El Camino Health

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

Monday, February 3, 2025 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

Pancho Chang will be participating via teleconference from 15 Fiske Street, Shrewsbury, MA 01545

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: 984 9372 0915 # 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 (12/02/2024) b. FY25 Pacing Plan	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:30 – 5:40**
6.	**AD HOC COMMITTEE UPDATE**	Krutica Sharma, MD Ad Hoc Committee Chair	Information	**5:40 – 5:50**
7.	**QUALITY COMMITTEE CHARTER** a. Approve Quality Committee Charter	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:50 – 6:00**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
8.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Discussion	**6:00– 6:05**
9.	**Q2 FY25 STEEEP DASHBOARD REVIEW / FY25 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:05 – 6:25**
10.	**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	**6:25 – 6:45**
11.	**RECOMMEND QUALITY IMPROVEMENT & PATIENT SAFETY PLAN (QIPS) FOR APPROVAL**	Shreyas Mallur, MD, Chief Quality Officer	**Motion Required**	**6:45 – 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 (12/04/2024) b. Quality Council Minutes (01/08/2025) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Carol Somersille, MD Quality Committee Chair	Discussion	**7:01– 7:06**
14.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (12/02/2024)** *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:06 – 7:11**
15.	**Q2 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	**7:11 – 7:16**
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**	**7:16 – 7:26**
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	**7:26 – 7:36**
18.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:36 – 7:37**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
19.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:37 – 7:38**
20.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:38 – 7:44**
21.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:44 – 7:45**

Next Meetings: 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, December 2, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD, Chair
Melora Simon, Vice Chair
Pancho Chang**
Shahram Gholami, MD
Steven Xanthopoulos, MD
John Zoglin

Members Absent
Jack Po, MD
Krutica Sharma, MD

Staff Present
Dan Woods, CEO (*joined at 6:48 p.m.)*
Mark Adams, MD, CMO
Theresa Fuentes, CLO (*joined at 6:48 p.m*.)
Shreyas Mallur, MD, CQO
Deb Muro, CIO
Cheryl Reinking, DPN, RN CNO
Lyn Garrett, Senior Director, Quality
Corneliu Delogramatic, MD, Director, Health Equity and Clinical Integrity
Priya Shah, Deputy Chief Legal Officer
Gabriel Fernandez, Coordinator, Governance Services

**via teleconference

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 **5:34 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Director Jack Po and Dr. Krutica Sharma were absent.	Call to order at **5:34 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	No members of the Quality Committee requested Emergency AB-2449 approval. Mr. Chang participated remotely under Just Cause and confirmed that no other adults were present in the room.	
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 members of the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. **Motion**: To approve consent calendar (a) Minutes of the Open Session of the Quality Committee Meeting (11/04/2024) **Received**: (b) FY25 Pacing Plan and (c) FY25 Committee Goals **Movant**: Zoglin **Second**: Simon **Ayes**: Somersille, Chang, Gholami, Simon, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Po, Sharma **Recused**: None	***Consent Calendar Approved***
6. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 5:38 p.m. **Movant**: Gholami **Second**: Simon **Ayes**: Somersille, Chang, Gholami, Simon, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Po, Sharma **Recused**: None	***Recessed to Closed Session at 5:38 p.m.***
7. AGENDA ITEM 12: 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 and the Closed Session Minutes of the November 4, 2024 meeting.	***Reconvened Open Session at 5:47 p.m.***
8. AGENDA ITEM 13: PATIENT STORY	Ms. Reinking shared the ninety-three (93) patient comments that nominated members of the nursing team for the October DAISY award, which recognizes exceptional care provided by nurses. She provided a brief history of the DAISY award and shared the process for nominations.	
9. AGENDA ITEM 14: COMMUNITY MEMBER RECRUITMENT UPDATE	Chair Somersille gave a verbal report of the progress made by the recruitment ad hoc committee since Dr. Sharma was absent. The goal of the recruitment is to find three community members with a particular emphasis on community members with expertise in health equity, customer and patient experience, and outpatient quality. The Committee will be finalizing the areas of expertise needed with this recruitment.	
10. AGENDA ITEM 15: HEALTH EQUITY REPORT	Dr. Mallur introduced Dr. Delogramatic who opened the discussion highlighting efforts to systematically collect and utilize data on social determinants of health (SDOH) to improve patient care. El Camino Hospital is aligning with CMS's roadmap, which emphasizes screening patients for SDOH and integrating responses into actionable interventions. The hospital has identified gaps in previous methods, such as unstructured data collection, and is working toward	***Dr. Xanthopoulos left at 5:58 p.m. and did not return. The discussion continued without quorum physically present in the district.***

	systematizing efforts, including assigning roles to nursing staff for initial screenings and care coordinators for follow-ups. Committee discussion included challenges in data collection—such as patient reluctance to share demographic or financial information—and the need to ensure cultural and linguistic sensitivity, particularly for Spanish-speaking patients. The team emphasized reducing redundancy in screenings, balancing the workload on healthcare providers, and ensuring that actionable steps accompany screening results. Partnerships with local organizations, like food banks and shelters, are crucial for providing meaningful support. Dr. Delogramatic acknowledged expanding these efforts to outpatient settings, optimizing technology to streamline patient responses, and ensuring alignment between inpatient and outpatient data collection to maintain consistency.	
11. AGENDA ITEM 16: PSI REPORT	Dr. Mallur and Ms. Garrett provided an update on the Patient Safety Indicators (PSIs) scores for FY23 and FY24. Discussion focused on the hospital's ongoing efforts to monitor and improve patient safety through the analysis of key indicators. The group discussed challenges with certain metrics, such as the broad and controversial definition of surgical complications, which often misrepresented outcomes. This measure will soon be replaced with a more precise one focused on post-surgical outcomes. Concerns about an increase in reported pressure ulcers and birth injuries were addressed, with explanations attributing some cases to medical devices and the complexities of end-of-life care. The team emphasized new measures, such as enhanced monitoring protocols and technology, to reduce these occurrences. Although some indicators showed increases, these were contextualized as part of routine fluctuations and ongoing improvements in reporting. The importance of comparing performance to peer institutions and using data to guide meaningful change was a recurring theme, with a commitment to continued evaluation and action	***Action:*** *Staff to analyze if the increase in PSI 17 (birth trauma) is statistically significant and provide context with rates from similar hospitals.* *Jack Po, MD logged into the zoom at 6:36 p.m. but was unable to meet AB 2449 requirements to join the meeting. However, he stayed on the line to view the open session.*
12. AGENDA ITEM 17: ARTIFICIAL INTELLIGENCE REPORT	Ms. Muro presented the Artificial Intelligence report. The discussion focused on the implementation and impact of various artificial intelligence tools at the hospital. These tools aim to streamline operations, enhance patient care, and improve physician workflows. Notable advancements included AI-generated responses to patient messages, which save time for physicians while maintaining empathy in communication, and ambient listening technology that translates physician-patient conversations into medical notes, reducing documentation burdens. Additionally, predictive analytics are being used to optimize operational areas such as infusion scheduling and operating room utilization.	*Mr. Woods and Ms. Fuentes joined the meeting at 6:48 p.m.*

	The committee also discussed emerging technologies, such as call center AI, which could automate patient interactions, though concerns about maintaining quality and human oversight were emphasized. Ethical considerations, including data privacy, security, and potential bias in AI models, were a focal point, with governance and training processes in place to ensure responsible use. The hospital is seen as an early adopter, progressing cautiously and aligning its efforts with broader industry trends while customizing tools to its unique needs.	
13. AGENDA ITEM 18: COMMITTEE SURVEY RESULTS	Before this topic was addressed Ms. Fuentes noted that there was not a quorum present, and the meeting could not proceed unless there was a quorum physically present within the district. Chair Somersille inquired whether Dr. Po could be considered present since he was on the line, but Ms. Fuentes advised that a committee member that does not meet remote participation requirements generally should not attend the meeting as a member of the public. Dr. Somersille decided to continue the meeting without committee action and to see if Dr. Xanthopoulos would return. Chair Somersille opened the discussion on the committee survey results and noted some of the items would be rectified by the work of the recruitment ad hoc committee. The remainder of the discussion focused on a review of committee effectiveness, highlighting areas for improvement and celebrating progress. Key issues included the need to address gaps in subject-matter expertise by adding community members and fostering a pipeline of qualified candidates based on competency criteria. Members expressed concerns about inconsistent involvement in strategic planning, emphasizing the importance of aligning committee knowledge with the organization's long-term goals. Upcoming plans include broader access to strategic planning presentations and town hall meetings to ensure committee members are well-informed. Another point of discussion was the balance between managerial and directorial oversight. Some committee members felt there was a tendency to delve too deeply into execution rather than focusing on governance. To address this, there were suggestions for targeted training sessions to refine this balance. The review also acknowledged the committee's improvement in areas such as culture and collaboration, with members advocating for a sustainable pipeline to maintain diverse and skilled membership. The committee emphasized the value of regular self-assessments to ensure continued growth and alignment with organizational objectives, while fostering a balance of stability and fresh perspectives within its membership	

14. AGENDA ITEM 19: QUALITY COMMITTEE CHARTER	Dr. Gholami confirmed that Dr. Xanthopoulos would not be returning to the meeting. Ms. Fuentes again recommended adjourning the meeting and tabling this topic to the next meeting as quorum was not physically present in the district.	***The topic was tabled for discussion at the next Quality Committee meeting.***
15. AGENDA ITEM 20: COMMITTEE ANNOUNCEMENTS	The Committee did not have any announcements.	
16. AGENDA ITEM 21: ADJOURNMENT	The meeting officially ended at 5:58 p.m. with the departure of Dr. Xanthopoulos. The remaining members of the Committee were present until 7:30 p.m.	

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

_____
Tracy Fowler, Director of Governance Services

Prepared by: Tracy Fowler, Director of Governance Services
Reviewed by: Carol Somersille, MD, Quality Committee Chair; Theresa Fuentes, Chief Legal Officer

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 Enterprise/ STEEEP 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 Board of Directors
Quality, Patient Care, and Patient Experience Committee Charter

Purpose

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

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

Authority

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

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

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

Membership

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

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

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

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

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

Executive Support and Participation

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

General Responsibilities

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

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

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

Specific Duties

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

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

Specific duties of the Committee include the following:

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

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

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

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

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

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

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

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

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

Committee Effectiveness

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

Meetings and Minutes

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

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

El Camino Health

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

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

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

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

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

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

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

El Camino Health

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

Term

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

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

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

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

Attendance:

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

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

Meetings:

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

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

El Camino Health

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

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

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

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

All committee communications must go through the designated committee Chair.

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

Hospital and Medical Network Organizational Structure November 2024

El Camino Healthcare District

ECHD Sole member of Hospital

El Camino Hospital Corporation MV & LG

Nonprofit 501(c)(3) Corp.

Doing business as (d/b/a) El Camino Health

Hospital Sole member of SVMD

Silicon Valley Medical Development, LLC

Limited Liability Company
H&S code 1206(g) clinics
d/b/a El Camino Health
d/b/a El Camino Health Medical Network

El Camino Hospital Board of Directors

Hospital Board Advisory Committees:
- Compliance and Audit
- Executive Compensation
- Finance
- Governance
- Investment
- Quality, Patient Care, and Patient Experience

SVMD Board of Managers

SVMD Advisory Committees
- Compliance
- Quality

Members:
- Bob Rebitzer, Chair
- President SVMD, ex officio
- Mark Adams
- Carlos Bohorquez
- Lanhee Chen
- Peter Fung, MD
- Shahram Gholami, MD
- Shabnam Husain, MD
- George Ting, MD
- Dan Woods

SVMD reporting requirements to Hospital per Operating Agreement:
- Semi-annually to Hospital Board on performance to strategic metrics
- Quarterly to Hospital Quality and Finance Committees
- Annually to Hospital Compliance Committee

Professional Services Agreement

San Jose Medical Group

Professional Corporation

Professional Services Agreement

USNC

Professional Corporation

Professional Services Agreement

El Camino Medical Associates

"Friendly" PC
Owner: Richard Ornelas, MD

MSO Services/Funding Agreements

(e.g., credentialing, quality, billing and collection, managed care functions)

El Camino Health Alliance

IPA
"Friendly" PC
Owner: Mark Adams, MD

Medical Dimensions, Inc.

IPA
Professional Corporation
Majority Owner: El Camino Health MDI

Professional and Administrative Services Agreements

*SVMD provides Physician and AHP professional medical services to **ECH Hospital patients** (e.g., Medical Director services, Cancer Center, Behavioral Health)*

Administrative Services Agreement

Services provided by Hospital to SVMD:
- *Procurement - equipment, inventory, and supplies*
- *Patient Experience Support*
- *Accounting, Payor, and Revenue Cycle Support*
- *IT support*
- *Facilities and leasing support*
- *Marketing and communications support*
- *Legal and Compliance support*
- *Transitional Executive staffing*

Operating Agreement

Business of SVMD is responsibility of SVMD Board of Managers, except sole power reserved by Hospital, including:
- *Approval of SVMD's Annual Budget*
- *Role of SVMD in strategic plans*
- *Unbudgeted expenditures exceeding $1M; capital expenditures exceeding $5M*
- *Selection of auditor to perform audits of SVMD*
- *Transfer, sale, merger, or disposition of assets*
- *Amendment of Operating Agreement*

Other entities owned by El Camino Hospital:

Nonprofits, Hospital Sole Member of:
- *Concern EAP*
- *El Camino Hospital Foundation*

(Note: El Camino Hospital Auxiliary owned by individual volunteers and members)

Spine Sports Surgery Center, LLC (51%)

El Camino Health Rehabilitation Institute, LLC (51%)

Pathways Homecare and Hospice (50%)

El Camino Surgery Center (100%) (dormant)

Satellite Dialysis of Mountain View (30%)

Satellite Dialysis of Los Gatos (30%)

Satellite Dialysis of Silver Creek (30%)

Satellite Dialysis of San Jose (30%)

Wellbound of Mountain View LLC (30%)

El Camino Health

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
Date: February 3, 2025
Subject: Patient Experience Feedback

Purpose: To provide the Committee with written patient feedback that is received from patients or families.

Summary:

1. Situation: Last month, a patient in the orthopedic unit at the Los Gatos campus had concerns about the noise level at night.

2. Background: After researching the concerns and speaking with other patients, the team learned that the "jet engine" sound was the floor buffer used to clean the floors at night on the ortho unit. The team recognized this noise as avoidable and wanted to explore other options for floor cleaning.

3. Outcomes: The nursing team met with the environmental services team and collaborated to determine if a different time could be utilized for floor cleaning that did not disrupt patients' sleep cycles. The team decided to change the time to earlier in the late afternoon to perform the buffing. In addition, the team has worked on making sure staff observe quiet time after 9 p.m.

Suggested Committee Discussion Questions:

1. How do you make sure that patients have a healing and quiet environment in other areas?

2. Is there technology available to help with providing a healing environment?

Press Ganey Comment

From Los Gatos Orthopedic Patient

“The biggest issue I had in the negative side is it was extremely noisy at night. From 9pm to 1am-- it sounded like voices were too loud and like jets were landing in the hallway. The first night I had hospital earplugs that didn’t do a thing. The next night I had my own better earplugs that helped to a degree. I believe healing needs good rest and that wasn’t happening. It was the noisiest overnight in a hospital I have ever had.”

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: February 3, 2025
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through December 2024

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety, and experience measure performance through December 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 16 (2.67 cases per month) (Goal: </= 27 infections FY 2025 or less than 2.25 cases/month) Hospital Acquired C=Diff infections in Q2 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 have measures described above in place which we believe will impact this rate)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 6 CAUTI in Q1 FY2025 with a goal to have less than ten for the fiscal year. Q2 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. We are also looking at spreading best practices across the organization)

c. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for the end of Q1 FY2025 year to date (0.16) 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 (4.33) 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 Q3/Q4 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 (83.2) to target of 80%. (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 through Q2 (71%) 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 (9.5%) 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 through Q2 FY25 (0.97) 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 through Q2 FY2025 (1.07) 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 October of 2024 (25.4%) 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 (1.06) 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).** Performance through Q2 2025 (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 (11%) 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 will be on track to meet this metric since a new Epic tool for screening was implemented. The latest month screening rate was 74%)

2. Voyce Interpretation Minutes Used: FY 2025 performance (335,532 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 FY25 YTD (80.9) 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 (82.2) 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 (78.8) through Q2 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 (81.6) to target of (83.4). We continue to perform in the top decile in the Bay Area and 87% nationally.

Attachments:

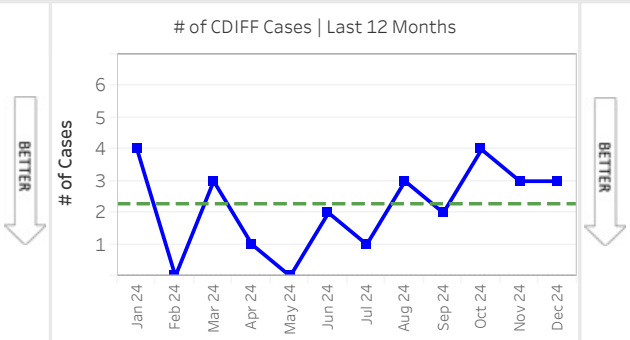
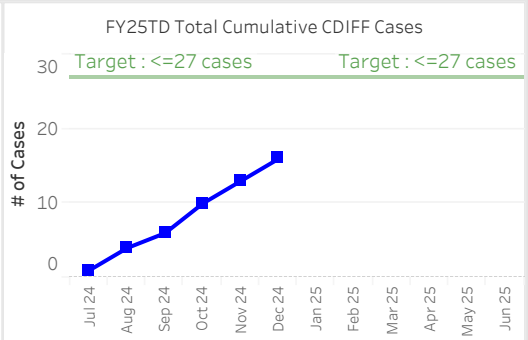
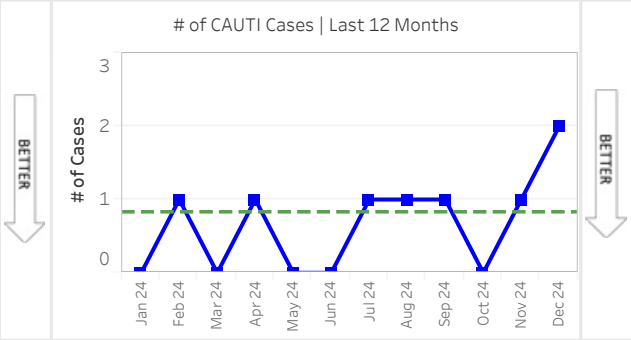
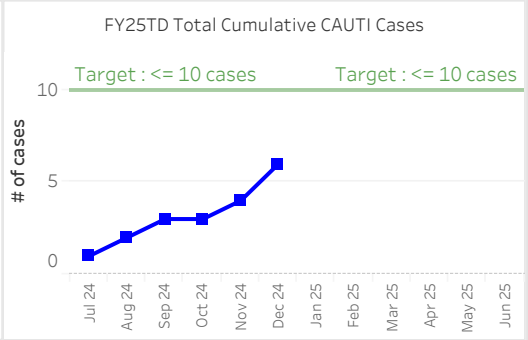
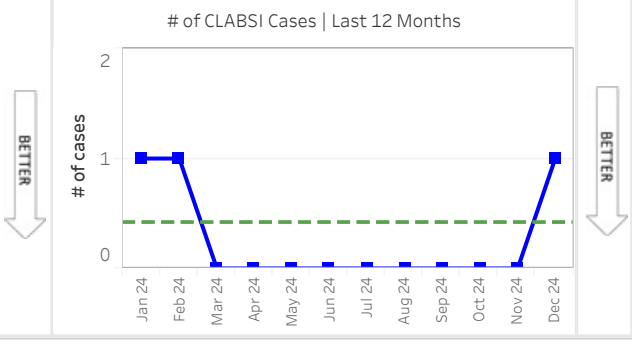
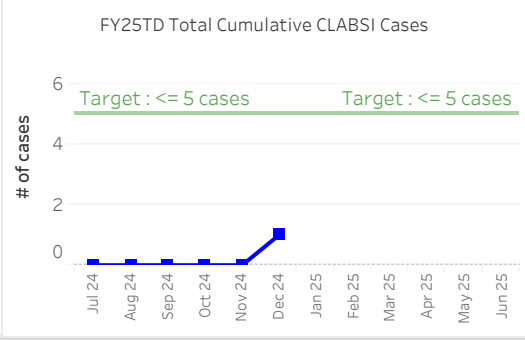
1. Enterprise Quality Dashboard through December of 2024
2. STEEEP Dashboard through December of 2024.

El Camino Health

FY25 Enterprise Quality, Safety and Experience Dashboard

December 2024 (unless other specified)

Month to Board Quality Committee : February 2025

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 : December 2024	3 cases	2.67 cases/mo	2.33 cases/mo	2.25 cases/mo		
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : December 2024	2 cases	1.00 cases/mo	0.92 cases/mo	0.83 cases/mo		
Central Line Associated Blood Stream Infection (CLABSI) cases Latest Month : December 2024	1 cases	0.17 cases/mo	0.25 cases/mo	0.42 cases/mo		

Quality Department | Note : updated as of January 21, 2025

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

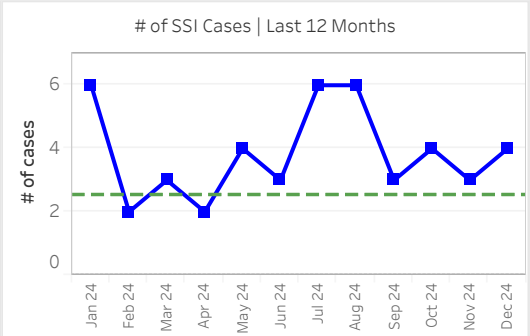
El Camino Health

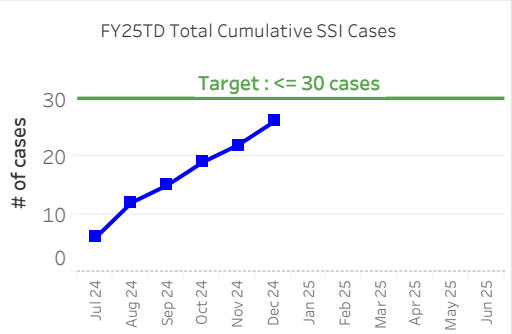
FY25 Enterprise Quality, Safety and Experience Dashboard

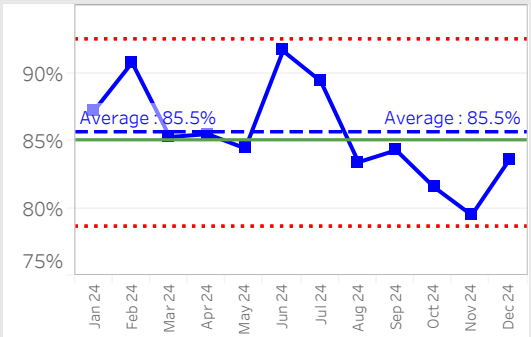
December 2024 (unless other specified)

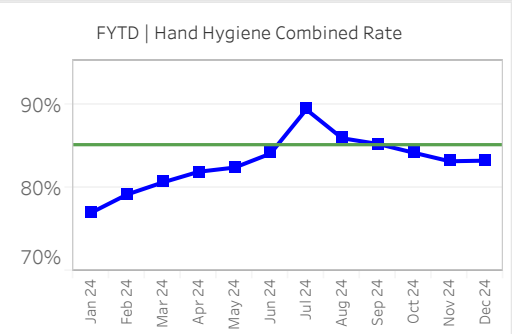
Month to Board Quality Committee : February 2025

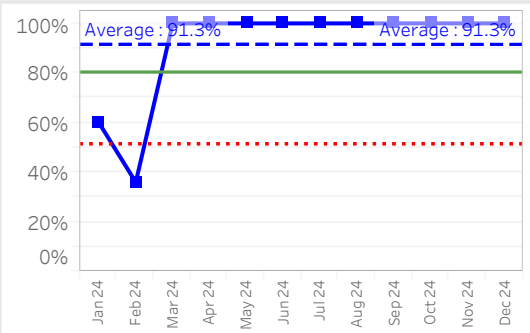
Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Surgical Site Infections (SSI) cases Latest Month : December 2024	4 cases	4.33 cases/mo	4.33 cases/mo	2.50 cases/mo	BETTER	BETTER
Hand Hygiene Combined Compliance Rate Latest Month : December 2024	83.6% (12954 / 15496)	83.2% (78275 / 94032)	84.1% (64956 / 77245)	85%	BETTER	BETTER
Hand Hygiene % of Departments Meeting Target Latest Month : December 2024	100.0% (25 / 25)	100.0% (150 / 150)	54.7% (164 / 300)	80% of units	BETTER	BETTER

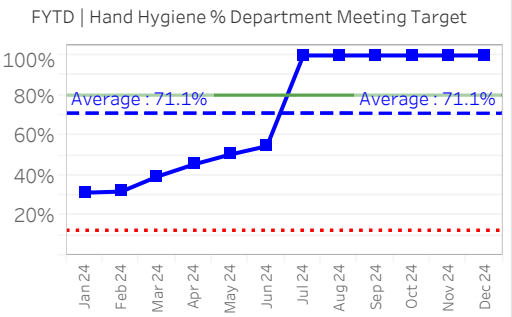












Quality Department | Note : updated as of January 21, 2025

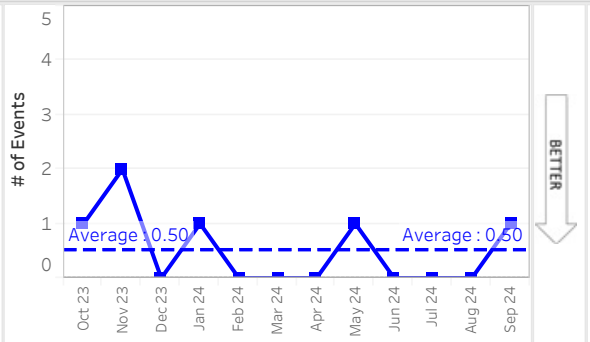
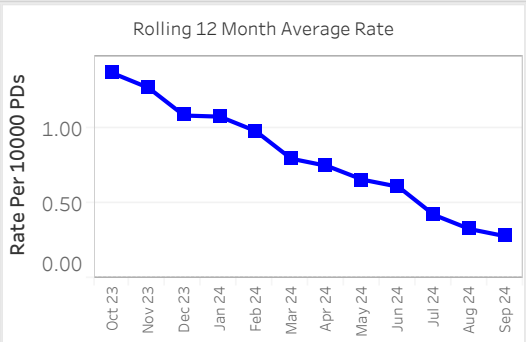
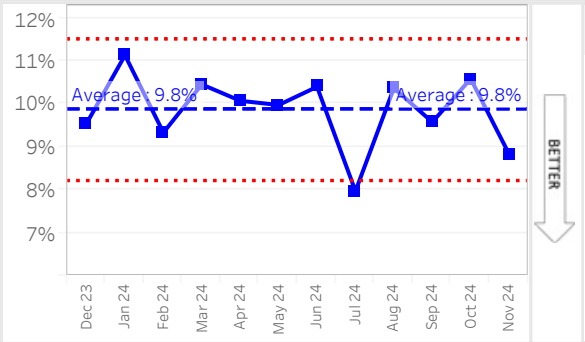
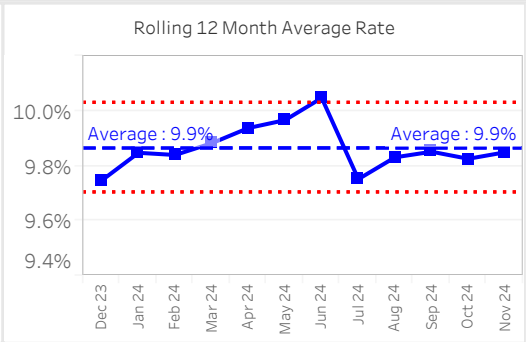
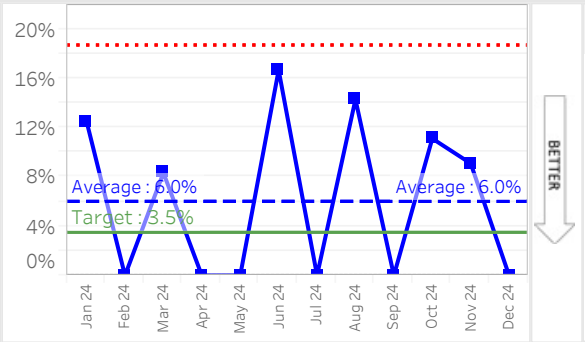
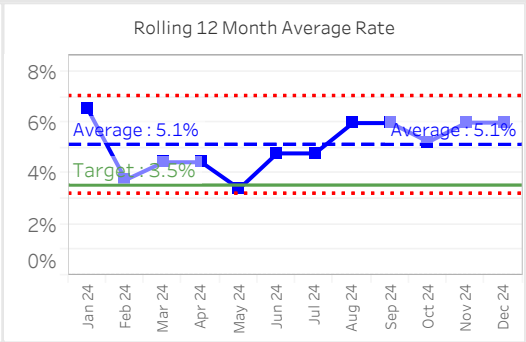
Measure	Definition Owner	Metric Definition	Data Source
Surgical Site Infections (SSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of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

December 2024 (unless other specified)

Month to Board Quality Committee : February 2025

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 : September 2024	1 events	0.56 (1 / 17964)	1.93 (41 / 212460)	n/a		
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : November 2024	8.8% (113 / 1280)	9.5% (614 / 6479)	9.8% (1519 / 15552)	<= 9.8%		
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : December 2024	0.0% (0 / 7)	5.2% (3 / 58)	5.9% (5 / 85)	<= 3.5%		

Quality Department | Note : updated as of January 21, 2025

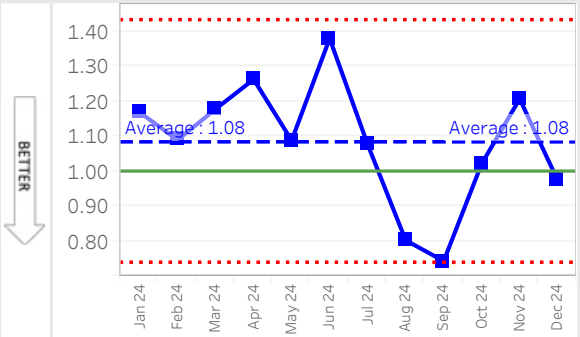
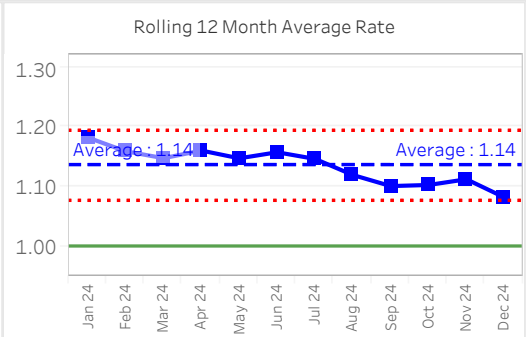
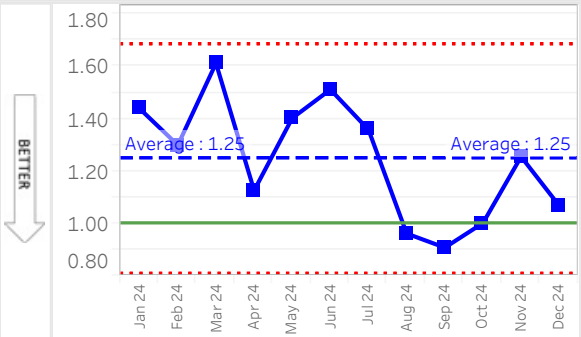
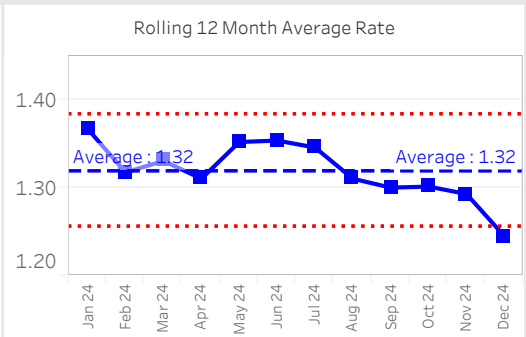
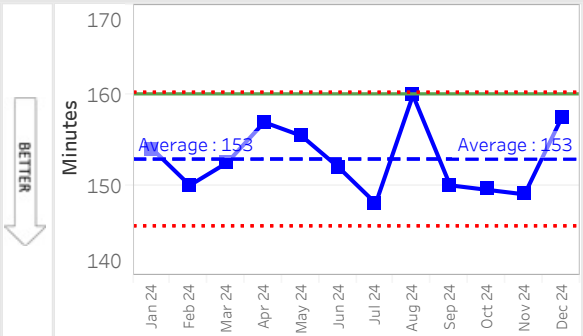
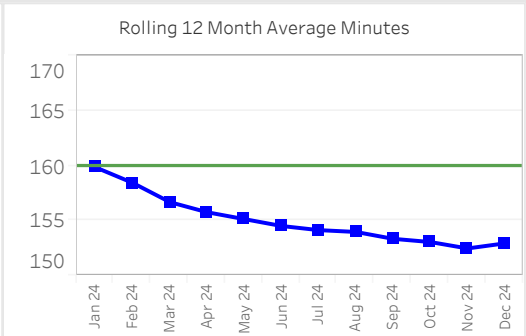
Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events 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

December 2024 (unless other specified)

Month to Board Quality Committee : February 2025

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 : December 2024	0.97 (2.13% / 2.19%)	0.97 (2.05% / 2.11%)	1.16 (2.55% / 2.20%)	1.00		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : December 2024	1.07 (9.52% / 8.92%)	1.07 (9.89% / 9.22%)	1.35 (13.37% / 9.91%)	1.00		
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : December 2024	MV : 173 mins LG : 142 mins ENT : 158 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 January 21, 2025

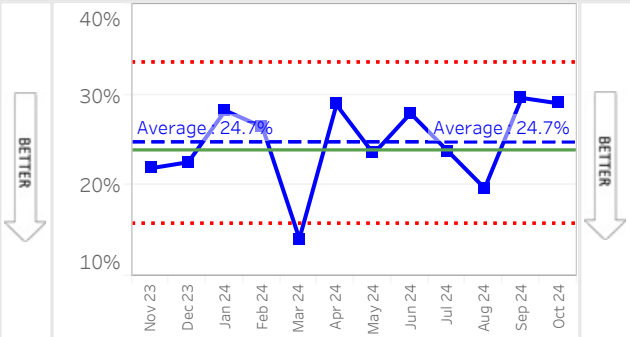
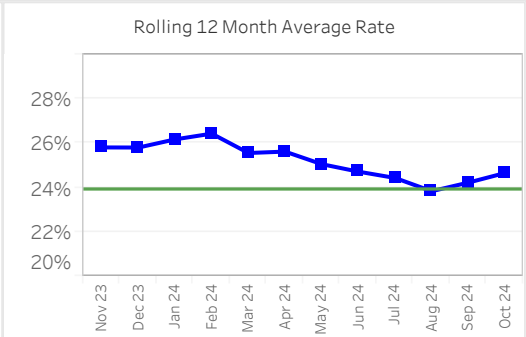
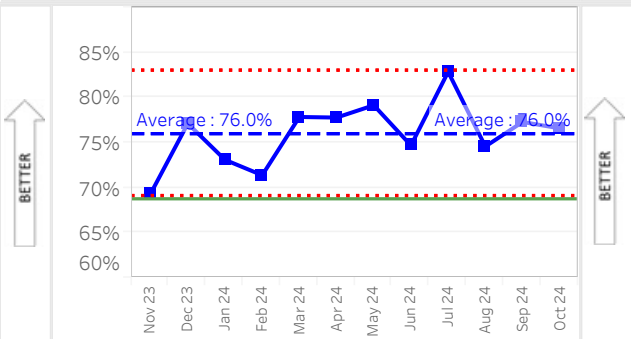
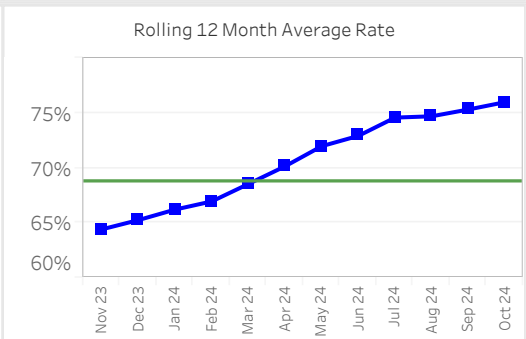
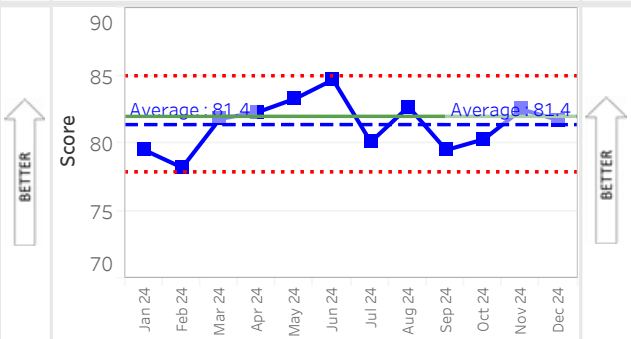
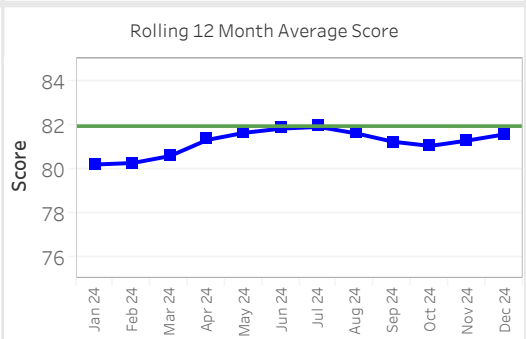
Measure	Definition Owner	Metric Definition	Data Source
Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2023 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health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

December 2024 (unless other specified)

Month to Board Quality Committee : February 2025

Measure	FY25 Performance		Baseline FY24 Actual	FY 25 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 29.9% (44 / 147)	MV : 25.8% (160 / 621)	MV : 27.6% (516 / 1870)	23.9% (FY24 ENT Target)		
	LG : 25.0% (8 / 32)	LG : 23.2% (26 / 112)	LG : 19.4% (62 / 320)			
Latest Month : October 2024	ENT : 29.1% (52 / 179)	ENT : 25.4% (186 / 733)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding	MV : 74.8% (225 / 301)	MV : 75.9% (873 / 1150)	MV : 58.1% (1998 / 3437)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 85.5% (53 / 62)	LG : 87.5% (196 / 224)	LG : 68.4% (428 / 626)			
Latest Month : October 2024	ENT : 76.6% (278 / 363)	ENT : 77.8% (1069 / 1374)	ENT : 59.7% (2426 / 4063)			
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	81.7	81.1	81.9	81.9		
Latest Month : December 2024						

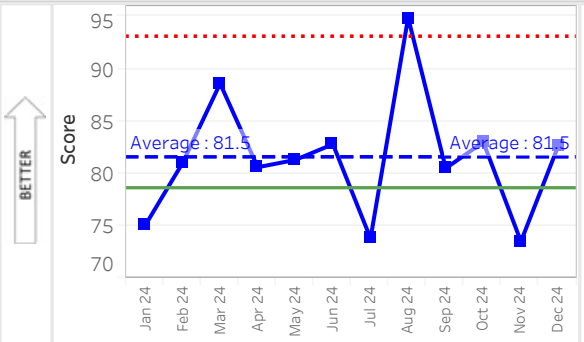
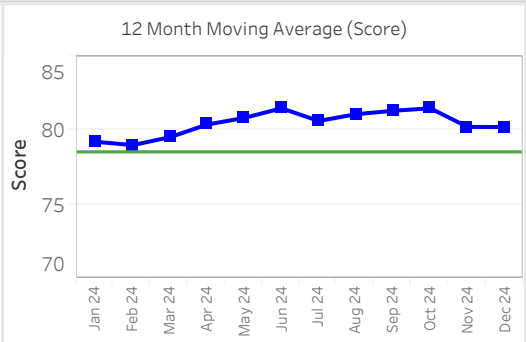
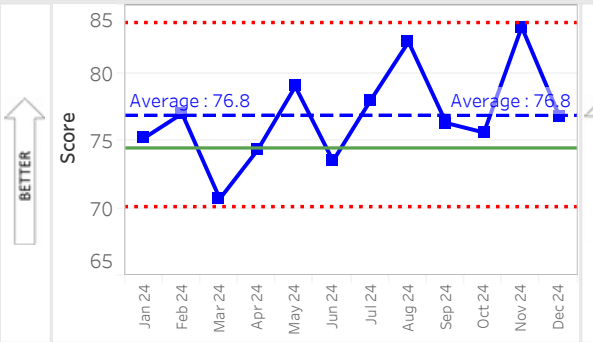
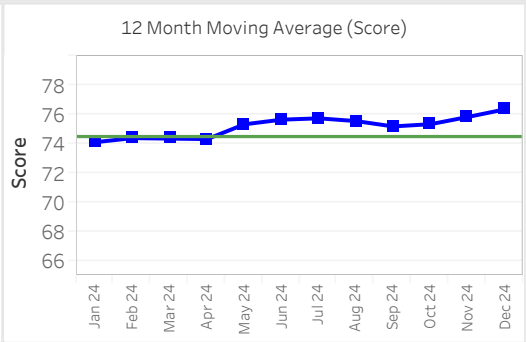
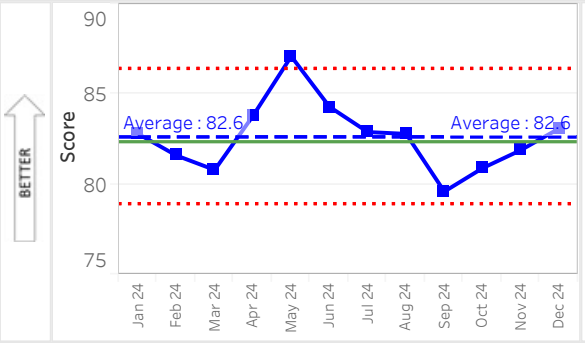
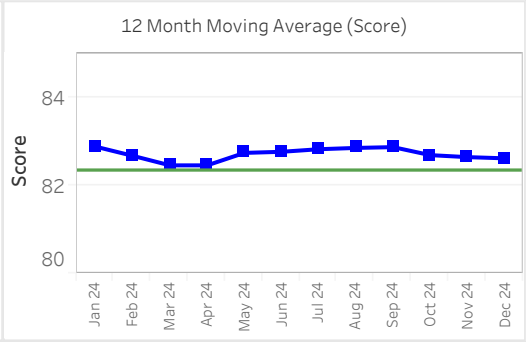
Measure	Definition Owner	Metric Definition	Data Source
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1)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

December 2024 (unless other specified)

Month to Board Quality Committee : February 2025

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 : December 2024	82.7	81.6	82.0	82.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2024	76.8	78.6	75.5	77.2		
ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : December 2024	83.1	81.6	82.1	83.4		

Quality Department | Note : updated as of January 21, 2025

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: 1/1/2024 12/31/2024

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator		Last 12 Months Trend
Safe Care	FY 24Q3	FY 24Q4	FY 25Q1	FY 25Q2	FY24	FYTD25			Trend Chart Period: 1/1/2024 to 12/31/2024
C-Diff Clostridioides Difficile Infection	7	3	6	10	28	**16**		<= 27 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	1	1	3	3	11	**6**		<=10 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	2	0	0	1	3	**1**		<=5 cases	Lower is Better
SSI (Surgical Site Infection)	11	9	15	11	38	**26**		<=30 cases	Lower is Better
Hand Hygiene Audit Compliance (Leapfrog measure)	87.2%	87.3%	85.3%	81.5%	84.1%	**83.2%**		>=80%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	81.4%	81.0%	74.0%	69.4%	77.7%	**71.7%**		>=84.0%	Higher is Better
Effective									
Readmission (Based on Vizient Risk Model)	10.3%	10.1%	9.3%	9.7%	9.8%	**9.5%**		<=9.8%	Lower is Better
Hospital Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.14	1.25	0.87	1.06	1.16	**0.97**		<= 1.0	Lower is Better
Sepsis Mortality Index (Vizient Risk-Adjusted Mortality Model)	1.43	1.36	1.06	1.10	1.35	**1.07**		<=1.0	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	23.0%	26.7%	24.2%	29.1%	24.7%	**25.4%**		<=23.9%	Lower is Better
Efficient									
Avg Length of Stay (ALOS) (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.07	1.07	1.06	1.07	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)	155	155	151	152	155.8	**151.3**		<=160	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate	2.1%	2.5%	4.0%	21.0%	2.1%	**11.1%**		50%	Higher is Better
Voyce Interpretation Minutes Used	53,231	59,672	57,925	53,919	617,023	**335,532**		TBD	
Patient-Centered									
Inpatient Hospital: Likelihood to Recommend Press Ganey	79.9	83.4	80.7	81.5	81.9	**80.9**		81.9	Higher is Better
ED: Likelihood to Recommend Press Ganey	74.3	75.6	78.9	78.3	75.6	**78.8**		77.2	Higher is Better
MCH - INPATIENT Press Ganey	83.2	81.4	82.8	80.5	82.0	**82.2**		82.0	Higher is Better

El Camino Health

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: February 3, 2025
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: For the 2024 calendar year, ECHMN successfully met all 10 core quality measures and both of the radar quality measures. Although 4 of the core measures were suppressed in the CMS 2024 decile benchmarking, ECHMN performed exceptionally well in the remaining 6 measures, with 1 measure in the 8th decile, 3 measures in the 9th decile and 2 measures in the 10th decile.

Since 2021, ECHMN has demonstrated a consistent pattern of continuous improvement in our core measures. Of note the following measures have shown the following 4-year trend:

- 35% improvement in Breast Cancer Screening
- 36% improvement in Colorectal Cancer Screening
- 32% improvement in Diabetes: HBA1c <9%
- 19% improvement in Controlling High Blood Pressure
- 11% improvement in Reconciliation of Current Medications

List of Attachments:

PowerPoint presentation to be reviewed beforehand, to support and serve as a reference during the 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- Q4 2024

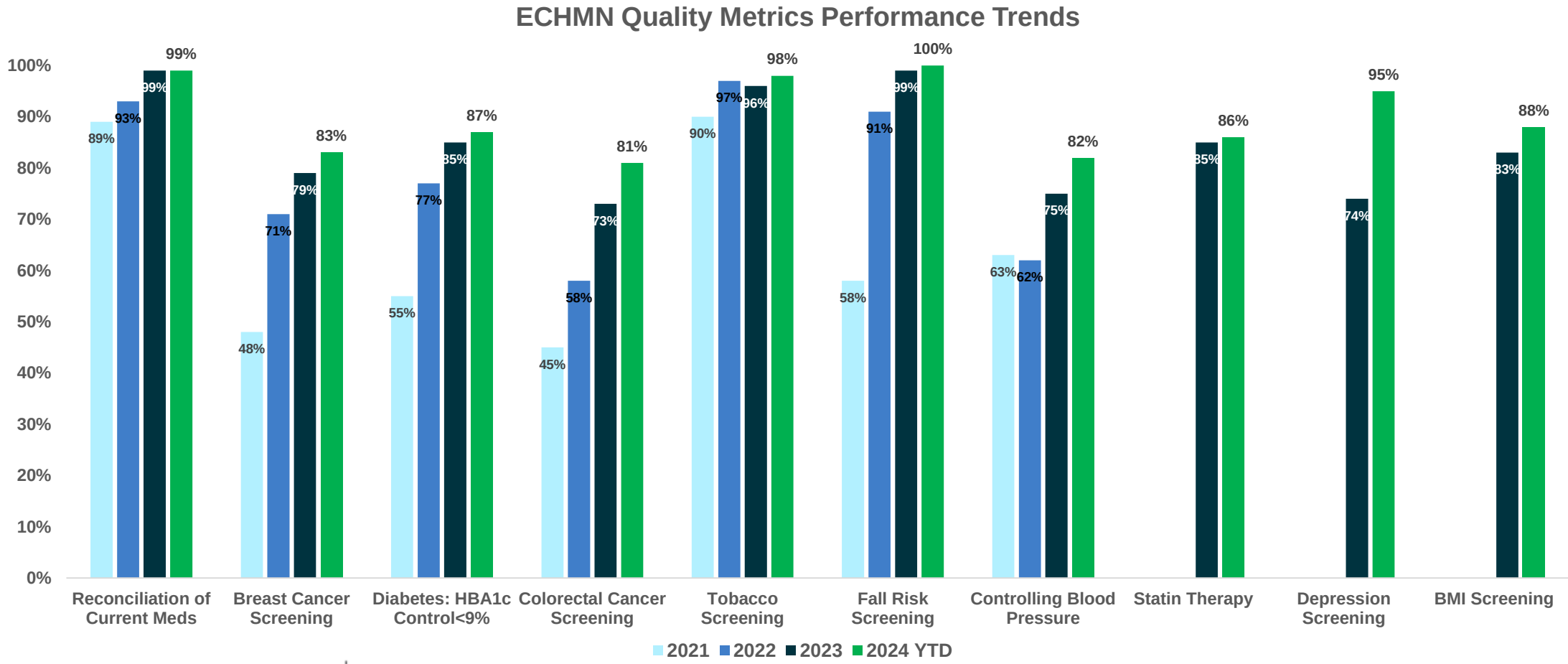
February 3, 2025

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

Year Over Year Trending from CY 2021 thru 12/31/2024

The following trends can be seen from CY21 to YTD24:

- 35% improvement in Breast Cancer Screening
- 36% improvement in Colorectal Cancer Screening
- 32% improvement in Diabetes: HBA1c <9%
- 19% improvement in Controlling BP



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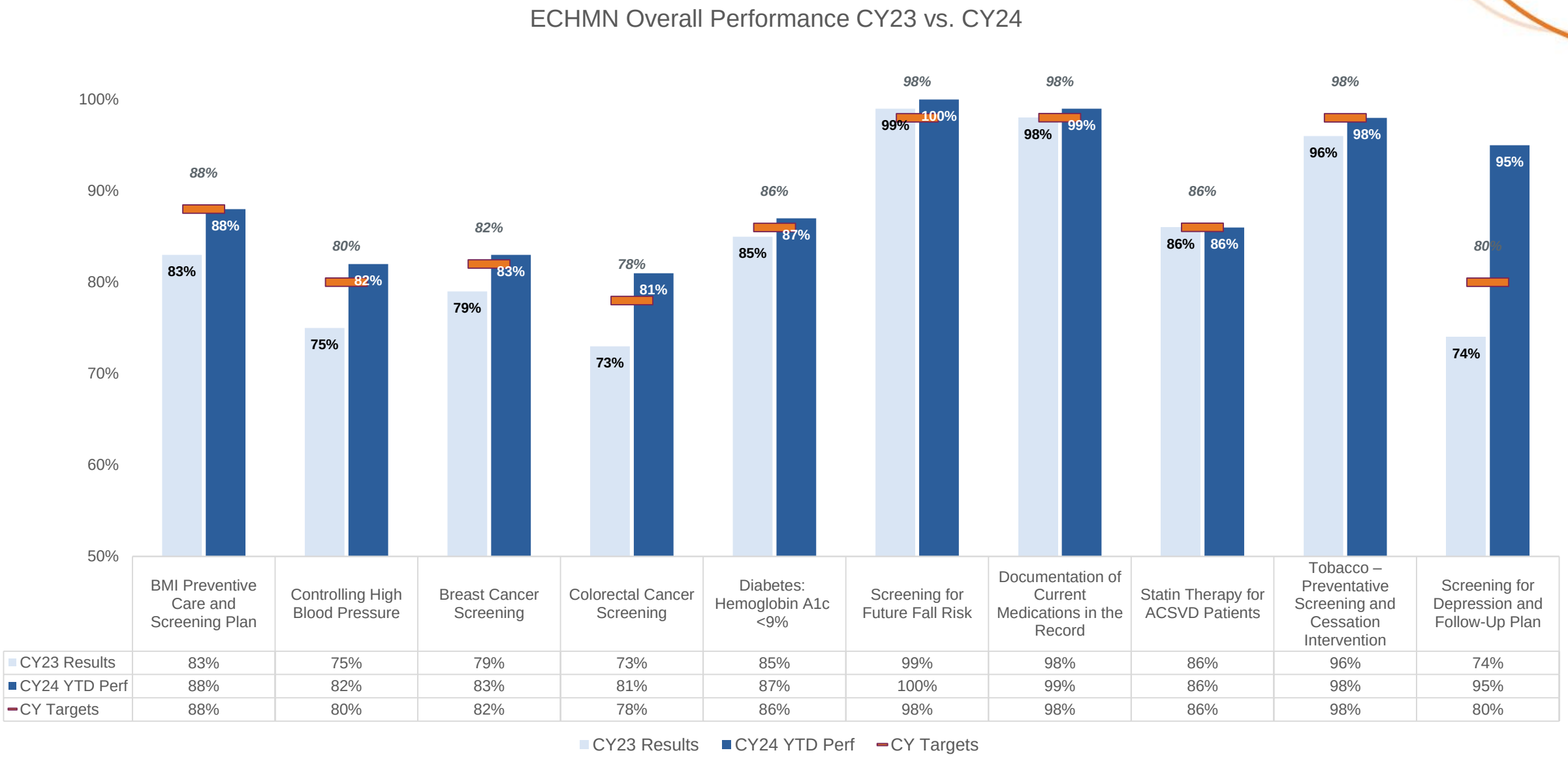
YTD24 Overall Performance vs CY23 Results thru 12/31/24



	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%	74%
CY24 YTD Perf	88%	82%	83%	81%	87%	100%	99%	86%	98%	95%
CY Targets	88%	80%	82%	78%	86%	98%	98%	86%	98%	80%

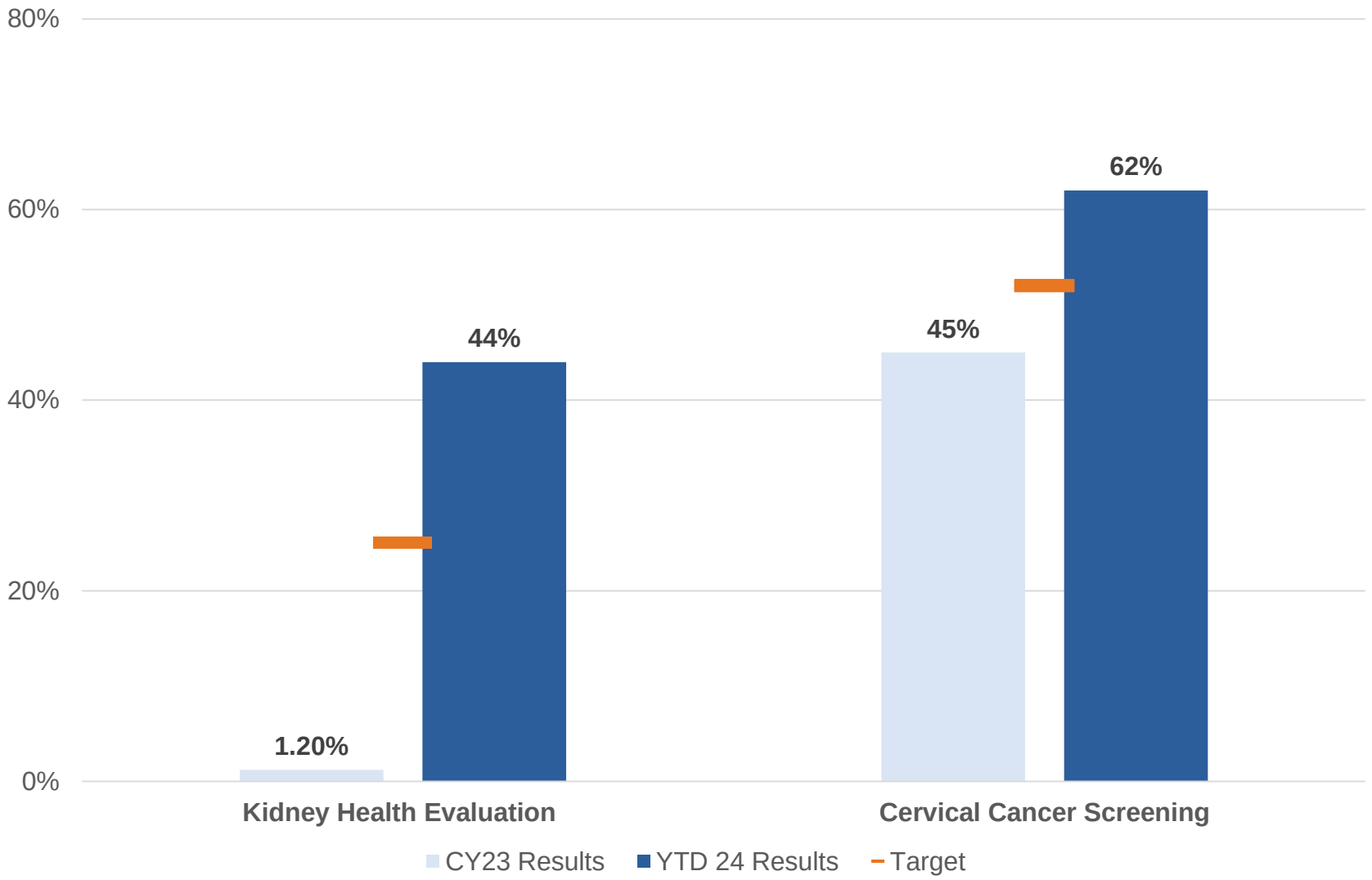
El Camino Health

Quality Metric Performance by Deciles Year over Year Trend

*Please note that 4 of the above measures have been suppressed. 2024 benchmarks are not available for the following measures: Colorectal cancer screening, CBP, depression screening and statin therapy.

*The deciles utilized are the published by Centers for Medicare and Medical (CMS)on an annual basis

CY 2024- Radar Quality Measures and Targets thru 12/31/24



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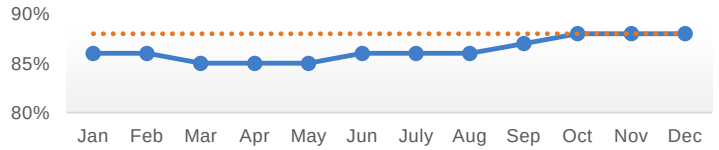
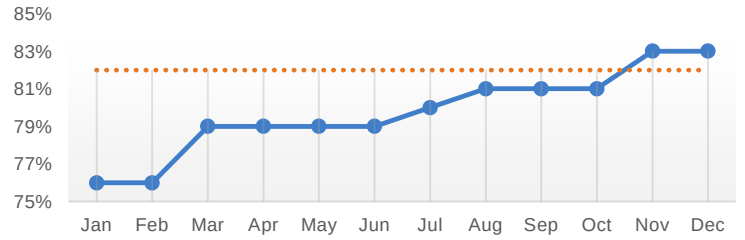
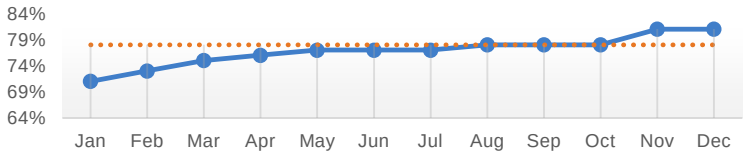
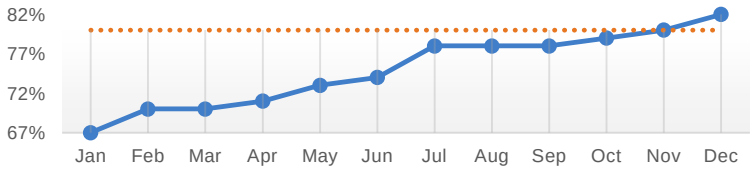
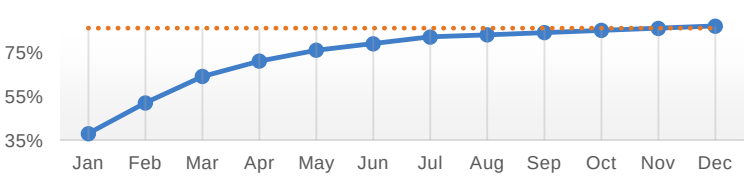
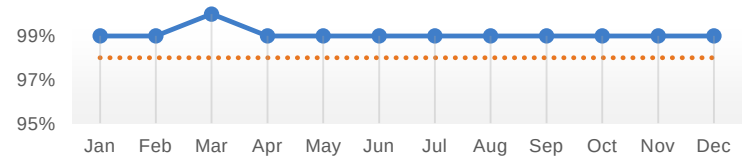
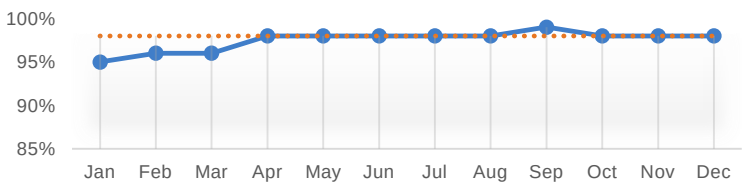
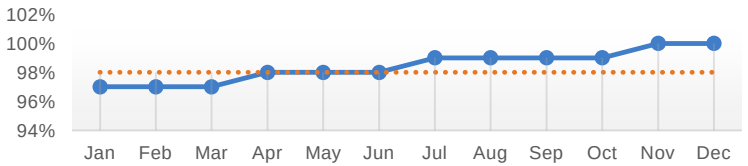
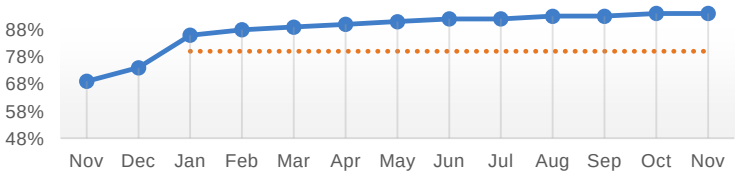
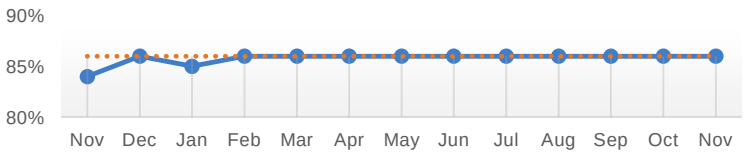
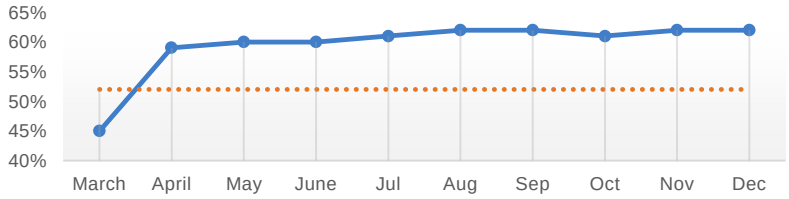
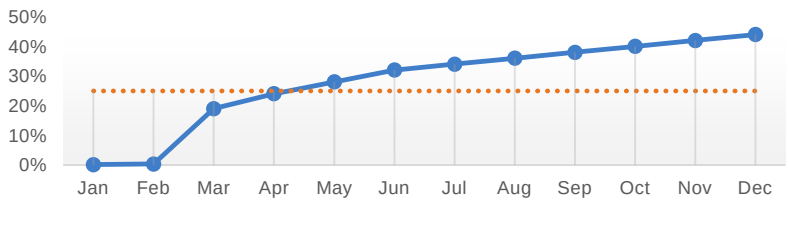
Calendar Year 2024 – Core Quality Measure and Targets YTD Thru 12/31/24

Core Quality Measures	CY 2024 Target	YTD 2024 Results	12 Month Trend	Notes
BMI Preventive Care and Screening Plan	88%	88%		• Providers that were not meeting target were sent an educational memo that documented the appropriate steps to achieve this measure.
Breast Cancer Screening	82%	83%		• Chart Abstraction project completed in November. • MAs received training on how to access the quality dashboard to identify patients needing screenings. The appropriate orders should be placed and communicated to the patients.
Colorectal Cancer Screening	78%	81%		• Chart Abstraction project completed in November. • MAs received training on how to access the quality dashboard to identify patients needing screenings. The appropriate orders should be placed and communicated to the patients.
Controlling High Blood Pressure	80%	82%		• MAs are completing patient outreach to all patients not meeting the blood pressure measure for a home blood pressure reading. • MyChart Home Blood Pressure Self Report Campaign • BPA for Specialist and Urgent Care providers to refer hypertensive patients to the PCP. This work queue has been managed by the advice nurses.
Diabetes: Hemoglobin A1c <9%	86%	87%		• PCPs received a list of their patients that need an A1c ordered. MAs completed a focused outreach for these patients. • All Primary Care locations have a point-of-care monitor to complete A1c checks on the patient during a visit.

Calendar Year 2024 – Core Quality Measure and Targets Thru 11/30/24

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%	98%		• Continue to monitor this measure to ensure trend is sustained.
Screening for Future Fall Risk	98%	100%		• Continue to monitor this measure to ensure trend is sustained.
Screening for Depression and Follow-Up Plan	80%	94%		• 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 11/30/24

Core Quality Measures	CY 2024 Target	YTD 2024 Results	Calendar Year 2024 Trend	Notes
Cervical Cancer Screening	52%	62%		• Chart Abstraction completed. • Issue identified and corrected with the coding in Epic. • Continue to monitor this measure to ensure trend is sustained.
Kidney Health Evaluation	25%	44%		• Issue identified and corrected with the coding in Epic. • The Quality Measures “Best Practice Guide” provides education about the correct labs to order.

2024 – Quality Initiatives Accomplishments

Hypertension Clinical Protocol Committee: *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*.

- Developed a hypertension clinical protocol and patient education material, which was approved by the Quality Committee.
- Patient BP Self-Reporting Campaign- MyChart message to patients not meeting the Controlling Hypertension measure, requesting home BP reading.
- Best Practice Alert (BPA) and Advice Nurse Work Queue Pilot- Using an ECHMN developed template, advice nurses follow up on hypertensive patients from Urgent Care and Specialist visits, document self-reported BP, and facilitate PCP visits. The pilot will be evaluated for successes and areas of opportunity before being rolled out networkwide.
- Medical Assistants conducted personal outreach to all patients not meeting the measure in Q4.

MIPS Value Pathways (MVPs): *CMS announced its plan to possibly sunset traditional MIPS by 2029. The shift from traditional MIPS to MVPs represents a significant change in how clinicians participate in quality reporting under Medicare. MVPs streamline this process by aligning measures into specific pathways based on specialties or patient conditions. This approach emphasizes value over volume. In preparation for the changes, the Quality Department has developed a strategy to prepare for the transition.*

- For performance year 2024, we will be submitting 3 MVPS.

Annual Wellness Visit (AWV) Campaign: *In collaboration with the Operations team, ensure that our Medicare Advantage patients receive their AWV. The AWV allows us to address open care gaps.*

- 77.6% completion for Alignment patients, a 50.6% improvement from CY23.
- The Network will continue the successful outreach program in 2025.

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 physician performance on core quality measures and provide training as needed.*

- PQQR provides the PCPs with their individual performance on the core quality measures and a comparison to ECHMN's performance.
- Provides insight to improve on measures they are not meeting.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: February 3, 2025
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QIPS) for 2025

Recommendation: Recommend El Camino Hospital Board approval of the Quality Assessment and Performance Improvement Plan (QIPS)

Authority: The Board Quality, Patient Care and Patient Experience Committee is responsible for the oversight of the QIPS program through its periodic review of the program, including, the development of a plan to implement and maintain the QIPS program, the review of the progress of QIPS projects, the determination of annual QIPS projects, and the evaluation of the effectiveness of improvement actions that the hospital has implemented. *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*

Background: The Centers for Medicare and Medicaid Services (CMS) requires hospitals to have a well-designed and well-maintained QIPS program as a condition of participation. CMS requires that a hospital's QIPS program "provides a process by which a hospital can fully examine the quality of care it delivers and implement specific improvement activities and projects on an ongoing basis for all of the services provided by the hospital, while considering the scope and complexity of those services and the patient populations it serves." *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*. The ECH QIPS program is updated annually to reflect, timely, the systems we have in place to identify and correct problematic events, policies or practices to ensure we are effective in improving performance, quality and safety.

Assessment: The El Camino Hospital QIPS plan describes our ability to develop, implement, and maintain an effective, ongoing, hospital-wide, and data-driven quality assessment and performance improvement program, which also includes tracking and monitoring of adverse events and medical errors.

Other Reviews: Reviewed and approved by the Quality Council, Patient and Employee Safety Committee and the Medical Executive Committee.

Outcome: The Committee will approve the QIPS Plan. There are no changes to the plan to report or review. Some update for FY 25 includes:

- Updated Organizational Goals for FY25
    - CDIFF
      CAUTI
    - Hand Hygiene audits
- Minor updates to Process Improvement
- Minor updates Patient Safety section

List of attachments:

1. Quality Assessment and Performance Improvement Plan with referenced QIPS addendums.

Status **Pending** PolicyStat ID **16872459**

Origination	05/2018	Owner	Michael Coston: Director Quality and Public Reporting
Last Approved	N/A		
Effective	Upon Approval	Area	Quality
Last Revised	11/2024	Document Types	Plan
Next Review	1 year after approval		

Quality Improvement & Patient Safety Plan (QIPS)

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip ~~and~~, Knee, & Shoulder, Hip Fracture, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center, in Joint Replacement for Hip ~~and~~, Knee & Shoulder, Spinal Fusion, Sepsis and Patient Blood Management, and as a "baby friendly hospital" by WHO/UNICEF.

The ECH Medical Staff includes over 1100 active, telemedicine, provisional and consultant, ~~328~~353 affiliate physicians, and 116 independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

El CAMINO HEALTH VISION

To provide consumers in the South Bay with a high quality, locally-oriented health system, across the full care continuum.

El CAMINO HOSPITAL VALUES

Quality: We pursue excellence to deliver evidence-based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

DEFINITIONS:

El Camino Hospital has adopted the Institute of Medicine's (IOM) Quality Framework – STEEEP – as its definition of quality. These six aims for a healthcare system comprise ECH's approach to quality:

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Efficient:** Avoiding wastes, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

SERVICES/PROGRAMS

ECH provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:	Emergency Services	Outpatient Services
Acute Rehabilitation	Basic Emergency	Advanced Care & Diagnostics Center
Cardiac Catheterization		Behavioral Services – Outpatient

Services		
Cardiovascular Surgery		Cancer Center
Intensive & Critical Care Unit		Cardio Pulmonary Wellness Center
Labor and Delivery (L&D)		Endoscopy
Medical/Surgical/Ortho		Infusion Services
Mental Health and Addiction Services (Inpatient Psychiatry)		Interventional Services
Mother/Baby		Occupational Therapy/Physical Therapy
Level II and Level III Neonatal Intensive Care Unit (NICU)		Outpatient Surgical Units
Operating Room (OR)		Pre-admission Service/ Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiation Oncology
Pediatrics		Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI, Breast Health Center, Mobile Imaging)
Post-Anesthesia Care Unit (PACU)		Rehabilitation
Progressive Care Unit (PCU) (Step-down)		Speech Therapy
Telemetry/Stroke		Wound Care Clinic

Section I Quality Improvement Plan

PURPOSE

The Quality Improvement Plan, as equivalent to CMS' Quality Assessment Performance Improvement (QAPI), describes the multidisciplinary, systematic quality improvement framework utilized by El Camino Hospital (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

OBJECTIVES

- Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
- Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety based on the complexity of the ECH's services/ programs.
- Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
- Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
- Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.

- Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
- Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
- Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
- Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.
- Enhance uniform performance of patient care processes throughout the organization, reducing variability.
- Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.
- Respond to external hospital environment or community needs in regards of providing equitable care and positive quality outcomes.

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health ~~bears~~has ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility and oversight for implementing the Quality Improvement, Patient Safety, and Patient Experience Plan to the hospital administration, medical staff, and its respective governance committees. Refer to Attachment A on Governance Information Flow.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, is responsible for the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting The Joint Commission and College of American Pathology accreditation standards, California Code of Regulations including Title 22, CMS Conditions of Participation and complying with applicable laws and regulations.

Other specific responsibilities with regard to quality improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

- Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered to patients in the hospital;
- Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and make recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
- Assisting in obtaining and maintenance of accreditation.

Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of three Enterprise departments which are those with constituency at both campuses (including MV & LG). All departments report to an Enterprise Medical Staff Executive Committee. The current departments are; (a complete list of all subspecialties in each department is available from the Medical Staff Office.)

- Medicine to include Radiology, Emergency Medicine, Hospitalists, Psychiatry, Neurology, and Family Medicine
- Surgery to include Pathology, Anesthesia, Orthopedics, Gynecologic Oncology, Otolaryngology, Ophthalmology, Plastic Surgery, Neurosurgery, General Surgery, Urology, Cardio-thoracic surgery, and Vascular Surgery
- Maternal Child Health to include Obstetrics/Gynecology, Pediatrics and Neonatology

Each of these three departments has monthly meetings of their Executive Committees where ongoing quality improvement projects are initiated and progress reported routinely to the Quality Council.

Other specific responsibilities with regard to quality improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A for a graphic depiction of the flow of quality information through committees and to the governing board.

Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes quality improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

- Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities

- Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
- Establish priorities for quality improvement and safety giving priority to high-volume, high-risk, or problem- prone processes for performance improvement activities and reprioritize these activities in response to changes in the internal and external environment
- Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff
- Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's quality performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
- Assure that staff are trained in quality and safety improvement approaches and methods and receive education that focuses on safety, quality, and high reliability
- Continuously measure and assess the effectiveness of quality and safety improvement activities, implement improvements for these activities, and ensure sustainability of improvements made
- Reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities

Medical Staff, Employees, and Contracted Services

Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, reporting adverse events, and implementing actions to sustain improvements.

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is chaired by the ~~past chief of staff~~delegated Medical Staff Leader, ~~their designee,~~ and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY ~~2023 is~~2025 includes the reduction of ~~the Hospital Acquired Conditions (HAC) Index~~C.difficile and CAUTI infections, and increased Hand Hygiene audits. Quality Council receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY ~~23~~25 Quality Council report schedule.

Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and improvement throughout the hospital. While implementation and evaluation of quality improvement activities

resides in each clinical department, the Quality Department staff serves as internal resources for the development and evaluation of quality improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including, but not limited to; the teams addressing the organizational quality, i.e. ERAS (Enhanced Recovery After Surgery) Team and the NV-HAP (non-ventilator hospital-acquired pneumonia) Team. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

- Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
- Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments C and D.
- Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
- Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment E for Data Registries in use)
- Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
- Collaborates with the Risk Management and Patient Safety department on efforts to manage and reduce risk through Root Cause, Apparent Cause and Common Cause Analyses as responses to adverse events and near misses and events reported to regulatory agencies
- Collaborates on performance of failure mode and effectiveness analysis (FMEA) at least every 18 months with Risk Management and Patient Safety
- Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
- Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
- Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
- Providing data as requested to external organizations, see data provided in Attachment F
- Providing oversight for the hospital's participation in Clinical Registries, see Appendix E for current list
- Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data
- Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health (CDPH) to improve the quality of care and safety of care provided to our patients.
- Facilitates identification of health care disparities in the patient population by stratifying quality and safety data

Hospital Services

All ECH departments and service lines participate in the Quality Improvement Plan by establishing

mechanisms that continuously and systematically evaluate the quality of specific service care processes and outcomes. Service directors and managers annually review and identify their expected quality and performance improvement efforts based on the findings of their measurement activities. Each clinical and non-clinical service is responsible for and supporting ECH completion of at least one (1) quality and performance improvement project annually that improves patient care, safety, and/or experience and demonstrates cost efficiency.

All clinical contracted services will be reviewed, evaluated, and will demonstrate a quality and performance improvement summary/assessment on an annual basis and presented to the Enterprise Quality Council.

IMPROVING ORGANIZATIONAL PERFORMANCE

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Quality improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. Quality improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(es) to quality improvement. These leaders set priorities for improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives is based upon the following criteria:

- Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
- Results of quality improvement, patient safety and risk reduction activities
- Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
- Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
- Low volume, high risk processes and procedures
- Meeting the needs of the patients, staff and others
- Resources required and/or available
- External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.
- Response to changes not only in the internal, but also in the external environment or the community it serves

Performance Processes

A. **Design**
The design of processes is in conjunction with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are

evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

B. **Measurement**

ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and ~~finance~~safety. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.

Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

1. Consistent with the organization's mission, vision, goals, objectives, and plans;
2. Meeting the needs of individuals served, staff and others;
3. Clinically sound and current;
4. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
5. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
6. Incorporated into the results of performance improvement activities.
7. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs

   Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:

   a. Establish a performance baseline;
   b. Describe process performance or stability;
   c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
   d. Identify areas for more focused data collection to achieve and sustain improvement.

C. **Analysis**

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.

a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy.

Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

1. Performance varies significantly and undesirably from that of other organizations;
2. Performance varies significantly and undesirably from recognized standards;
3. When a sentinel event occurs;
4. Blood Utilization to include confirmed transfusion reactions;
5. Other types of safety events identified in the Safety Event Management and Cause Analysis procedure;

Improvement Model and Methodology

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other The Plan-Do-Study-Act (PDSA) Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

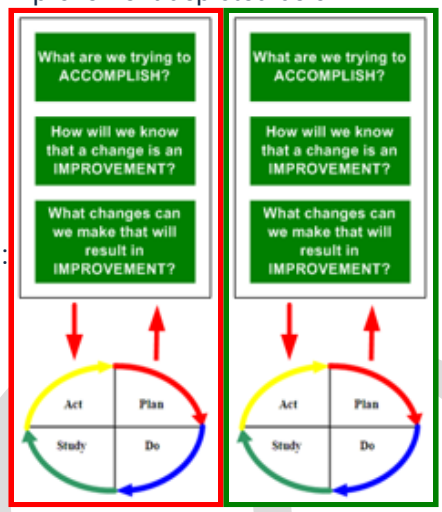
The model has two parts:

A. ***Three fundamental questions, which can be addressed in any order.***

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?
   This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

B. ***The Plan-Do-Study-Act (PDSA) Cycle***
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.
   Step 1: Plan
   Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
   Step 2: Do
   Try out the test on a small scale. What did we observe that was not a part of our plan?

Step 3: Study
Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
Summarize and reflect on what was learned.
Step 4: Act
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.
In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



C. ***Goal Setting and Auditing Methodology***

1. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
The acronym stands for:
S – Specific
When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.
Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking

business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

M – Measurable

What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.

A – Achievable

This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.

R – Relevant

Relevance refers to focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.

T – Time-Bound

Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

2. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.
   Measure of Success (MOS) auditing process has specified the following minimums:
   a. Sample all cases for a population size of fewer than 30 cases
   b. Sample 30 cases for a population size of 30–100 cases
   c. Sample 50 cases for a population size of 101–500 cases
   d. Sample 70 cases for a population size of more than 500 cases
   e. Sample 100 cases for a population greater than 500 cases
      To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

Process Improvement ~~and the El Camino Health Operating System~~

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of

~~concepts,~~ principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. As a High Reliability ~~Organizations~~Organization, we deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Process Improvement department has been in existence since 2012~~, and has adopted the use of~~. Our goal is to support a culture of continuous improvement to create problem-solvers at every level and together to make health care better using Lean methodology and ~~principles~~techniques as the foundation ~~for~~of our interventions. We also use tools from Six Sigma, Change Management, and ~~PDCA, to support our transformation in becoming a High Reliability Organization~~PDSA to achieve both incremental and breakthrough improvements. ~~We do this by focusing on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the foundation.~~

The Process Improvement department provides resources to the organization for problem solving, as well as ~~deploying ECHOS,~~deployment of our ~~El Camino Health Operating~~Daily Engagement System. ~~The~~Our dedicated team is comprised of Process Improvement Advisors and Project Managers with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization.

The El Camino Health Daily Engagement System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work. It includes leader behaviors that support our teams and visual management to create transparency. It is the way that we lead and accomplish work at El Camino Health.

The success of Process Improvement is dependent on robust education and training programs. ~~Our PI Academy, a 90-day project based~~We provide focused training ~~program designed to encourage and support all staff to be problem-solvers, is an example of how we engage with front line staff in continuous improvement. We also provide ad hoc training sessions covering~~of Lean/PI tools and methods within improvement projects and workshops throughout the enterprise ~~to assist departments with project completion~~. We also offer specific topic training sessions via PI Talks designed to encourage and support our culture of continuous improvement.

~~The Process Improvement department also has a year-long fellowship program, which has been designed to develop and grow talented, high performing and high potential leaders by providing an accelerated and intensive hands-on learning opportunity with focus on the ECHOS Daily Management and Performance Improvement Systems. Participants leave their current department and join the Performance Improvement team to gain a foundation in core management and improvement system behaviors, methods, and tools to build on their talents. They do this through high-impact assignments that help the organization drive continuous improvement to achieve the highest level outcomes across patient experience, quality, safety, affordability and physician and staff engagement.~~

~~**ECHOS: El Camino Health Operating System**~~

~~The El Camino Health Operating System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work, and, includes leader behaviors that support our teams. It is the way that we lead and accomplish work at EL Camino Health. Our True North incorporates our mission, vision and values, and is supported by our True North pillars. ECHOS as our foundation, is built on the Lean principles of respect for people and pursuit of~~

~~continuous improvement. These concepts, methods and tools, support our overall Daily Management System.~~

~~The Daily Management System, with our patients as the focus, has three components which define how we:~~

The ECH True North incorporates our mission, vision and values, and is supported by our True North pillars. Daily Engagement is our foundation. It is built on the Lean principles of respect for people and pursuit of continuous improvement. These concepts, methods and tools, support our overall Management System and define how we:

- **Align** the goals of the organization from the Executives to the Front Line with annual *Strategy Deployment*
- **Engage** our people in daily front line problem solving ~~daily~~ through the *Daily ~~Management~~Engagement System* using Tiered Huddles, Linked Visual Systems, intentional Gemba walks, Standard Calendar, and Leader Standard Work
- **Continuously Improve** our processes across departments, using structure and tools that enable both local and large cross-functional processes to be improved and even transformed.

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in ~~three~~two areas: quality & safety, and service ~~and finance~~. See below for the Fiscal Year ~~2024~~2025 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the ~~Hospital Acquired Conditions Index,~~FY 25 Organization Quality Goals ECH formed ~~four~~three teams to address opportunities with ~~Hospital-acquired Pneumonia (nvHAP),~~ C. Difficile infections, ~~Central Line~~Catheter-Associated ~~Bloodstream~~Urinary Tract Infection ~~(CLABSI), and Cather-Associated Urinary Tract Infection~~ (CAUTI) and Hand Hygiene Audits. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

Pillar	Goal	Measurement Defined			
		FY 23	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.453	1.424	1.410	1.395
Service	Likelihood to Recommend (LTR) – Inpatient	78.5	74.7	76.4	78.1
	LTR – El Camino Health Medical Network	82.7	80.0	81.3	82.6
People	Culture of Safety	3.98	3.95	4.00	4.02
Finance	Operating EBIDA Margin	256.9M	$221M	$233M	$245M

Fiscal Year 2025 Goals

Pillar	Goal	Target
Quality & Safety	CAUTI	< 10
	C.Diff	< 27
	Hand Hygiene Audits	30,744
Service	Likelihood to Recommend (LTR) – Inpatient	81.9
	LTR – El Camino Health Medical Network	84.5
People	Employee Engagement	4.23
Finance	Operating EBIDA	$232.8M

Commitment to Patient Experience

ECH has embraced the concept of an exceptional patient experience as foundational. It is our goal to form trusting partnerships among health care practitioners, staff members, and our patients and families that have been proven to lead to better outcomes and enhance the quality, safety and experience of patients and the health care team. Consequently, ECH solicits and captures feedback from a myriad of sources to ensure that the Patient/Family voice is embedded in all that we do. The comments and insights received through our feedback cards and patient satisfaction surveys are shared on a regular basis with our service lines and departments and used for recognition and improvement efforts. Understanding the experience of our patients throughout the continuum of care is imperative as we embark on our high reliability journey. In addition to the regular feedback received through these mechanisms, ECH has also engaged prior patients to work collaboratively with our organization. The Patient and Family Advisory Council (PFAC) was established as a mechanism for involving patients and families in shared decision making as we explore performance improvement efforts, policy and program decision-making and other operational processes. The patient and family advisors partner with our various service lines and departments, providing unique perspective and aiding us in achieving the ideal patient experience. They are engaged in reviewing communication to patients and families to ensure messaging is consistent, and easily understood. Also serving as members of hospital committees, our patient and family advisors collaborate and co-design alongside our team members. They provide insights on the services they value and what is important to them as we look closely at our processes.

To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.

SECTION II: Patient Safety Plan

PURPOSE

El Camino Health (ECH) is committed to the health of our community. That means we provide the highest quality, personalized care to everyone who comes through our doors — treating them not simply as a patient, but as a whole person. Fundamental to that care is our culture of Safety First/Mission Zero. In each action, decision and process, we accept nothing less than putting safety first to achieve our mission of zero harm for our patients, visitors and workforce.

El Camino Health ~~uses the diagram above to depict the organization's Mission, Vision and Values and True North Pillars. El Camino Health~~ is on a ~~contuing~~continuing journey to build a culture of high reliability with a focus on safety to eliminate preventable harm to patients, visitors and our workforce-what we call Safety First/ Mission Zero. El Camino Health uses the following high reliability principles to support patient safety: Preoccupation with Failure, Sensitivity to Operations, Reluctance to Simplify, and Commitment to Resilience and Deference to Expertise. El Camino Health has established leadership expectations found in Attachment H and has also established universal SAFETY skills and behaviors that all of our workforce have been trained to use to eliminate preventable harm (See Attachment I).

The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing quality and patient safety initiatives. In addition, the Patient Safety program at ECH strives to accomplish the requirements listed out in Leapfrog and the NQF Safe Practices in implementation of its program.

GUIDING PRINCIPLES

A. We believe that patient safety is at the core of a quality healthcare system.

B. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.

C. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.

D. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.

E. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.

F. We will foster a culture that respects diversity and inclusivity as a shared responsibility promoting access and equity for our workforce and patients.

OBJECTIVES

A. Deliver high quality safe care for every patient.

B. Engage our workforce and patients in safe practices at work at all levels of the organization using SAFETY skills (universal skills).

C. Promote a culture of safety.

D. Build processes that improve our capacity to identify and address patient safety issues.

E. Classify patient safety events and perform cause analysis to better ~~undertand causess~~understand causes of errors and areas of improvement using the root cause or apparent cause analysis tools as delineated in the Safety Management and Cause Analysis procedure.

F. Educate workforce, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm.

G. Encourage organizational learning about medical/health care errors.

H. Incorporate recognition of patient safety as an integral job responsibility.

I. Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame.

J. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions.

K. Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.

L. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

There are a number of integral and connected structures at El Camino Hospital that address Patient Safety.

Governing Board

The Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Board shall delegate responsibility for implementing this Patient Safety Plan to the medical staff and hospital administration and the committees noted below.

Quality Committee of the Board

The Quality Committee of the Board oversees Patient Safety at the hospital. They review patient safety indicators on an ongoing basis and provide direction and input to senior leadership on patient safety concerns and initiatives. An annual report of the Patient Safety program, which includes a summary of incident reports, regulatory activity and summary of reports made to the Department of Public Health and

actions taken to address patient safety, shall be presented to the Quality Committee of the Board

Enterprise Hospital Committees

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that oversees hospital patient safety related activity. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly.

The **Enterprise Patient and Employee Safety Committee (PESC)** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), Culture of Safety surveys, National Patient Safety Goals, Safety/ Security, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Employee Injuries and the Grievance Committee. (See Attachment G: Patient and Employee Safety Dashboard). It is a multidisciplinary committee with hospital and medical staff representation, and the minutes and dashboard are shared with Quality Council monthly. The PESC is responsible for initiating performance improvement related to patient and employee safety concerns based on identified trends and concerns. Aggregated reports of patient safety events and actions taken to promote patient safety are reported quarterly to the Patient and Employee Safety Committee.

The **Cause Analysis Oversight Steering Committee** is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). This committee is responsible for providing oversight and monitoring of the Cause Analysis program described in Safety Event Management and Cause Analysis procedure. This group is responsible for ensuring that action plans are implemented for root cause analyses and overall effectiveness of the Cause Analysis program. The **Enterprise Patient Safety Oversight Committee (PSOC)** is a hospital senior leadership committee that meets weekly to review new patient safety events and prioritize actions needed for patient safety. Information reviewed is brought forward by Risk and Patient Safety, Medical Staff leadership, Quality and Regulatory leaders. These leaders provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

Patient Safety Department

El Camino Hospital has a Patient Safety Department consisting of a Senior Director of Risk Management and Patient Safety (designated as the Patient Safety Officer), Assistant Director of Risk Management and Patient Safety and Risk Safety Specialists. These individuals work closely with members in the Risk Management and Quality Department on implementation of the patient safety program as described below. The Risk and Patient Safety Department works across disciplines and with team members across the organization to support and promote patient safety and drive our goal of Zero Preventable Harm.

The scope of the Patient Safety program includes the following but is not limited to:

- Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
- Coordination of ~~an annual~~any requested Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.

- Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
- Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
- Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach ~~and Leader Mentor program as well as development of a Patient Safety Academy.~~
- In partnership with Risk Management and Quality, performance of Failure and Effects Mode Analysis (FMEA).
- In partnership with Risk Management, implementation of performance improvement related to culture of safety, patient safety based on trends or needed risk mitigation.
- Regulatory follow up needed related to patient safety
- Promote transparency of errors and mistakes through sharing lessons learned
- ~~Annual~~Regular assessment of culture of safety ~~and identified~~, defined as least every 2 years from prior survey, and identification of opportunities for improvement
- Assist and facilt ate the coordination and delivery of any needed training and education related to improving the culture of safety based on the hospital's culture of safety results

PATIENT SAFETY PLAN

The mechanism to ensure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines.

A. Incident reporting is a cornerstone of Safety First/Mission Zero and our Culture of Safety. Training is provided to all workforce members upon hire and with refreshers on reporting concerns using ISAFE, the hospital's electronic incident reporting system with the expectation that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/ improvements. The ISAFE system also allows for reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to ensure timely response and follow-up, track and trend feedback themes and inform quality improvement opportunities.

B. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment J) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.

C. As this organization supports the concept that errors occur due to a breakdown in systems and processes and a fair and just culture, workforce members involved in an event with an adverse outcome will be supported by:

    1. A non-punitive approach and without fear of reprisal, as evidenced by the Fair and Just Culture policy.
    2. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
    3. Resources such as Support our Staff (SOS) or EAP should the need exist to provide support for our workforce after an event
    4. Culture of Safety surveys about their willingness to use our safety reporting systems

D. PESC Dashboard and Patient Safety Targets, Refer to Attachment G. The PESC establishes a dashboard annually to monitor patient and employee safety events with desired quality targets based on any available benchmarks and organizational goals.

E. Patient Safety Priorities are based on the following:

1. Serious Safety Events as identified by the Safety Event Classification team whose process is described in the Safety Event Management and Cause Analysis procedure
2. Other patient safety events that are not classified as an SSE but raise concerns due to aggregate trend or potential for harm
3. Information from internal assessments related to patient safety such as tracers
4. Information from external organizations related to patient safety such as the Joint Commission Sentinel Event Alerts, ISMP
5. Accreditation and regulatory requirements related to patient safety
6. Fallouts from PESC dashboard.

Patient Safety Initiatives

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- Safety First Mission Zero SAFETY skill program
- Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis
- Hand Hygiene Audits
- Monthly Leader and Executive Rounding using 4C SAFETY skill scripts
- New hire and manager Orientation to include SAFETY skill education
- HeRO Recognition and Award Program

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<tr><td colspan="2">Quality Indicators of Patient Safety:</td></tr>
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- Nurse Sensitive Indicators (Medication Safety, Falls)
- Healthcare Associated Infections
- Surgical site infections
- Surgical Safety Checklist

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- Pressure Injuries
- Transfusion reactions/ blood/blood product administration
- Use of Restraints
- Employee Safety
- Serious Safety Event Rate
- Culture of Safety Survey results

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<tr><td colspan="2">Safety Programs:</td></tr>
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- Central Safety Committee
- Emergency Preparedness Committee

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- Antibiotic Stewardship Program

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• Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Radiation Safety Committee
Data from Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

Confidentiality

The Quality Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Quality Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the Quality Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality, Risk Management and Patient Safety Departments and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Chief Quality Officer, Sr. Director, Quality Services Department, Director of Risk Management or Patient Safety or the Compliance Officer.

Annual Evaluation

~~The Chief~~Patient Safety: The Senior Director of Risk Management and Patient Safety shall provide an annual evaluation and presentation of the Patient Safety program to the Patient and Employee Safety Committee and the Quality ~~Officer or the Sr. Director of Quality Services, and the Director of Risk Management and~~

~~Patient Safety shall coordinate the annual evaluation of the Quality and Patient Safety program and written plan for submission to the Enterprise Quality Council, the Medical Executive~~ Committee ~~and the Governing~~of the Board. The annual appraisal shall address ~~both~~the program's effectiveness in preventing harm to patients and visitors, improving patient care~~, patient~~ and safety, ~~and clinical performance,~~ resolving problems, and achieving program objectives. ~~The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.~~

Quality: The Chief Quality Officer or the Sr. Director of Quality Services, shall coordinate the annual evaluation of the Quality program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address both program's effectiveness in improving patient care, and clinical performance, resolving problems, and achieving program objectives. The annual report of the Quality program will be done at the end of each fiscal year reviewing the organization goals, and enterprise quality dashboard.

Modifications will be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Quality Council, Medical Executive Committee, and the Governing Board.

Attachments

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY~~24~~25)

Att C Enterprise Quality, Safety and Experience Dashboard FY~~24~~25

Att D Board Quality and Safety Dashboard FY~~24~~25

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicators ~~2023~~

Att G Patient and Employee Safety Dashboard FY~~24~~25

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Attachments

- Att A - Governance Information Flow.pdf
- Att B - Quality Council Reporting Calendar.pdf
- Att C - Enterprise Quality, Safety and Experience Dashboard.pdf

Att D - STEEEP 10.21.2024 V3.pdf

Att E - Abbrev Registries List.pdf

Att F - External Regulatory Compliance Indicator.pdf

Att G - FY25 Q1 PESC Dashboard (updated).pdf

Att H - Leader Skills Toolkit.pdf

Att I - Universal Skills Toolkit.pdf

Att J - HPI Classification Tools for SEC.pdf

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Approval Signatures

Step Description	Approver	Date
Quality Committee	Michael Coston: Director Quality and Public Reporting	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
Quality Council	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	10/2024
	Michael Coston: Director Quality and Public Reporting [PS]	10/2024