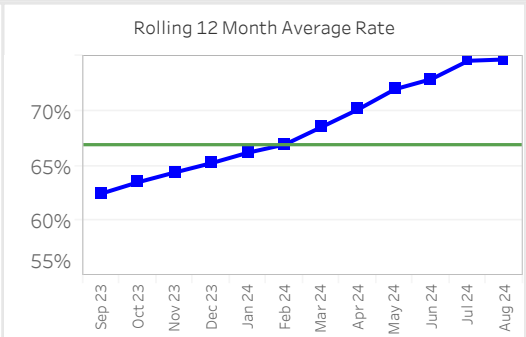
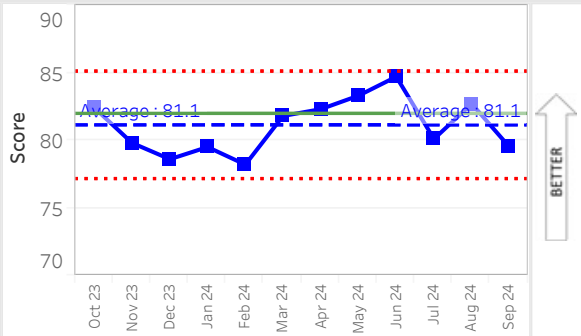
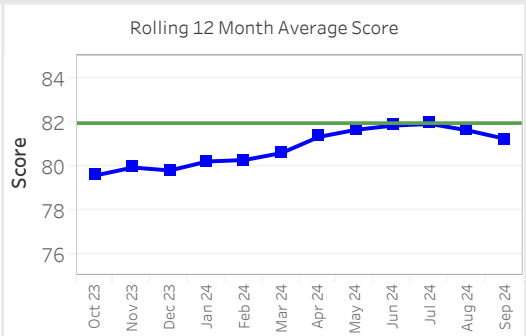
Measure	Definition Owner	Metric Definition	Data Source
Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2023 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (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

September 2024 (unless other specified)

Month to Board Quality Committee : November 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 : 20.2% (33 / 163)	MV : 22.2% (71 / 320)	MV : 27.6% (516 / 1869)	23.9%		
	LG : 16.7% (5 / 30)	LG : 19.4% (12 / 62)	LG : 19.4% (62 / 320)			
Latest Month : August 2024	ENT : 19.7% (38 / 193)	ENT : 21.7% (83 / 382)	ENT : 26.4% (578 / 2189)			
PC-05 : Exclusive Breast Milk Feeding	MV : 72.0% (208 / 289)	MV : 76.3% (441 / 578)	MV : 58.1% (1998 / 3437)	65.1% (MV Target)		
	LG : 86.9% (53 / 61)	LG : 90.5% (105 / 116)	LG : 68.4% (428 / 626)	70.0% (LG Target)		
Latest Month : August 2024	ENT : 74.6% (261 / 350)	ENT : 78.7% (546 / 694)	ENT : 59.7% (2426 / 4063)	65.1% (ENT Target)		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	79.5	80.7	81.9	81.9		
Latest Month : September 2024						

Quality Department | Note : updated as Oct 16, 2024

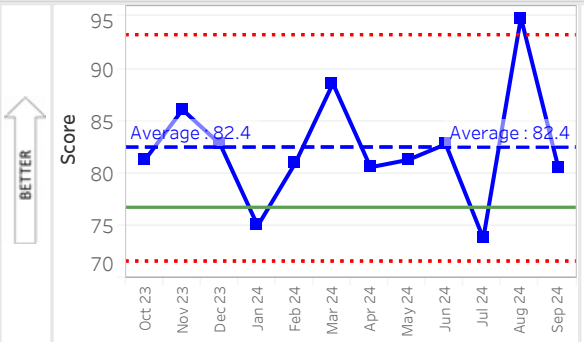
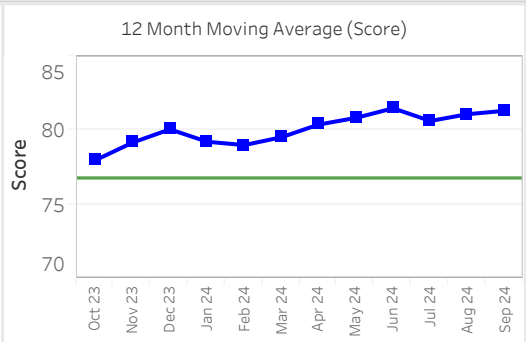
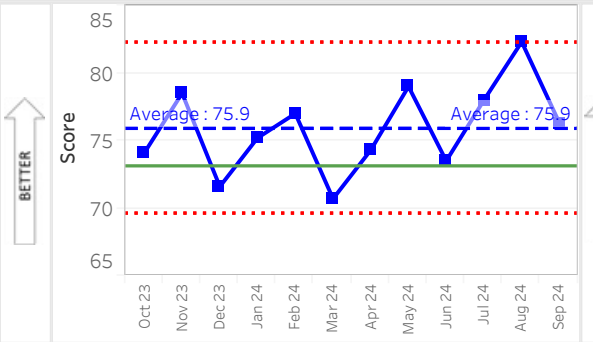
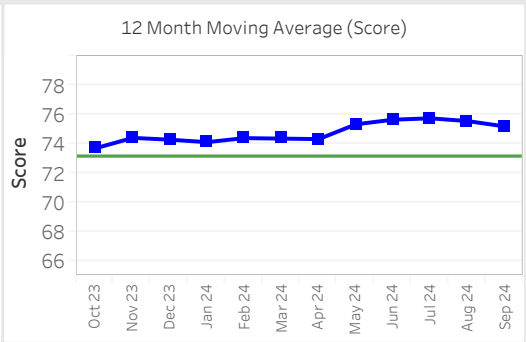
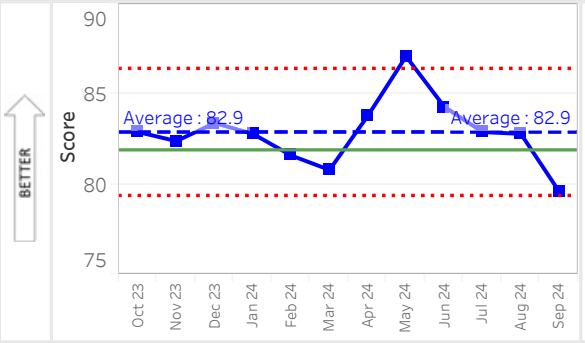
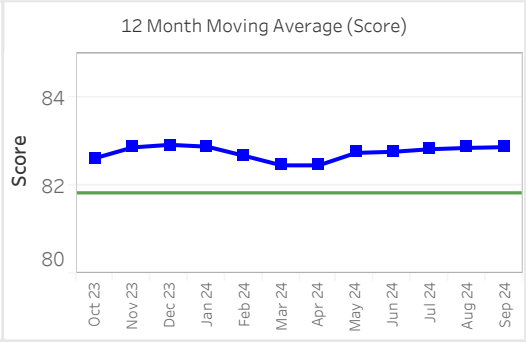
Measure	Definition Owner	Metric Definition	Data Source
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **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

September 2024 (unless other specified)

Month to Board Quality Committee : November 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 : September 2024	80.5	82.8	82.0	82.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2024	76.3	78.9	75.5	77.2		
ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2024	79.6	80.9	82.1	83.4		

Quality Department | Note : updated as of Oct 16, 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

El Camino Health Quality Board: FYTD25 STEEEP

El Camino Health

Show Filter

Date: 10/1/2023 09/30/2024

Measures	FY 24Q2	FY 24Q3	FY 24Q4	FY 25Q1	Baseline FY24	FYTD Result FYTD25	Target Indicator		Last 12 Months Trend
Safe Care									
C-Diff Clostridioides Difficile Infection Count	11	7	3	6	28	**6**		<= 27 cases	Lower Better
CAUTI Catheter-Associated Urinary Tract Infection Count	3	1	1	3	11	**3**		<=10 cases	Lower is Better
CLABSI Central Line-Associated Bloodstream Infection Count	1	2	0	0	3	**0**		<=5 cases	Lower is Better
SSI Surgical Site Infection Count	7	11	9	14	38	**14**		<=30 cases	Lower is Better
Hand Hygiene Compliance (Entry and Exit Combined Rate)	76.5%	87.2%	87.3%	85.3%	84.1%	**85.3%**		>=80%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	76.9%	81.4%	81.0%	74.0%	77.7%	**74.0%**		>=84.0%	Higher is Better
Effective									
Readmission (Based on Vizient Risk Model) ***Includes data up to Aug 2024 Only*	8.9%	9.6%	9.3%	8.3%	9.8%	**8.3%**		<=9.8%	Lower is Better
Hospital Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.15	1.14	1.25	0.88	1.16	**0.88**		<= 1.0	Lower is Better
Sepsis Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.33	1.43	1.36	1.07	1.35	**1.06**		<=1.0	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure) ***Includes data up to Aug 2024 Only*	22.7%	23.0%	26.8%	21.7%	24.7%	**21.7%**		<= 23.9%	Lower is Better
Efficient									
Avg Length of Stay (ALOS) (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.08	1.07	1.07	1.06	1.07	**1.06**		<= 1.02	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	156	155	155	151	155.8	**151.0**		<=160	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate	2.2%	2.1%	2.5%	4.0%	2.1%	**4.0%**		50%	High is better
Voyce Interpretation Minutes Used	46,915	53,231	59,672	57,925	617,023	**173,776**		TBD	
Patient-Centered									
Inpatient Hospital: Likelihood to Recommend Press Ganey	80.3	79.9	83.4	80.7	80.12	**80.7**		81.9	Higher is Better
ED: Likelihood to Recommend Press Ganey	74.5	74.3	75.6	78.9	75.0	**78.9**		77.2	Higher is Better
MCH - INPATIENT Press Ganey	83.7	83.2	81.4	82.8	75.00	**82.8**		82.0	Higher is Better

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Board Quality, Patient Care and Patient Experience Committee ("ECHB Quality Committee")
From: Dr. Jaideep Iyengar, MD, FAAOS, Peter Goll, Chief Administrative Officer and Kirstan Smith, BSN, CPHQ, Director of Clinical Quality
Date: November 4th, 2024
Subject: ECHMN Quarterly Quality Report

Purpose:

Provide the ECHB Quality Committee with a quarterly update on the status of quality of care within the El Camino Health Medical Network (ECHMN).

Summary:

1. Situation: Silicon Valley Medical Development (SVMD) is a separate limited liability corporation (LLC) formed in 2008 for the purposes of, among other things, developing and maintaining ambulatory ventures, establishing initiatives between independent physicians and El Camino Hospital, and establishing and providing management services to medical groups. This ambulatory and physician network is generally referred to as ECHMN. El Camino Hospital is the sole corporate member of the LLC. Pursuant to the Second and Amended Restated Limited Liability Company Operating Agreement for the LLC dated November 18, 2019 ("Operating Agreement"), SVMD is required to report to the ECHB Quality Committee on a quarterly basis. The Operating Agreement does not specify requirements for the reports, thus deferring to SVMD's managers to provide appropriate information.

2. Authority: The ECHB Quality Committee is tasked with advising the ECHB and to monitor and support the quality and safety of care provided at El Camino Hospital. Governing authority for SVMD resides with the SVMD Board of Managers. However, the overall quality of ECHMN is an area of interest for the ECHB Quality Committee as the quality of care provided by ECHMN may directly and indirectly impact the quality of the care delivered to El Camino Hospital patients.

3. Background: SVMD was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital-based outpatient care.

4. Assessment:

As of September 30, 2024, ECHMN is meeting or exceeded targets in six of our ten core quality measures. The remaining 4 measures are within 2% from goal. Since 2021, ECHMN has demonstrated a consistent pattern of continuous improvement in our core measures. Of note, both Screening for Breast and Colorectal Cancer have improved 33%, Diabetes: HBA1c <9% shows a 29% improvement and Controlling Blood Pressure shows a 15% improvement in the 4-year period.

List of Attachments:

PowerPoint background material to pre-read to facilitate the discussion and use as a reference for discussion.

Suggested Committee Discussion Questions:

What additional information would be helpful for the ECHB Quality Committee to receive in the quarterly reports from ECHMN?

El Camino Health Medical Network

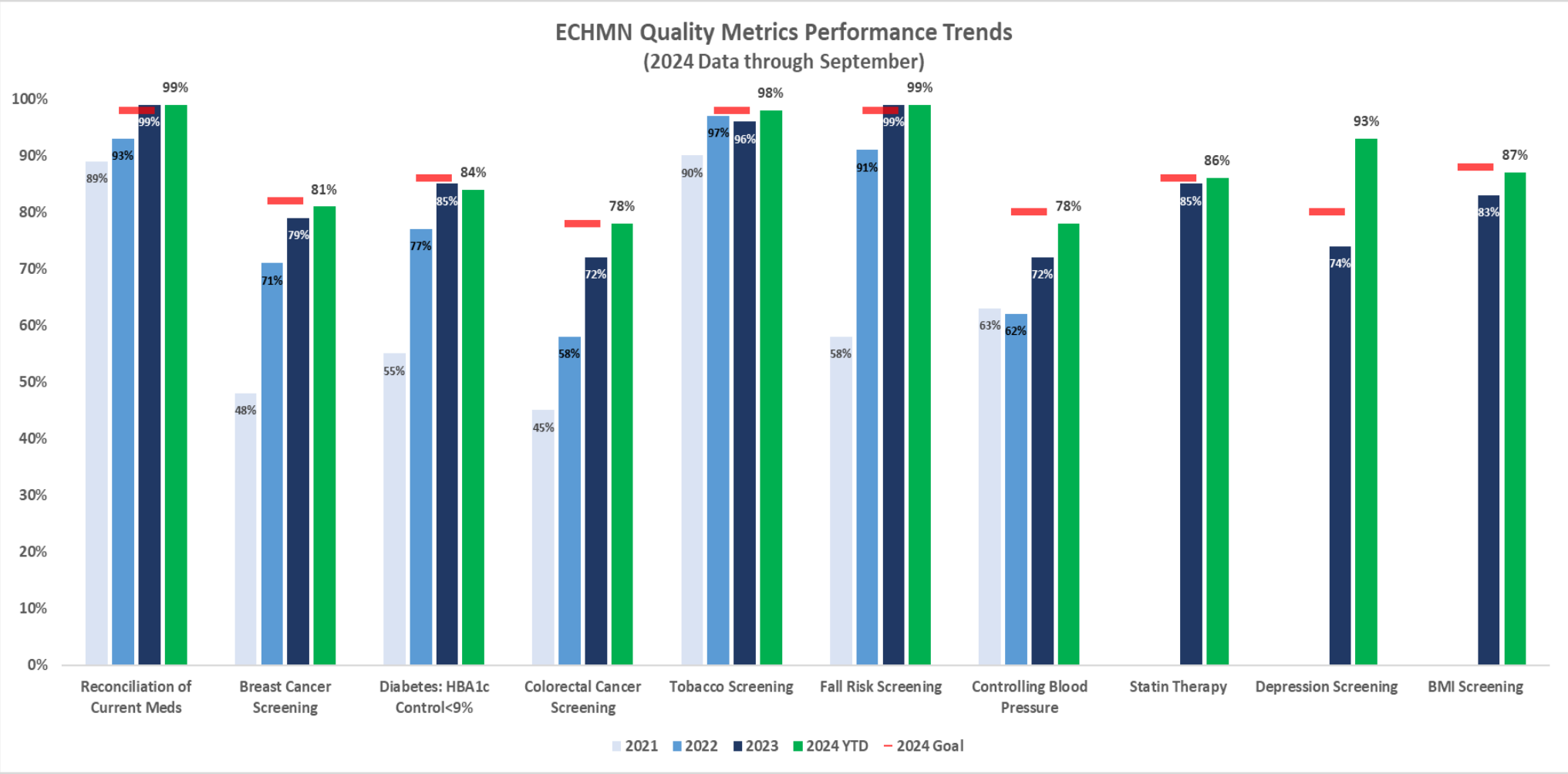
Quality Update- Third Quarter of Calendar Year 2024

Dr. Jaideep Iyengar, MD, FAAOS, Co-Chair of Quality
Peter Goll, Chief Administrative Officer
Kirstan Smith, BSN, CNN, CPHQ, Director of Clinical Quality
November 4, 2024

Year Over Year Trending from CY 2021 thru 9/30/2024

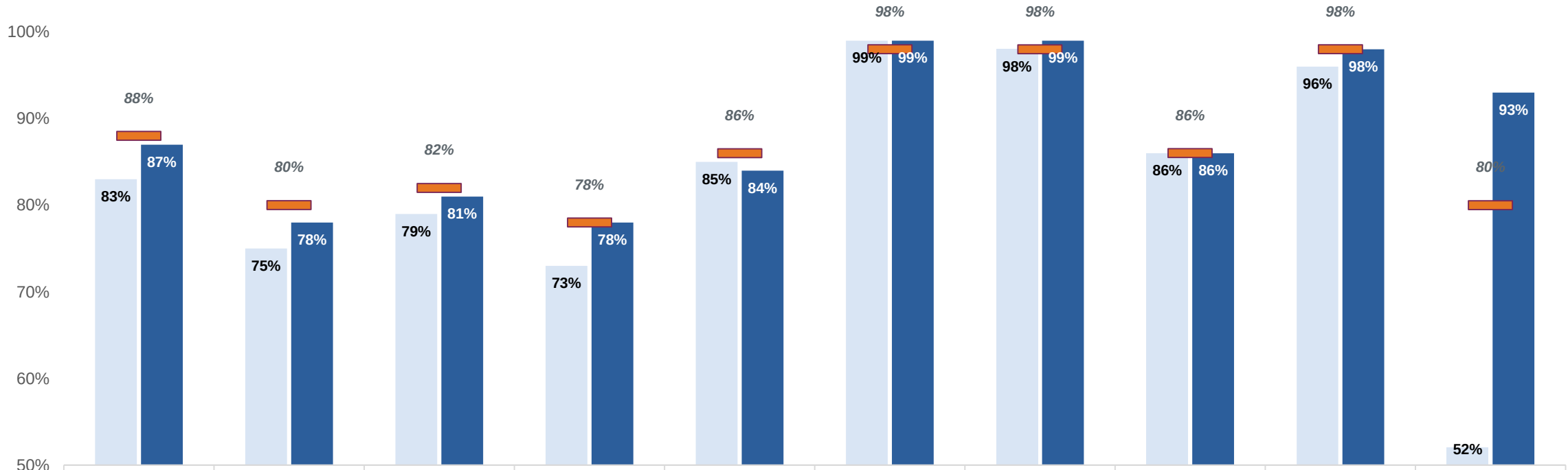
The following trends can be seen from CY21 to YTD24:

- *Both Breast Cancer Screening and Colorectal Cancer Screening show a 33% improvement.*
- *Diabetes: HBA1c <9% shows a 29% improvement.*
- *Controlling Blood Pressure shows a 15% improvement.*



YTD24 Overall Performance vs CY23 Results thru 9/30/24

ECHMN Overall Performance (CY24 Through Sept) vs. CY23

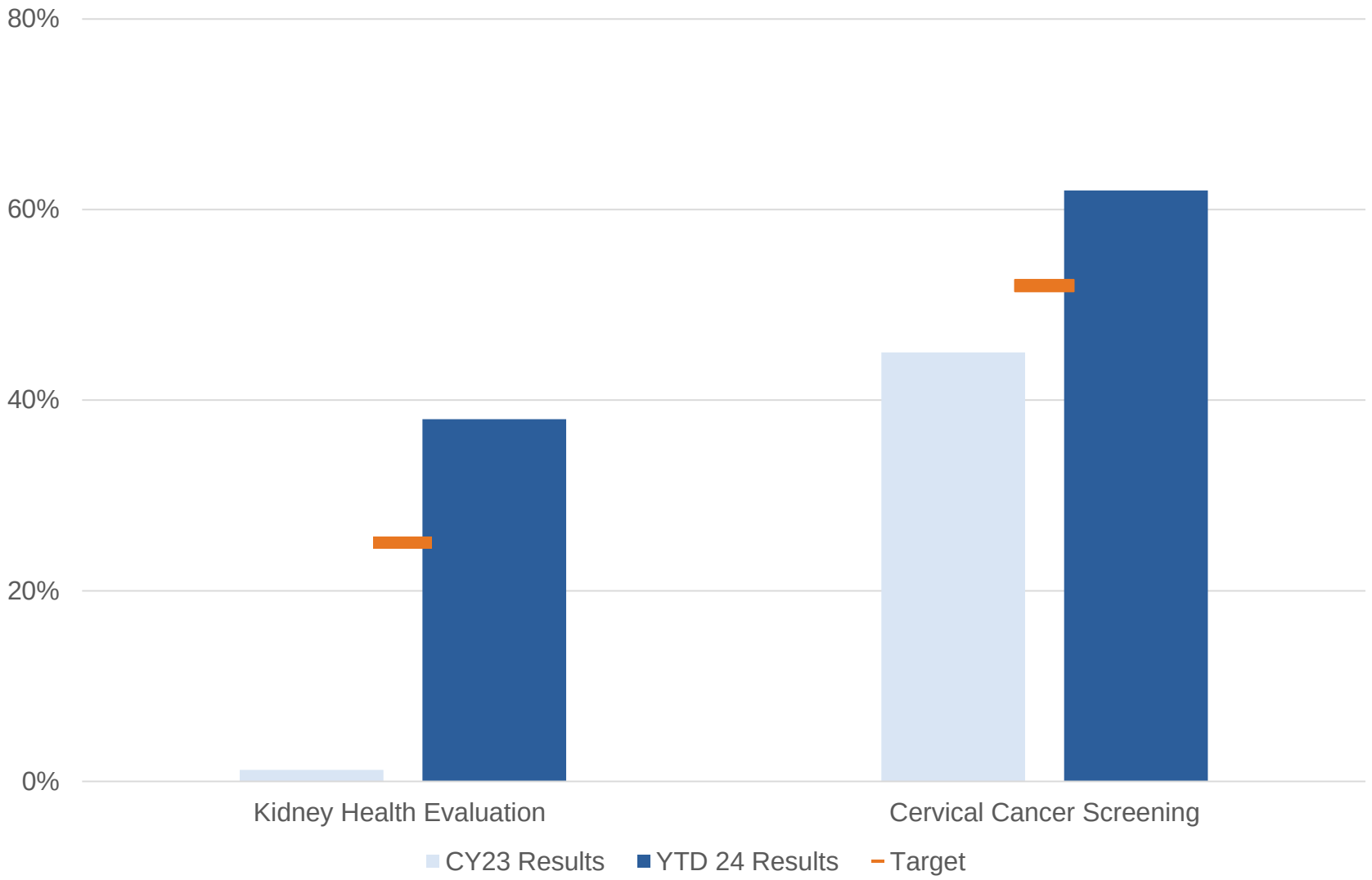


	BMI Preventive Care and Screening Plan	Controlling High Blood Pressure	Breast Cancer Screening	Colorectal Cancer Screening	Diabetes: Hemoglobin A1c <9%	Screening for Future Fall Risk	Documentation of Current Medications in the Record	Statin Therapy for ACSVD Patients	Tobacco – Preventative Screening and Cessation Intervention	Screening for Depression and Follow-Up Plan
CY23 Results	83%	75%	79%	73%	85%	99%	98%	86%	96%	52%
CY24 YTD Perf	87%	78%	81%	78%	84%	99%	99%	86%	98%	93%
CY Targets	88%	80%	82%	78%	86%	98%	98%	86%	98%	80%

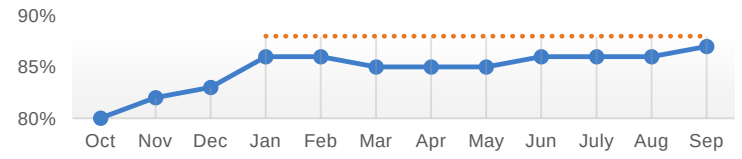
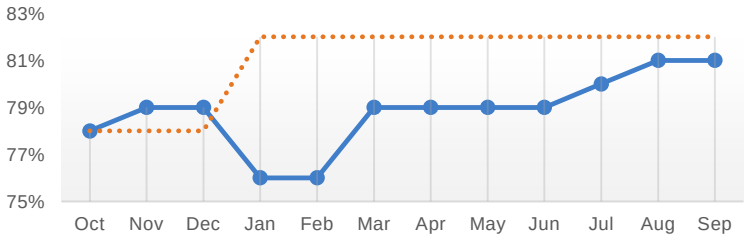
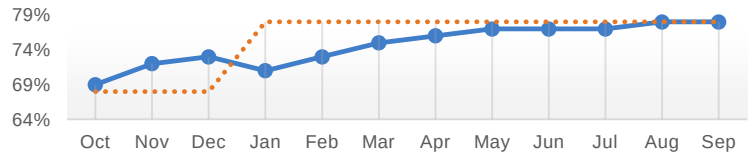
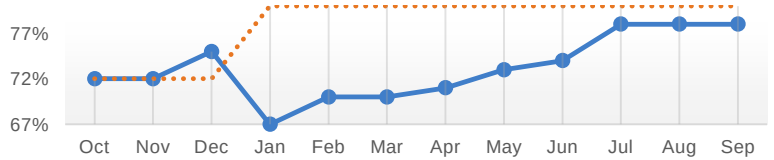
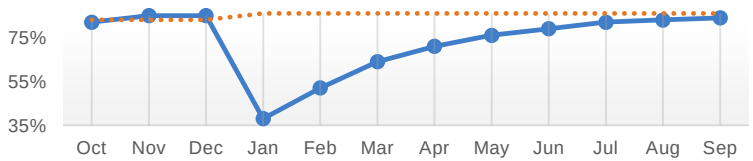
CY23 Results CY24 YTD Perf CY Targets

El Camino Health

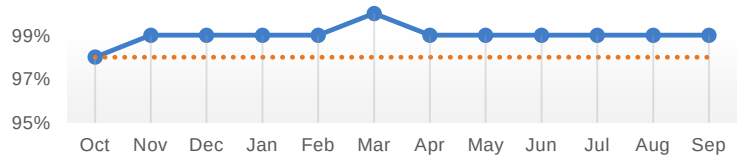
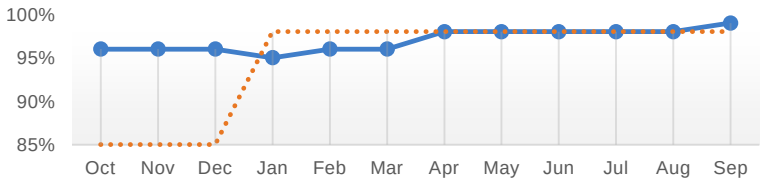
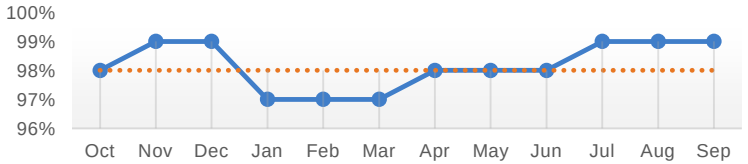
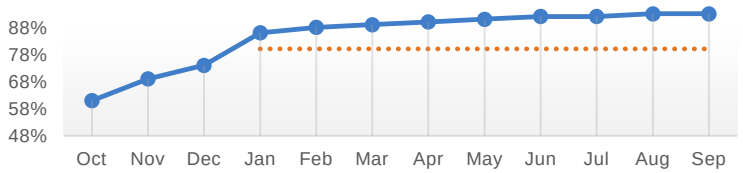
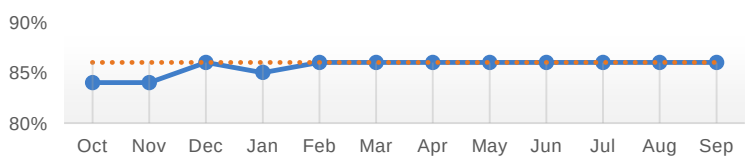
CY 2024- Radar Quality Measures and Targets thru 9/30/24



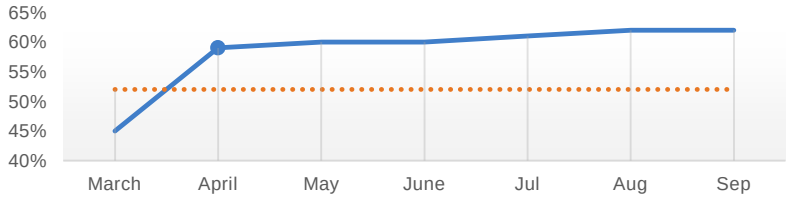
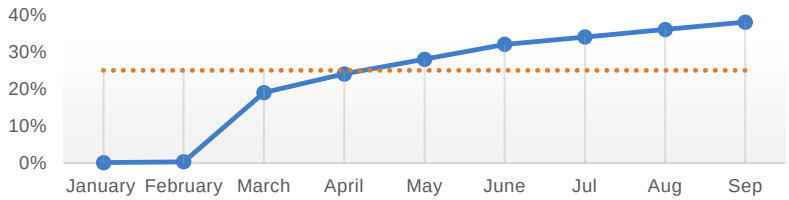
Calendar Year 2024 – Core Quality Measure and Targets YTD Thru 9/30/24

Core Quality Measures	CY 2024 Target	YTD 2024 Results	12 Month Trend	Notes
BMI Preventive Care and Screening Plan	88%	87%		• Providers that were not meeting target were sent an educational memo that documented the appropriate steps to achieve this measure.
Breast Cancer Screening	82%	81%		• Chart Abstraction to be completed by 11/30/24. • The Quality Department will work with the Manager of the Radiology Department to schedule patients that have an order for mammogram. • PCPs will receive a list of their patients needing screenings with the ask for the list to be reviewed and orders placed and communicated to the patients appropriately.
Colorectal Cancer Screening	78%	78%		• Chart Abstraction to be completed by 11/30/24. • PCPs will receive a list of their patients that need CRC screening orders placed. PCPs will be asked to review their lists and place the appropriate order and communicate this to patients.
Controlling High Blood Pressure	80%	78%		• “Home Blood Pressure Monitoring” patient educational material created and disseminated to the clinics. • MyChart Home Blood Pressure Self Report Campaign • BPA for Specialist and Urgent Care providers to refer hypertensive patients to the PCP. This work queue would be managed by the advice nurses.
Diabetes: Hemoglobin A1c <9%	86%	84%		• Based on the continuing positive trend, we are on trend to achieve this measure. • PCPs will receive a list of their patients that need an A1c ordered with the ask for the list to be reviewed and orders placed and communicated to the patients appropriately.

Calendar Year 2024 – Core Quality Measure and Targets Thru 9/30/24

Core Quality Measures	CY 2024 Target	YTD 2024 Results	12 Month Trend	Notes
Documentation of Current Medications in the Record	98%	99%		• Continue to monitor this measure to ensure trend is sustained.
Tobacco – Preventative Screening and Cessation Intervention	98%	99%		• Continue to monitor this measure to ensure trend is sustained.
Screening for Future Fall Risk	98%	99%		• Continue to monitor this measure to ensure trend is sustained.
Screening for Depression and Follow-Up Plan	80%	93%		• Continue to monitor this measure to ensure trend is sustained.
Statin Therapy for ACSVD Patients	86%	86%		• Continue to monitor this measure to ensure trend is sustained.

Calendar Year 2024 – Radar Quality Measures and Targets Thru 9/30/24

Core Quality Measures	CY 2024 Target	CY 2024 Results	Year-to-Date Trend	Notes
Cervical Cancer Screening	52%	62%		• Chart Abstraction to be completed by 11/30/24. • Continue to monitor this measure to ensure trend is sustained.
Kidney Health Evaluation	25%	32%		• Issue identified and corrected with the coding in Epic. • The Quality Measures “Best Practice Guide” provides education about the correct labs to order.

Calendar Year 2024 – Quality Initiatives Action Plans

The Quality Department is working on the following initiatives:

- Hypertension Clinical Protocol Committee: *This a sub-committee of the quality committee. The focus is to establish a standardized approach for management of hypertension to include clinical protocols, patient education and enhancements to EPIC*.
  - *The sub-committee developed a hypertension clinical protocol and patient education material, which was approved by the Quality Committee.*
  - *Patient Blood Pressure Self-Reporting Campaign*
    - *A MyChart message will be sent to all patients not meeting the Controlling Hypertension Measures, asking the patient to provide a home blood pressure reading.*
  - *Best Practice Alert (BPA) and Advice Nurse Work Queue Pilot*
    - *Using a ECHMN-developed template, the advice nurses will help to manage patients that were hypertensive during Urgent Cares and Specialists visits. The Advice Nurses will follow up with the patient and an attempt to document a self-reported blood pressure and/or facilitating a visit with their PCP as appropriate. The pilot will be evaluated for successes and areas of opportunity before being rolled out networkwide.*
- Annual Wellness Visit (AWV) Campaign: *In collaboration with the Operations team, ensure that our Medicare Advantage (MA) patients are receiving their annual wellness visits. The AWV allows us to address open care gaps.*
  - *As of October 14th, 71.5% of AWV have been completed for our Alignment patients. This is a 44.5% improvement from CY23. The Clinics continue to provide ongoing outreach to the remaining patients.*
  - *The Patient Experience Coordinator has reached out to all UHC MA patients to offer an AWV appointments.*
- Quality Assurance Performance Improvement (QAPI): *Ongoing monthly meetings with the Operations team to review quality performance, identify opportunities and implement action plans.*
  - *We have streamlined our monthly collaboration between Safety, Operations and Quality to continue to improve quality measures.*
- Provider Performance Review: *Monitor and review quality performance of physicians and provide necessary training as needed.*
  - *The PQQR provides the PCPs with their individual performance on the core quality measures and a comparison to ECHMN's performance; as well as insight to improve on measures they are not meeting.*
  - *PQQRs have been sent to all PCP's for first, second, third quarters of this year.*