El Camino Health

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

Monday, June 6, 2022 – 5:30 pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

PURSUANT TO GOVERNMENT CODE SECTION 54953(e)(1), El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION TO THE PUBLIC FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 934 3877 4707#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	George Ting, Quality Committee Vice Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	George Ting, Quality Committee Vice Chair		**information** **5:32 – 5:33**
3.	**PUBLIC COMMUNICATION**	George Ting, Quality Committee Vice Chair		**information** **5:33 – 5:36**
4.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	George Ting, Quality Committee Vice Chair	*public comment*	**motion required** **5:36 – 5:41**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (05/02/2022) ***Information*** b. Report on Board Actions c. FY 22 Pacing Plan d. FY 22 Enterprise Quality Dashboard e. FY 23 Committee Planning (Pacing Plan, Committee dates, Charter) f. QC Follow-Up Items			
5.	**CHAIR'S REPORT**	George Ting, Quality Committee Vice Chair		**information** **5:41 – 5:56**
6.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion** **5:56 – 6:06**
7.	**HRO JOURNEY UPDATE**	Mark Adams, MD, Chief Medical Officer		**discussion** **6:06 – 6:21**
8.	**LEAPFROG**	Lyn Garrett, MHA, MS, CPHQ Senior Director, Quality		**discussion** **6:21 - 6:31**

A copy of the agenda for the Regular 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) 988-7609** 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		ESTIMATED TIMES
9.	**QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN**	Holly Beeman, MD, MBA, Chief Quality Officer	*public comment*	**motion required 6:31 – 6:41**
10.	**FY 23 ORGANIZATIONAL GOALS**	Holly Beeman, MD, MBA, Chief Quality Officer	*public comment*	**motion required 6:41 – 6:51**
11.	**ADJOURN TO CLOSED SESSION**	George Ting, Quality Committee Vice Chair	*public comment*	**motion required 6:51 – 6:52**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	George Ting, Quality Committee Vice Chair		**information 6:52 – 6:53**
13.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (05/02/2022) b. Quality Council Minutes (05/04/2022)	George Ting, Quality Committee Vice Chair		**motion required 6:53– 6:54**
14.	**CHAIR'S REPORT**	George Ting, Quality Committee Vice Chair		**information 6:54 – 6:59**
15.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:59 – 7:09**
16.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 7:09 – 7:14**
17.	**ADJOURN TO OPEN SESSION**	George Ting, Quality Committee Vice Chair		**motion required 7:14 - 7:15**
18.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	George Ting, Quality Committee Vice Chair		**information 7:15– 7:16**
19.	**CLOSING WRAP UP**	George Ting, Quality Committee Vice Chair		**discussion 7:16 – 7:19**
20.	**ADJOURNMENT**	George Ting, Quality Committee Vice Chair	*public comment*	**motion required 7:19– 7:20 pm**

Next Meeting: TBD

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, May 2, 2022
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Julie Kliger, MPA, BSN**,** Chair**	**Terrigal Burn,** MD
Michael Kan, MD**	
Apurva Marfatia, MD**	
Jack Po, MD**	
Krutica Sharma, MD**	
Carol Somersille, MD	
George O. Ting, MD, Vice Chair	
Alyson Falwell**	
Melora Simon**	**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 Hospital (the "Committee") was called to order at 5:30 pm by Chair Julie Kliger. A verbal roll call was taken. Dr. Burn was absent. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any Committee member would like to pull an item from the consent calendar. Dr. Somersille pulled item 3a – Minutes of the Open Session of the Quality Committee Meeting (04/04/2022). She requested to have her statement added to Agenda item 5 – Quality Committee Member Addition. Her statement is as follows: "*The Finance Committee had just gone through the new Committee Membership recruitment efforts and had some well-defined guidelines for this process, and we should use that as the guideline for the Quality Committee Recruitment process."* **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (04/04/2022) with the notated update; For information: (b) Report on Board Actions, (c) FY 22 Pacing Plan, (d) FY 22 Enterprise Quality Dashboard (e) FY 23 Quality Committee Goals (f) CDI Dashboard (g) Core Measures (h) QC Follow-Up items **Movant**: Somersille **Second**: Ting	***Consent Calendar approved***

	Ayes: Kliger, Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Burn **Recused**: None	
4. CHAIR'S REPORT	Chair Kliger deferred her time to Dr. Holly Beeman, CQO to debrief on The Joint Commission survey that was completed and the key takeaways from the Education Session. Dr. Beeman started by sharing a safety story about an occupational therapist named Tiffany who performed a pain assessment on a patient who recently had Spinal Fusion surgery. When completing the assessment, the patient complained about intense right knee pain. The occupational therapist alerted the nurse. The nurse escalated this to the physician and the physician ordered an ultrasound, which demonstrated the presence of a deep vein thrombosis in the patient's right lower extremity. This story represents a great catch and Dr. Beeman hopes that through the HRO training, more people will feel safe to speak up when they see something of concern. Dr. Beeman also provided a summary of the recent Joint Commission Survey and highlighted the following: • Dr. Ting and Dr. Somersille joined the Executive Session that was held with TJC • TJC was here for 4 days – 8 Surveyors were present • All staff was eager to share their processes with TJC • Successful SPD • 0 red findings • Sepsis performance – the prior week had a successful Sepsis Survey with 0 Findings and the surveyors were impressed with the ED nurses and their knowledge. • Ligature Risk – there were a few findings in the Taube Pavilion. Dr. Marfatia also recognized the Director of the Medical Staff Office, Raquel Barnett, and the Medical Staff team for the exceptional performance, with zero findings, during The Joint Commission Survey. Dr. Beeman provided a brief overview of the Board and Committee Education Session that was held last week. She asked Dr. Po to share a few highlights from the session. Dr. Po shared three topics of discussion from the quality and compliance table: • Needing to be a system and what that means • The importance of alignment of physicians from the medical foundation • How we enable this alignment while we expand and continue to grow	

5. PATIENT STORY	Cheryl Reinking, CNO presented a patient letter received in Administration. This patient sent a handwritten letter regarding his dissatisfaction with the care he received over three different episodes at the LG and MV campuses. The hospital grievance team met with the patient to learn about his experiences and how we might engage him in our improvement efforts. The patient did not want discuss his specific personal experiences and instead wanted to focus on how he could participate and help lend his voice to improvement work at ECH. The offer to join the patient and family advisory council (PFAC) was discussed with the patient. He was thrilled and agreed to join the PFAC. The first meeting he will attend is this week.	
6. PROPOSED FY23 ORGANIZATIONAL GOALS	Dr. Beeman presented the FY23 Organizational Goals and provided more details about the HAC (Hospital Acquired Condition) Index. There are two reasons to adopt this organizational goal. This first is that having an organization focus on reducing patient harm is in alignment with our HRO transformation to eliminate patient harm. The second reason is to have increased focus on patient harm events as our performance over this past year has worsened. Details are noted in the Packet.	
7. EL CAMINO HEALTH MEDICAL NETWORK	Ute Burness, VP of Quality and Payer Relations presented on the El Camino Health Medical Network and reviewed the following: • Measuring Quality in Ambulatory Care • Quality Composite Metric Performance – FY22 Q3 • Quality Improvement Activities – 3rd Quarter FY22 • 2022 Complaints Year to date through March 31, 2022 • 2022 Grievances Year to date through March 31, 2022 • FY23 Quality Metrics and Targets • Subcommittee Recommendations • FY23 Proposed PCP Quality Metrics • FY23 Proposed Specialty Metrics Dr. Ting expressed concern regarding this report and the lack of improvement that has been made. He asked what are we doing to make things better and why have the results not improved. Vince Manoogian responded by sharing that improvements have been made but not as substantial as we would have liked and provided examples. Dan Woods, CEO acknowledged Dr. Ting's concerns. He advised that we have a trend line of where we have come to identify if we have improved or not. Also, show what percentile we are in for each metric. Dr. Somersille concurred with these recommendations. Chair Kliger concurs and recommends a written report on the progress of ECHMN. Additionally, she suggested we see the data by different demographic groups.	

	Dr. Kan pointed out that several patient screening tests are performed once a year or once every few years. So, collecting quarterly may not be an accurate reflection of quality performance. Chair Kliger added that we need to have the correct denominator for this data. Dr. Po noted that we have been aiming for the 50th percentile for many years now. Two or three years ago, the hospital was challenged to get into the 90th percentile and asked what resources were needed and how long this would take. Dr. Po believes this is something we should do with ECHMN. Ute responded that due to the data being reported on a Fiscal Year, the data looks worse than it actually is. The MIPS module hard-wired in EPIC is collected and reported on the calendar year. So, when the fiscal year ends in June, the ECHMN report is reflecting 6 months of a 12-month data collection process. This reporting style creates confusion in how to truly interpret the results.	
8. QUARTERLY BOARD QUALITY DASHBOARD REPORT	Dr. Beeman presented the Quarterly Board Quality Dashboard Report, which is further detailed in the Memo of the packet.	
9. PUBLIC COMMUNICATION	There were no comments from the public.	
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:50 pm. **Movant**: Ting **Second**: Po **Ayes**: Kliger, Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Burn **Recused**: None	***Adjourned to closed session at 6:50 pm***
11. AGENDA ITEM 18: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:10 pm. Agenda items 11-17 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (04/04/2022), the Quality Council Minutes (04/06/2022), and the Medical Staff Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 19: CLOSING WRAP UP	No additional comments	
13. AGENDA ITEM 20: ADJOURNMENT	**Motion**: To adjourn at 7:11 pm **Movant**: Simon **Second**: Falwell **Ayes**: Kliger, Kan, Marfatia, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None	***Adjourned at 7:11 pm***

	Abstain: None **Absent**: Burn **Recused**: None	

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Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Nicole Hartley, Executive Assistant II

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Stephanie Iljin, Manager of Administration
Date: June 6, 2022
Subject: Report on Board Actions

Purpose: To keep the Committee informed regarding actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. Situation: It is essential to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive; still, it includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

2. Authority: This is being brought to the Committees at the request of the Board and the Committees.

3. Background: Since the last time we provided this report to the Quality Committee, the Hospital Board has met twice, and District Board has not once. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)

ECH Board	April 27, 2022	- Education Session to discuss the Enterprise Strategy with the Board and Advisory Committee Members
		  ○ Strategic Framework focused on the three major areas (ACE)
		  ○ Alignment with Physicians
		  ○ Leadership in Clinical Program
		  ○ Expanding our Reach

	May 11, 2022	- Resolution 2022-05: Recognizing retired auxiliary member Judy Van Dyck - Board Officer Elections Procedure - Credentialing and Privileges Report - FY 22 Period 9 Financials - Resolution 2022-06: Approving OB/GYN Call Panel Agreement for Carol A. Somersille, MD

ECHD Board	May 17, 2022	- Resolution 2022-04: El Camino Health District Mission Statement Review Ad Hoc Committee Formation, Appointment of Director John Zoglin
		- Community Benefits Mid-Year Update
		- Report on COVID-19 Community Program
		- FY 23 El Camino Healthcare District Policy Bylaw Review Ad-Hoc Committee Recommendation:
		  ○ P.2 Compliance Review Process
		  ○ P.3 Director Compensation Policy
		  ○ P.6 Appointment of Board Members to El Camino Hospital Board

Report on Board Actions
June 6, 2022

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Executive Compensation Committee	May 18, 2022	- Proposed FY23 Organizational Performance Incentive Goals - Proposed FY 23 Individual Executive Strategic Pick Goals - Proposed Salary Range Change & Base Salary Change for VP Payor Relations - Executive Performance Incentive Plan
Compliance and Audit Committee	May 19, 2022	- Review Internal Audit Assessment & Proposed FY 23 Internal Audit Work Plan - Compliance Work Plan Updates FY 22
Finance Committee	- N/A	

List of Attachments: None.

Suggested Committee Discussion Questions: None.

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 11/18/2021 **FY22 Pacing Plan**

FY2022 Q1		
JULY 2021	**AUGUST 2, 2021**	**SEPTEMBER 7, 2021**
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 22 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals (Quarterly)** ▪ **FY22 Pacing Plan (Quarterly)** ▪ **Med Staff Quality Council Minutes (Closed Session)** ▪ **Hospital Update** **Additional Agenda Items:** 1. Health Care Equity 2. ~~Culture of Safety~~ (Oct 4) 3. Patient Perspective 4. Likely to Recommend 5. ~~Sepsis Mortality Goal/Target~~ (Dec 6) 6. Quality Metric Trends 7. OPPE 8. Systemness 9. Nurse Sensitive Indicators	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items 7. Q4 FY21 Quarterly Quality and Safety Review 8. Quarterly Board Dashboard Review 9. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report QC Follow-Up Items Special Agenda items: 6. Annual Patient Safety Report 7. Pt. Experience (HCAHPS)
FY2022 Q2		
OCTOBER 4, 2021	**NOVEMBER 1, 2021**	**DECEMBER 6, 2021**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. FY 21 & FY 22 Quality Dashboard Results 8. Culture of Safety Survey Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Safety Report for the Environment of Care 8. Q1 FY22 Quarterly Quality and Safety Review 9. FY 22 Quarterly Board Dashboard Review 10. EL Camino Health Medical Network Report 11. Medical Staff Office Audit Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda items: 7. Readmission Dashboard 8. PSI Report 9. Report on Medical Staff Peer Review Process 10. Sepsis Mortality Goal/Target Discussion

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 11/18/2021 **FY22 Pacing Plan**

FY2022 Q3		
JANUARY 2022	**FEBRUARY 7, 2022**	**MARCH 7, 2022**
No Committee Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Q2 FY22 Quality and Safety Review 8. EL Camino Health Medical Network Report 9. Quarterly Board Quality Dashboard Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. ~~Proposed FY23 Committee Goals~~
FY2022 Q4		
APRIL 4, 2022	**MAY 2, 2022**	**JUNE 6, 2022**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Value Based Purchasing Report 8. ~~Pt. Experience (HCAHPS)~~ 9. Approve FY23 Committee Goals 10. Proposed FY23 Committee Meeting Dates 11. Proposed FY23 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar(CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow Up Items Special Agenda Items: ~~7. Proposed FY23 Pacing Plan~~ 8. Q3 FY22 Quality and Safety Review 9. Proposed FY23 Organizational Goals 10. EL Camino Health Medical Network Report 11. Quarterly Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. ~~Readmission Dashboard~~ 8. ~~PSI Report~~ 9. Approve FY23 Pacing Plan 10. ~~Medical Staff Credentialing Process~~ 11. ~~Progress on Quality and Safety Plan~~ 12. Finalize FY23 Organizational Goals 13. Approve Quality Assessment and Performance Improvement Plan (QAPI)

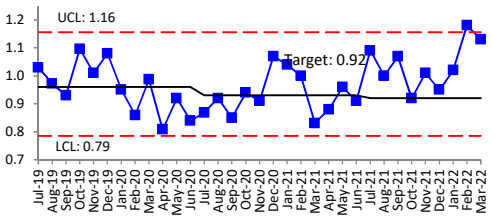
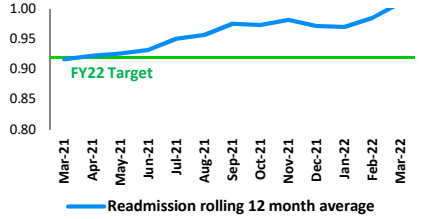
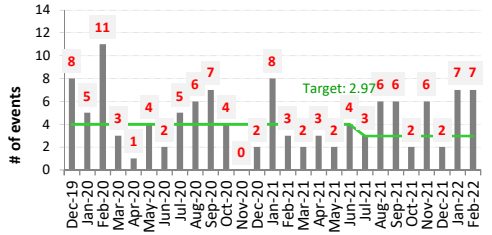
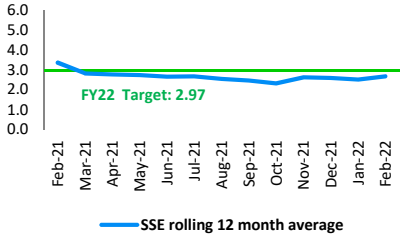
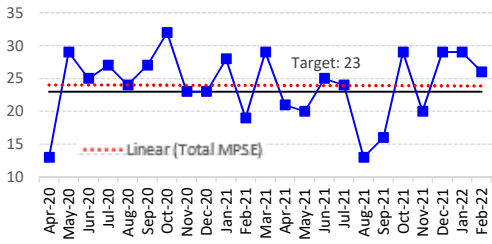
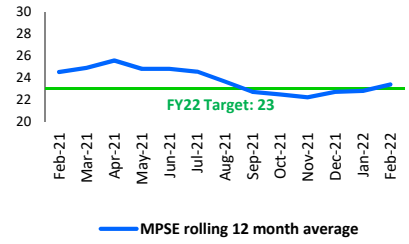
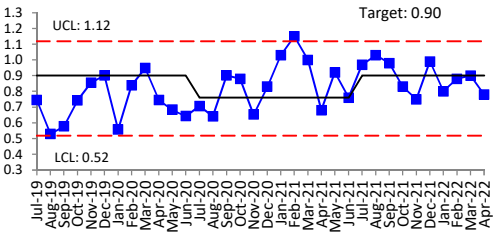
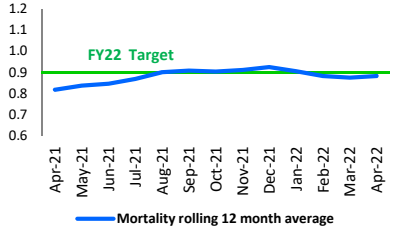
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2022 (unless otherwise specified)

Month to Board Quality Committee:

June, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
1	***Organizational Goal** **Readmission Index (All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ****Latest data month: March, '22*	1.13 (10.09%/8.91%)	1.04 (8.92%/8.56%)	0.93	0.92		
2	***Organizational Goal** **Serious Safety Event Rate (SSER)** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ****Latest data month: Feb, '22*	7	2.66 (50/187793)	3.13 (Dec 2019 - Jun 2021)	2.97		
3	**Actual # of Medication Precursor Safety Events (MPSE) per month/** FYTD rolling 12 month average ****Latest data month: Feb, ' 22*	26	23.4/ mo (12 month rolling average)	320 (25/month) *(April 2020 to April 2021)*	304 (23/month) *(5% reduction from baseline)*		
4	***** Strategic Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: Apr, '22*	0.78 (1.43%/1.83%)	0.89 (1.82%/2.05%)	0.86	0.90		

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
1	**1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)**		Holly Beeman, MD	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2	**2. Serious Safety Event Rate (SSER)**		Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI Systems**
3	**3. Actual # of Medication Precursor Safety Events per month**		Deep Mattapally	All medication events classified as precursor safety events by Safety Event Classification Team EPSI report used for Patient days and # of events provided by Deep M. **Target data received from S. Shah 8/12/21 via email - 5% reduction from baseline**	iSafe Reports / EPSI Report / Safety Event Classification
4	**4. Mortality Index (Observed/Expected)**		Holly Beeman, MD	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	Premier Quality Advisor

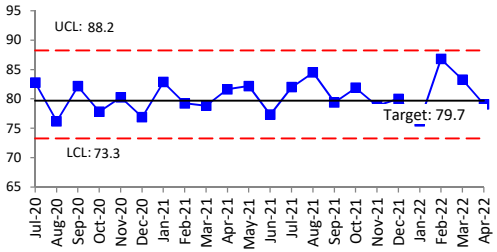
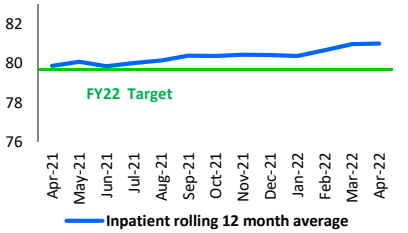
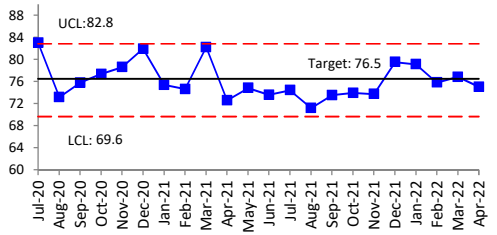
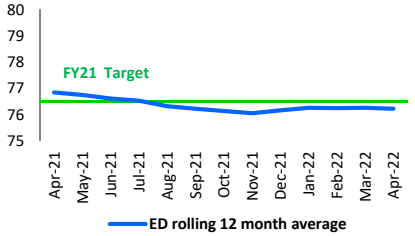
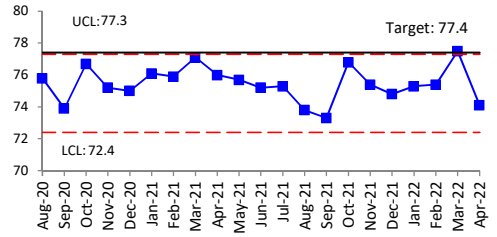
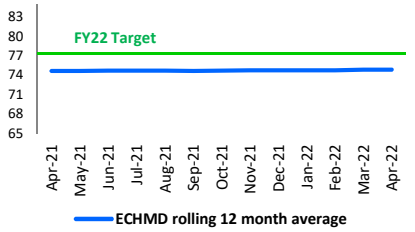
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2022 (unless otherwise specified)

Month to Board Quality Committee:

June, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Apr, '22*	79.1	81.1	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Apr, '22*	75.0	75.5	76.1 (2347)	76.5		
7	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted** *Latest data month: Apr, '22*	74.1	74.9	76.0 (n=15,330)	77.4		

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
5	**5. Inpatient Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' % , Adjusted**		Christine Cunningham	IP Units only, Excludes MCU. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Adjusted' **New FY22 Target received 10/18/21. Criteria changed to Adjusted score for Board reports/ external reports** *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey**
6	**6. ED - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.'%, Adjusted**		Christine Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' **New FY22 Target received 10/18/21. Criteria changed to Adjusted score for Board reports/ external reports** *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey**
7	**7. ECH MD/ ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted**		Christine Cunningham	ECHMD – does not have HCAHPS – we use only one data point that is NPS (net promotor score), which is a likelihood to recommend care provider (SVMD only). Switching Vendor NRC to PressGaney in January 2022. Data run criteria, 'Top Box, Received Date, and Adjusted' **New FY22 Target received 0/18/21. Criteria changed to Adjusted score for Board reports/ external reports** *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**NRC**

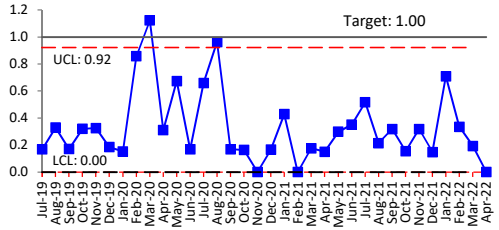
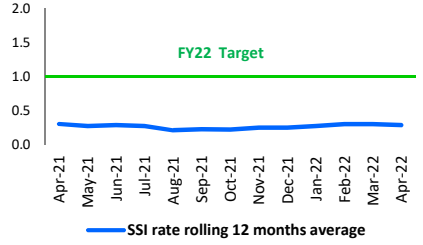
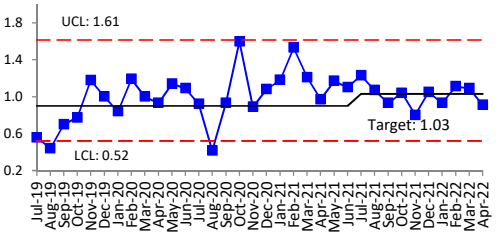
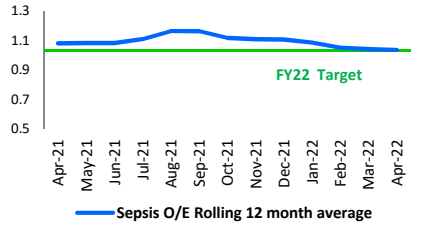
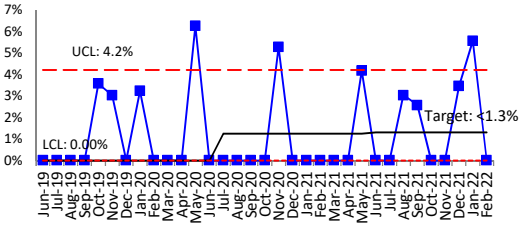
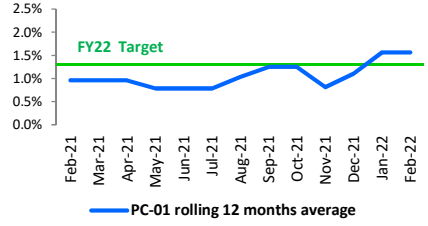
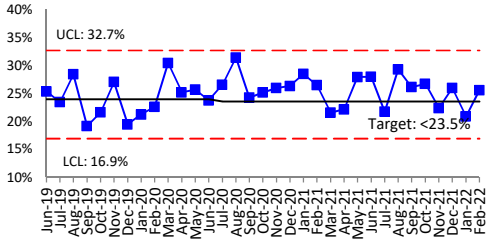
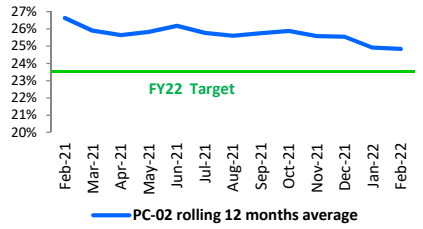
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2022 (unless otherwise specified)

Month to Board Quality Committee:

June, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of **available** data)	Rolling 12 Month Average
		Latest month	FYTD				
8	**Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: Apr, '22*	0.00 (0/588)	0.29 (17/5889)	0.30 (21/7016)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: Apr, '22*	0.91 (12.17%/13.36%)	1.01 (12.55%/12.42%)	1.08 (12.86%/11.87%)	1.03		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) *+Latest data month: Feb, '22*	MV: 0.0% (0/15) LG: 0.0% (0/5) ENT: 0.0% (0/20)	MV: 0.5% (1/183) LG: 5.6% (3/54) ENT: 1.7% (4/237)	MV: 0.41% (1/244) LG: 1.32% (1/76) ENT: 0.63% (2/320)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) *+Latest data month: Feb, '22*	MV: 28.2% (42/149) LG: 14.3% (5/35) ENT: 25.5% (47/184)	MV: 26.0% (323/1241) LG: 20.2% (59/292) ENT: 24.9% (382/1533)	MV: 27.58% (422/1530) LG: 20.69% (72/348) ENT: 26.30% (494/1878)	23.5%		

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
8	**8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100**		Holly Beeman, MD/ Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable. **FY22 Target, Ent = same as last year =< 1.0 (SIR)** *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average . Lower Control Limit is not visible if it is less than or equal to zero.*	**CDC NHSN database - Infection Control**
9	**9. Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)*		Jessica Harkey, Holly Beeman, MD	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10	**10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed**		TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed FY22 Target, Ent. = 1.3% (same as FY21) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11	**11. PC-02: Cesarean Birth - Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth**		TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation FY22 Target, Ent. = 23.5% (same as FY21) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**

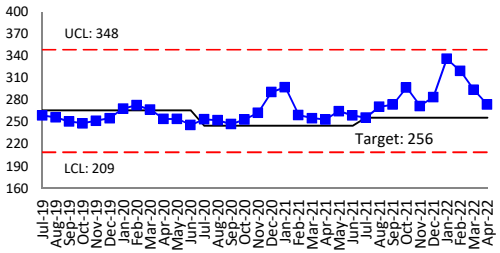
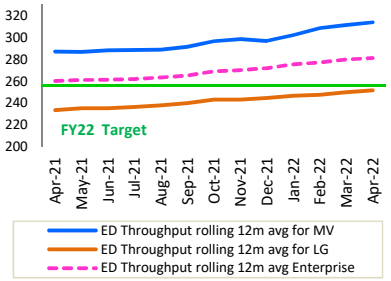
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2022 (unless otherwise specified)

Month to Board Quality Committee:

June, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
12	***Strategic Goal** **Patient Throughput-Median Time from Arrival to ED Departure** *(excludes psych patients, patients expired in the ED, newborns, & transfer between sites)* *Latest data month: Apr, '22*	MV: 302 min LG: 246 min Ent: 274 min	MV: 315 min LG: 256 min Ent: 286 min	MV: 288 min LG: 239 min Ent: 264 min	MV: 263 min LG: 227 min Ent: 256 min		

*** SSE and MPSE available up to February

** Readmission data available up to March

+ PC-01 and PC-02 data available only up to February

Report updated: 5/20/22; final: 5/27/22

Definitions and Additional Information

	Measure Name	Comments	Definition Owner	Definition	Source
12	**12. Patient Throughput-Median Time from Arrival to ED Departure** (excludes psychiatric patients, patients expired in the ED, newborns, & transfer between sites		Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, newborns and transfer between sites FY22 Target, Ent. = 256 mins (same as FY21) Arrival: Patient Arrived in ED ED Departure: Departed ED *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY23 Pacing Plan - DRAFT

FY2023 Q1		
JULY 2022	**AUGUST 1, 2022**	**SEPTEMBER 6, 2022**
No Committee Meeting Routine (Always) Consent Calendar Items: ▪ Approval of Minutes ▪ Report on Board Actions ▪ FY 23 Enterprise Quality Dashboard ▪ Progress Against FY 2023 Committee Goals (Quarterly) ▪ FY23 Pacing Plan (Quarterly) ▪ Med Staff Quality Council Minutes (Closed Session) ▪ Quality Committee Follow-Up Items	Standing Agenda Items: 1. Consent Calendar a. FY23 Pacing Plan 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items 5. Health Care Equity 6. Q4 FY22 **STEEEP** Dashboard Review 7. EL Camino Health Medical Network Report 8. Q4 FY22 Quarterly Quality and Safety Review of reportable events	Standing Agenda Items: 1. Consent Calendar a. ED Patient Satisfaction b. Progress Against FY 2023 Committee Goals 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda items: 5. Annual Patient Safety Report 6. Pt. Experience (HCAHPS) 7. High Reliability progress
FY2023 Q2		
OCTOBER 2022	**NOVEMBER 7, 2022**	**DECEMBER 5, 2022**
No Committee Meeting	Standing Agenda Items: 1. Consent Calendar a. CDI Dashboard b. Core Measures c. FY23 Pacing Plan d. Safety Report for the Environment of Care 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items: 5. Culture of Safety Survey Results 6. Q1 FY23 Quarterly **STEEEP** Dashboard Review 7. EL Camino Health Medical Network Report 8. Q1 FY23 Quarterly Quality and Safety Review of reportable events 9. Medical Staff Office Audit Report	Standing Agenda Items: 1. Consent Calendar a. Progress Against FY 2023 Committee Goals 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda items: 5. Report on Medical Staff Peer Review Process 6. Safety Report for the Environment of Care 7. PSI Report 8. Readmission Dashboard 9. Sepsis Mortality Index

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY23 Pacing Plan - DRAFT

FY2023 Q3		
JANUARY 2023	**FEBRUARY 6, 2023**	**MARCH 6, 2023**
No Committee Meeting Routine (Always) Consent Calendar Items: ▪ Approval of Minutes ▪ Report on Board Actions ▪ FY 23 Enterprise Quality Dashboard ▪ Progress Against FY 2023 Committee Goals (Quarterly) ▪ FY23 Pacing Plan (Quarterly) ▪ Med Staff Quality Council Minutes (Closed Session) ▪ Quality Committee Follow-Up Items	Standing Agenda Items: 1. Consent Calendar a. FY23 Pacing Plan 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items: 5. Q2 FY23 **STEEEP** Dashboard Review 6. EL Camino Health Medical Network Report 7. Q2 FY23 Quarterly Quality and Safety Review of reportable events	Standing Agenda Items: 1. Consent Calendar a. Progress Against FY 2023 Committee Goals 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items: 5. Health Care Equity 6. High Reliability progress
FY2023 Q4		
APRIL 3, 2023	**MAY 1, 2023**	**JUNE 5, 2023**
Standing Agenda Items: 1. Consent Calendar 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items: 5. Value Based Purchasing Report 6. Propose FY24 Quality Committee Goals 7. Propose FY24 Committee Meeting Dates 8. Propose FY24 Enterprise Organizational Goals	Standing Agenda Items: 1. Consent Calendar a. CDI Dashboard b. Core Measures c. FY23 Pacing Plan 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items: 5. Q3 FY23 **STEEEP** Dashboard Review 6. Approve FY24 Organizational Goals, QC Charter, FY24 Pacing Plan, and FY24 QC dates 7. EL Camino Health Medical Network Report 8. Q3 FY23 Quarterly Quality and Safety Review of reportable events	Standing Agenda Items: 1. Consent Calendar a. Leapfrog b. Progress Against FY 2023 Committee Goals 2. Patient Story 3. Serious Safety/Red Alert Event as needed 4. Credentials and Privileges Report Special Agenda Items: 5. Medical Staff Credentialing Process 6. Approve Quality Assessment and Performance Improvement Plan (QAPI)

El Camino Health

Quality Committee Meetings
Proposed FY2023 Dates

RECOMMENDED QC DATE MONDAYS
Monday, August 1, 2022
Tuesday, September 6, 2022 *(Monday – 9/5 Labor Day)*
Monday, November 7, 2022
Monday, December 5, 2022
Monday, February 6, 2023
Monday, March 6, 2023
Monday, April 3, 2023
Monday, May 1, 2023
Monday, June 5, 2023

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") in constantly enhancing and enabling a culture of quality and safety at El Camino Hospital and its affiliated entities where ECH is the sole corporate member ("the Organization"). The Committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the Organization's strategic plan related to delivering high quality healthcare to all patients. High quality care is defined as care that is: safe, timely, effective, efficient, equitable, and person-centered.

The Organization will provide to the Committee standardized quality metrics with appropriate benchmarks so that the Committee can adequately assess the level of quality care being provided.

Authority

All governing authority for the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated 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. 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 the Enterprise Chief of the Medical Staff 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 in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management,

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

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) and 2) no more than two (2) patient advocate members who have had significant exposure to 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, with the exception of new Community members, *ex-officio* members and alternates, shall be 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 one year 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.

Staff Support and Participation

The ~~Chief Medical Officer (CMO)~~Chief Quality Officer (CQO) ~~-~~shall serve as the primary staff 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 ~~CMO~~ CQO and subsequent approval from both the CEO and Committee Chair.~~.~~

General Responsibilities

The Committee's primary role is to develop a deep understanding of the Organizational strategic plan, the quality plan, and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction 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 that performance metrics meet the Board's expectations; 2) align those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring that communication to the Board and external constituents is well executed.

Specific Duties

The specific duties of the Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT).

- Review and approve an annual "Quality Dashboard" for tracking purposes.

- Oversee management's development of the Organization's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services.

- 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 LEAN management activities and cultural transformation work.
    - Organization-wide patient satisfaction and patient experience surveys.
    - Organization-wide physician satisfaction surveys.

- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to including, but 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 Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts as per the hospital and board policy.

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

- Ensure that the Organization's scope of service and community activities and resources are responsive to community need.

- Review the 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.

El Camino Health

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 forwarded 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.

As of: 04/04/22

Quality Committee Follow-Up Items

Date Requested	Committee Member Name	Item Requested	Completion Date
2/7/2022	Krutica Sharma	Please add the definitions back onto the Enterprise Dashboard	3/7/2022
2/7/2022	Krutica Sharma	Please include the Red Flags for the Medical Staff Credentialing Privileges Report	3/7/2022
3/7/2022	Julie Kliger	Follow up Disscussion - Include patients in Quality Committee Meetings. Dr. Burn, Cheryl and Dr. Beeman will explore other models of this process.	
4/4/2022	Holly Beeman	Update FY23 Quality Committee Goals to include: DEI, HRO	5/2/2022

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: May, 26, 2022
Subject: Patient Experience Feedback via Press Ganey Survey

Purpose: To provide the committee with written patient feedback and subsequent follow up or changes as a result of the feedback.

Summary:

1. Situation: This comment was from a patient who recently delivered a baby at the Mountain View campus. This comment was provided via the Press Ganey survey comment section.

2. Authority: To provide insight into one patient's experience while at El Camino Health.

3. Background: This comment illustrates the patient's attention and concern related to the environment of care in MV MCH. The patient found the paint chipping in labor room #8 and the ventilation problematic in the maternity unit.

4. Assessment: While the renovation project of the MCH will address the concerns expressed by this patient, we must continue to assure the environment of care is safe, comfortable, and clean. The bathtub replacement and entire new HVAC system for the building along with all the other upgrades will create an environment of care where families will feel comfortable and safe. However, until the renovation we must continue to find measures to improve the current conditions to promote a feeling of safety and cleanliness.

5. Outcomes: After sharing this with concern with our EVS staff, a note will be left next to the labor tub from the EVS staff after each cleaning indicating the tub has been cleaned thoroughly. In addition, facilities is evaluating if there additional interventions that can be done to repair the paint in room #8.

6. List of Attachments: See patient letter

Suggested Committee Discussion Questions:

1. What is your process for addressing facility concerns?

2. What are the renovations that will be put in place in MV MCH to address the patient and families comfort, cleanliness, and safety?

PG = MV L&D 5/13 (to discuss our new renovation) The bathtub in the delivery room (#8) looked dirty/paint was chipped so it seemed dirtier than it actually was, but didn't look appealing to labor into. Also the maternity room's bathroom had no ventilation.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: June 6, 2022
Subject: HRO Update

Purpose: Provide an update on the status of HRO (high reliability organization) implementation.

Summary:

1. Situation: El Camino Health has embarked on a journey to become a high reliability organization.

2. Authority: The Board is ultimately responsible for the safety of our patients and caregivers.

3. Background: A high reliability organization is an organization that has succeeded in avoiding harm in an environment where normal accidents can be expected due to risk factors and complexity. Reliability means that there are predictable and repeatable systems in place that allow for the consistent execution of operations while catching and correcting potentially catastrophic errors.

   We have engaged Press Ganey to help organize and implement this work. (One of the leading HRO companies, HPI, was acquired by Press Ganey) They completed an initial assessment which included focus group interviews of a cross section of ECH and a review of serious safety events over the past two years. Common causes associated with past events included the following:

   - Lack of attention to detail
   - Staff uncomfortable with peer checking
   - Poor communication
   - Lack of questioning attitude or critical thinking skills
   - Non-compliance with policy, procedure, or expectations (including normalized deviance)

   Following the assessment we received the following recommendations:

   - Message on Safety—NO HARM—as fundamental to ECH and Clinics
   - Define explicit leadership actions to clearly communicate and demonstrate the organization's commitment to protect from harm
   - In addition to SSER, add leading and real time metrics to your balanced scorecard to measure progress to this core value
   - Continue to make safety performance transparent
   - Develop a core "reliability science" curriculum, adaptable and required for leaders and anyone involved in "blunt end design and influence" of the system
   - Define principles for high-reliability leadership and adopt tools and techniques for real-time operational risk management
   - Establish prescriptive leader performance expectations
   - Align and integrate the Leadership Skills strategy as a core component of the leadership development program

- Adopt behavior-based expectations for Safety that guide individual and team actions, interactions, and decision making
- Educate and train all stakeholders—leaders, staff, and medical staff—on behavior-based expectations
- Continue a systems thinking model for cause analysis to improve accuracy of root cause identification, alignment of corrective actions, effectiveness of corrective action implementation
- Increase operational ownership for cause analysis by engaging senior leaders in cause analysis program oversight and executive sponsorship for cause analysis investigations
- Align internal Learning Systems to improve organizational learning
- Adopt local learning systems to improve engagement and continuous improvement

We are currently working on all of these recommendations. We have established 6 key work groups to address many of these items:

- Education and Training
- Marketing and Communication
- Toolkit Workgroup
- Metrics/Key Performance Indicators
- Fair and Just Culture
- Cause Analysis

An example from the Cause Analysis workgroup progress—completion of the "CAPE" (cause analysis performance evaluation) is included in the attachment.

According to the IHI (Institute for Healthcare Improvement) Board support for HRO is critical to successful implementation and sustainment of best practices.

4. Assessment: Establishing a high reliability organization approach will reduce the impact of human error and enhance the safety of our patients and staff.

5. Other Reviews: None

6. Outcomes: The Quality Committee will have confidence in the rigorous process that is used to evaluate both new medical staff applicants and renewals.

List of Attachments:

1. HRO presentation

Suggested Questions:

What can we learn from other industries that have become highly reliable?

How can the Board QC support the HRO work?

The "Power of Habit" is an essential engine of HRO. How can we embed that into our culture?

El Camino Health

Board Quality Committee

Mark Adams, CMO

June 6, 2022

High Reliability Organization

- A **high reliability organization** (**HRO**) is an organization that has succeeded in avoiding harm in an environment where normal accidents can be expected due to risk factors and complexity.
- Reliability means that there are predictable and repeatable systems in place that allow for the consistent execution of operations while catching and correcting potentially catastrophic errors.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What is Reliability?

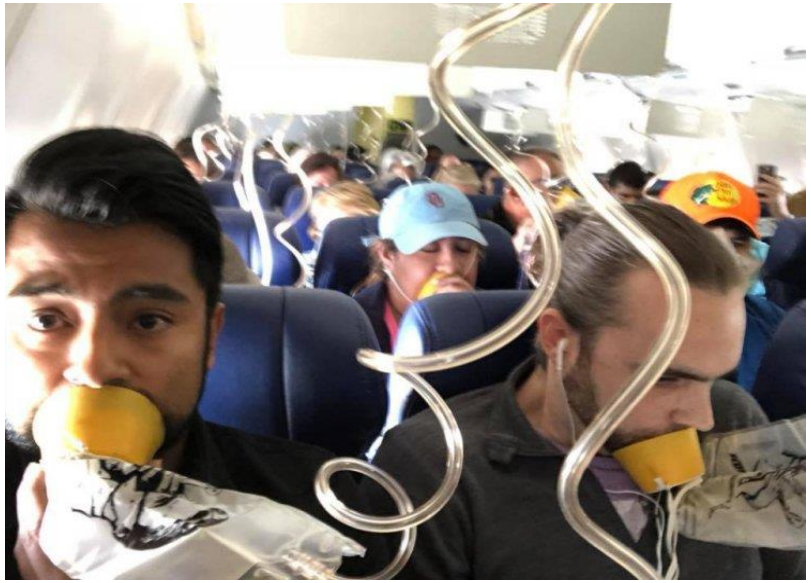
- Reliable = reproducible, consistent, "without error"
- Valid = accurate, correct, conforms to a standard

Examples from other industries:

Aviation CRM

Alcoa aluminum

O-ring catastrophe



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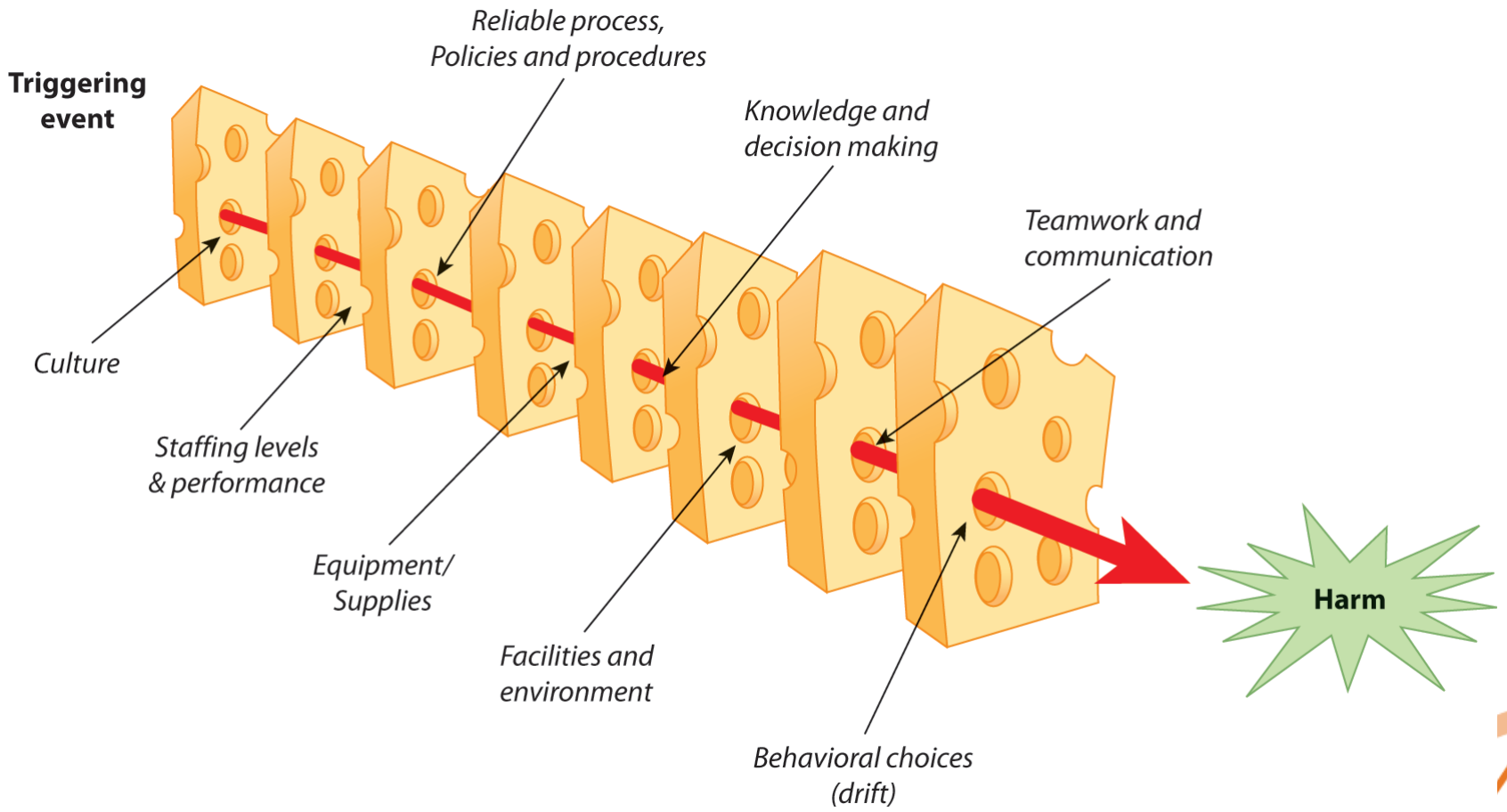


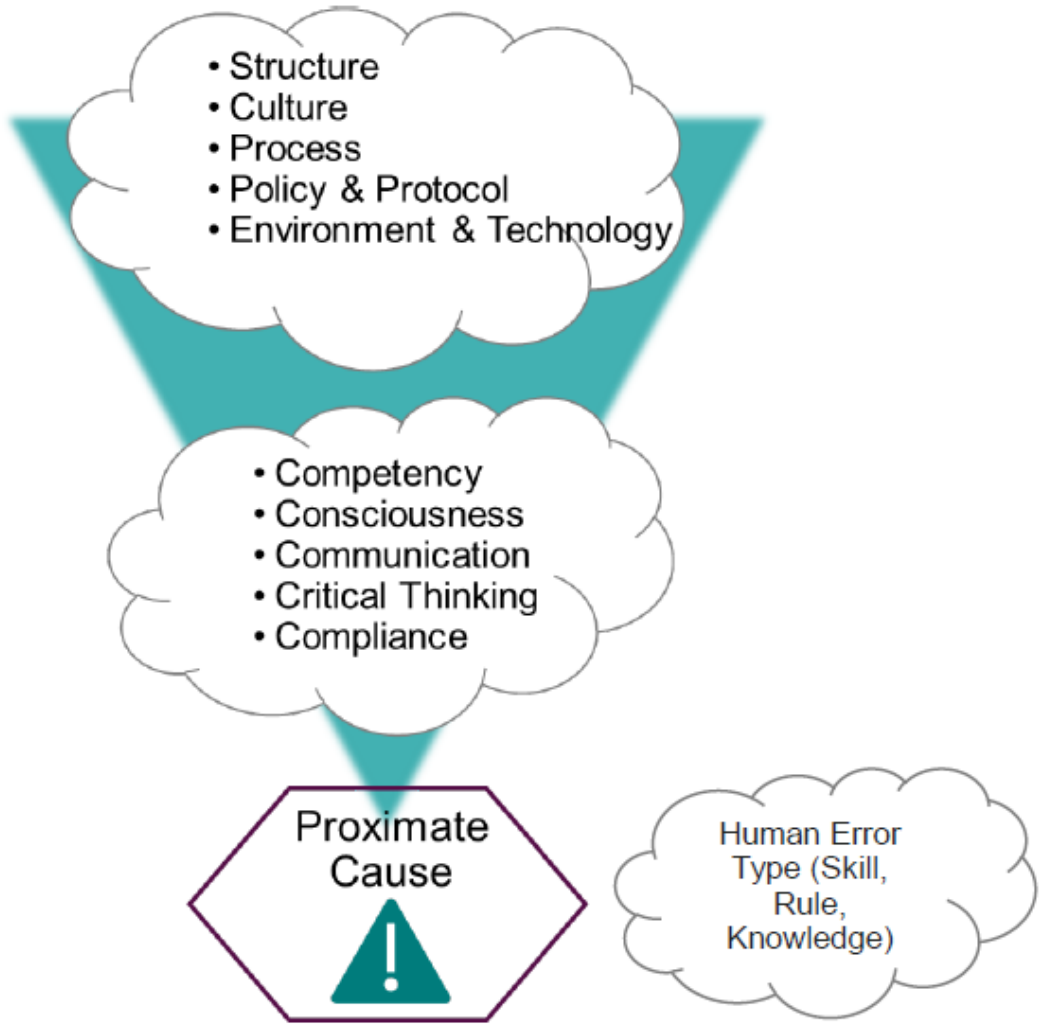
ANATOMY OF A PROXIMATE CAUSE

WHY did they experience the error (system failure mechanism)

AND…

HOW did they experience the error (individual failure mechanism)

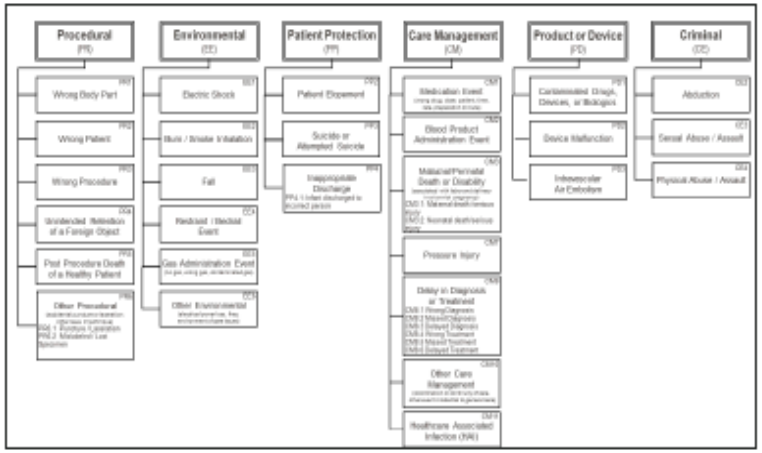
What went wrong… **WHO** did **WHAT** **BECAUSE**…



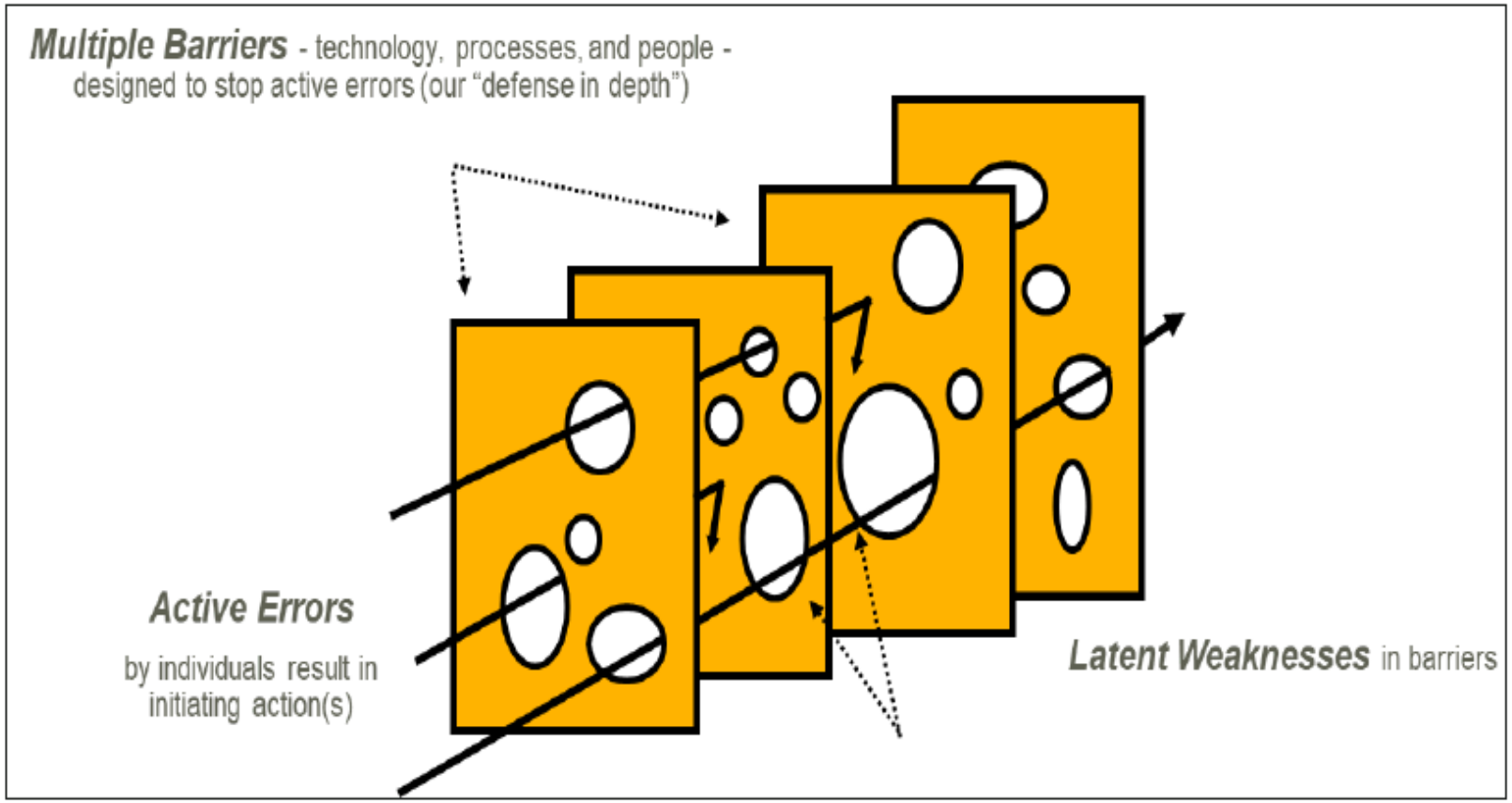
PRESS GANEY®

ANATOMY OF A SAFETY EVENT

Understanding WHAT happened



Understanding WHY it happened



HUMAN ERROR CLASSIFICATION

BASED ON THE SKILL / RULE / KNOWLEDGE CLASSIFICATION OF JENS RASMUSSEN AND THE GENERIC ERROR MODELING SYSTEM OF JAMES REASON

	Skill Based	Rule Based	Knowledge Based
Activity Type	Familiar, routine acts that can be carried out smoothly in an automatic fashion	Problem solving in a known situation according to set of stored "rules," or learned principles	Problem solving in new, unfamiliar situation for which the individual knows no rules – requires a plan of action to be formulated
Error Types	▪ Slips ▪ Lapses ▪ Fumbles	▪ Wrong rule ▪ Misapplication of a rule ▪ Non-compliance with rule	▪ Formulation of incorrect response
El Camino Health%	**17.4**	**73.9**	**8.7**
PG Clients %	**15.4**	**66.4**	**18.2**

Common Causes of Harm at El Camino Hospital

- We looked at past serious events at our hospitals to identify the common reasons why they occurred.

- Common causes associated with our past events:
  - *Lack of attention to detail*
  - *Staff uncomfortable with peer checking*
  - *Poor communication*
  - *Lack of questioning attitude or critical thinking skills*
  - *Non-compliance with policy, procedure, or expectations*
    - *Including Normalized Deviance*

Normalized Deviance is when a group doesn't comply together – such that deviating from the norm becomes an acceptable way to practice.

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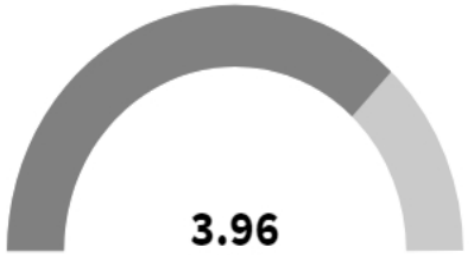
Culture of Safety: Employees

Safety Culture Index



Historical Performance

2018 Resul 4.04

-0.05 vs. Nat'l Healthcare Avg (Employee) 2021

	Score	vs. Nat'l Healthcare Avg (Employee) 2021	vs. 2018 Results
Safety Culture	3.96	-0.05	-0.08
Prevention & Reporting	4.03	-0.12	-0.08
Resources & Teamwork	3.70	-0.04	-0.11
Pride & Reputation	4.25	+0.04	-0.04

Culture of Safety: Physicians

Safety Culture

Evaluation of attitudes and behaviors impacting patient and workplace safety

	2021	Natl Phys	2019
Prev & Report	4.07	-.11	+.18
Res & Tmwk	4.01	+.14	+.19
Pride & Rep	4.30	+.06	+.07

Culture of Safety

What is Just Culture

- An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.

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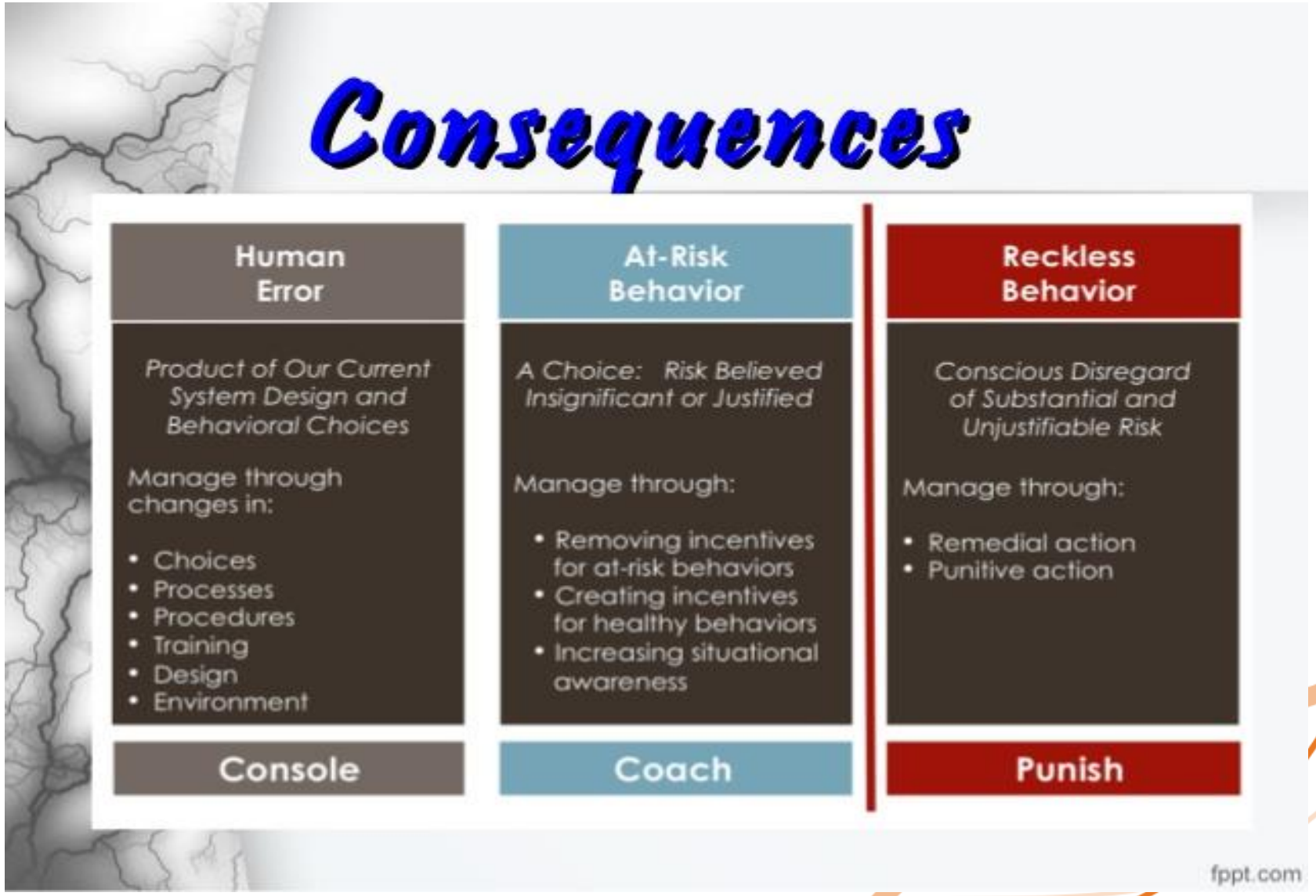
Culture of Safety



"Today we are going to decide who to blame."

Six key success factors

Senior leaders who actively own and lead the work.

Allocate resources to support the change.

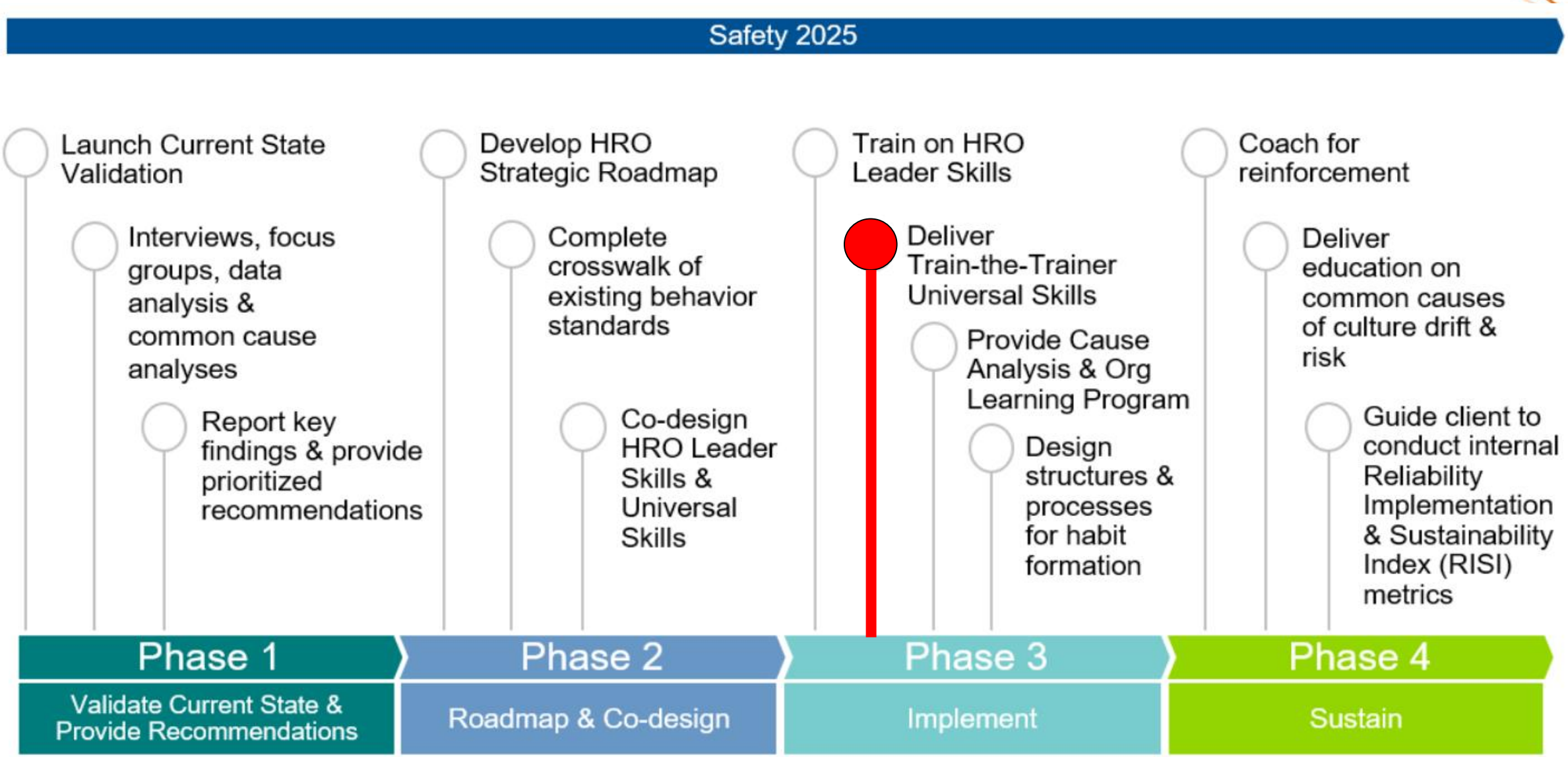
Meaningful engagement of all constituency groups (medical staff, etc.).

Habit formation (new behaviors and skills become standard work).

Sustain focus and vision in the face of leadership changes and competing priorities.

Ongoing two-way communication across team members.

High Reliability & Safety Engagement



Workgroups in process

6 workgroups in process with medical staff participation:

- **Education and Training**-reviewing all educational material with Press Ganey, customizing content for ECH as needed, developing supporting job aids/educational material

Marketing and Communications-ongoing communications about journey in Physician Briefings and ECH communications. Producing safety video that captures core messages of HRO, will include MEC leadership: watch for emails about scheduling. Goal to have ready by early May for Hospital week

Toolkit Workgroup: To create job aids and establish standard work of how to operationalize universal and leader skills in clinical and non-clinical areas (new practices for master daily huddle, daily department safety huddles, learning boards, new rounding practices)

Metrics/Key Performance Indicators: To establish key performance indicators to track progress on HRO journey (eg SSER, # of preventable harm events, # incident reports filed, % staff/physicians trained, # learning boards rolled out. % recall of universal/leader skills from staff etc)

Fair and Just Culture: rollout use of Performance Decision Management guide and just culture principles for staff and medical staff (consider using just culture principles as part of peer review process)

Cause Analysis: redesign of root cause analysis and FMEA processes, rollout of apparent cause analysis for use by leaders and common cause analysis

Cause Analysis Workgroup: Assessment of Current Practices (CAPE)

Executive Sponsor: Dr. Mark Adams

Workgroup Lead: Laura Wadas

Workgroup Members:
Erin Sanders
Mari Numanlia-Wone
Deepthi Mattapally
Poopak Barirani
Anna Aquino
Catherine Nalesnik
Dr. Daniel Shin
Dr. Shreyas Mallur
Melina Hrynewycz
Sheetal Shah
Franz Encisa
Susan Schubert
Tonya Stuart
Caroline Stewart
Elena Gonzalez
Eduard Tesnado
Marissa Panem

Initiation		Screening		Analysis		Implementation		Monitoring	
Identification of potential serious safety events; notification and reporting process; initial investigation (preserve evidence, collect initial facts); implement immediate actions IF APPROPRIATE		*Screening: Initial high-level event review (usually by quality/risk); assign a preliminary classification (SSE, PSE, NM and level of harm); assign executive sponsor.*		*Executive Sponsor fulfills role; RCA team is formally chartered, structured process for investigation; Three-Meeting-Model implemented (FACTS meeting, CAUSES meeting, CORRECTIONS meeting)*		*Executive Sponsor approves analysis and action plan; specific operational ownership and due dates for action plan items (extensions only can be approved by Executive Sponsor); progress on action plan is tracked and loops closed.*		*Verification that corrective actions are completed and were effective; inappropriate acts are identified, coded, and entered to support periodic (annual) Common Cause Analysis (CCA).*	
I1	Notify appropriate individuals, departments, and facilities in a prompt and systematic manner	S1	Conduct initial high-level event review by quality/risk leadership team	A1	Executive Sponsor demonstrates ownership and reviews/approves event analysis	P1	Specify operational ownership and due dates for corrective actions to prevent recurrence	M1	Capture and code information about the event and proximate causes
I2	Preserve physical evidence and collect initial information	S2	Classify the event for physical harm, emotional or other harm	A2	Prepare charter, including clear definition of scope, team members, priority, and schedule	P2	Escalate due date extensions to Executive Sponsor for review/approval	M2	Verify that corrective actions are complete
I3	Implement immediate remedial actions specific to the event and extent of condition	S3	Select cause analysis technique and escalate/de-escalate based on significance	A3	Identify cause analysis team, team leader, and stakeholder group	P3	Track status and closeout of corrective actions using a formal, systematic process	M3	Verify that corrective actions were effective
I4	Communicate with patient/family and workforce involved in the event	S4	Assign Executive Sponsor for the investigation	A4	Use structured investigation methods for identification of root solutions	P4	Conduct resolution with patient/family and workforce involved in the event	M4	Periodically perform Common Cause Analysis of events
I5	Document the event in the problem reporting system	S5	Evaluate for adverse trend and repeat event	A5	Use Three Meeting Model to obtain input from and build consensus of stakeholder group	P5	Share lessons learned throughout the organization	M5	Review root cause analysis program metrics and effectiveness

SCORING CRITERIA

GREEN	Fully implemented with consistent practice *"We have a policy/process for this and do it 100% of the time."*	YELLOW	Fully implemented but with some gaps in performance *"We have a policy/process for this and follow it most of the time."*	ORANGE	Partially implemented with moderate to wide variation in practice *"We are in the process of implementing this."*	RED	Not currently implemented *"We currently do not do this."*

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Universal Skill Training

- Universal Skill Training for All Staff-2 hours, in person, starts in June-December
- Taught by certified ECH staff and medical staff (looking for interested volunteers, training to be provided in May)
- Pending final decision about participation by all medical staff, working on CME credits
- Universal Skill Training consists of focused training on use of the following behavioral skills

  Speak up for Safety (ARCC, iSAFE)

  Accurate Communication (SBAR, Repeat Back, Letter and Number Clarification, Respectful, Communication)

  Focus on the Task (STAR)

  Embrace a Questioning Attitude (Qualify/Validate/Verify, Clarifying Question)

  Take Thoughtful Action (Continuous Use, Reference Use, SORT)

  You and Me Together (Cross Checks, Respectful Communication)

Health Safety KPI Scorecard: Culture of Safety

Metric Type	Metric	Desired Trend	FY21 Target	FY20 Baseline	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	FYTD
Culture of Safety																				
Outcome	Serious Safety Event Rate per 10,000 adjusted patient days (rolling)	↓	Establishing Baseline		1.98	1.66	1.58	1.71	1.80	1.89	2.23	2.20	2.22	2.35	2.54	2.66	2.97	3.20	3.28	3.33
Outcome	Number of Reported Serious Patient Safety Events	↓	N/A	126	3	2	2	13	16	14	23	8	8	16	19	19	30	26	19	94
Outcome	OSHA Recordable Caregiver Injury Percentage	↓	17.08%	18.98%	28.57%	27.73%	21.01%	12.50%	18.42%	8.22%	11.84%	12.06%	8.98%	12.08%	11.11%	11.39%	9.09%	19.91%	12.26%	13.16%
Outcome	Number of OSHA Recordable Caregiver Injuries	↓	278	299	32	33	25	12	28	12	18	41	23	18	32	45	27	45	26	143
Lead	**Reported Number of Safety Related Events (Patient + Caregiver)**	↑	13868	12607	926	945	977	875	967	1138	1200	1240	945	1150	1241	1379	1370	2127	1509	6385
Lead	% of Leaders Completing HRO Training	↑	80.0%	57.3%			74.6%	74.6%	74.6%	64.6%	57.2%	57.3%	57.3%	57.3%	57.3%	57.3%	62.4%	70.2%	69.9%	69.9%
Lead	Reported Number of Near Miss Events	↑	2103	1829	150	145	160	170	191	232	224	151	56	121	140	109	241	212	226	788
Outcome	Reported Patient Fall Rate with Injury (Level 2-5)	↓	3.47	4.34	2.67	3.78	3.76	1.70	3.49	4.13	3.79	5.04	4.05	7.26	6.37	5.59	6.60	3.16	6.17	5.38
Outcome	Reported Number of Patient Falls with Injury (Level 2-5)	↓	208	260	16	22	23	10	18	25	21	26	14	35	34	34	37	17	36	124
Lead	Cause Analysis Training for Leaders	↑	80%	N/A															27.62%	27.62%
Outcome	DLO Reported Number of Rejected Specimens and BC Contamination	↓	15762	19703	1446	1443	1507	1625	1641	1983	1883	1966	1375	1626	1781	1871	1868	1706	1879	7324

El Camino Health

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: June 6, 2022
Subject: Leapfrog Hospital Safety Grade Spring 2022

Recommendation: Review Leapfrog Hospital Safety Grade Spring 2022 for both Mountain View (MV) & Los Gatos (LG) Campuses which receive separate grades. There are 2 domains to the Leapfrog Hospital Safety Grade: 1) Process/Structural Measures [12 measures] from the Leapfrog Hospital Survey & 2) Outcome Measures from CMS [10 measures]. Each domain represents 50% of the Safety Grade. Fall 2021 MV scored an A grade, as did LG. Spring 2022 MV maintained an A, and LG fell to a B. Identify opportunities for improvement.

Summary: Provide the Committee with a review of the MV & LG Leapfrog Hospital Safety Grade.

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients.

2. Background: Leapfrog started with a focus on employers looking at the safety of hospital care. In 2012 they decided to expand this work to reach out to consumers directly with a Hospital Safety Grade. This grade is meant to help patients determine how safe hospitals are for patients. The safety grade aims to provide patients with a letter grade rating that summarizes how likely they are to experience accidents, injuries, errors or harm while in the hospital.

3. Assessment:

- **A.** In the Fall 2021 Leapfrog Patient Safety Grade release both ECH sites were designated as “A” Hospitals. In Spring 2022 LG campus fell to a “B” grade.
- **B.** Biggest opportunities identified are the ICU Physician Staffing at LG, as well as that the enterprise HCAHPS fell for this time period.
- **C.** Only the publicly reported data was updated from Fall 2021 to Spring 2022 – thus the only true impact was the drop in HCAHPS scores. We perform in the top tier for HCAHPS – but a decline in each Leapfrog metric was noted in this time period.
- **D.** All of the HCAHPS scores dropped in this time period: Nurse Communication from 92 to 90; Doctor Communication from 93 to 92; Staff Responsiveness from 85 to 81; Communication about Medicines from 80 to 75; and Discharge Information from 86 to 85.
- **E.** There was also 1 CLABSI and 1 SSI-colon that was attributed to LG in this time period, an increase from 0 for both the categories in the Fall grade.

List of Attachments: None

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: June 6, 2022
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QAPI) for 2022

Recommendation: Approve revised QAPI plan for 2022

Summary:

1. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to El Camino Health patients.

2. Background: The QAPI plan provides the blueprint for quality and safety improvement at ECH and is required as the "QAPI Plan" in CMS Conditions of Participation and Joint Commission Standards. The California of Department of Public Health also requires hospitals to have a Patient Safety Plan. This plan defines the structure, function, and processes utilized to accomplish the overall quality and safety strategy of the organization. The progress and success of the plan is measured by the many quality and safety metrics that are tracked and trended.

3. Assessment: The changes in this plan for 2022 include:

    a. Detailed description of the process by which we will become a high reliability organization to achieve zero preventable harm.
    b. Description of our updated root cause analysis process.
    c. Goal setting and auditing methodology using S.M.A.R.T. goals.

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

5. Outcomes: The Quality Committee will recommend to the board the QAPI plan for 2022 is approved.

List of attachments: Quality Improvement and Patient Safety Plan plus addendums.

El Camino Health

Origination:	*05/2018*
Effective:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Franz Encisa: Director Quality and Public Reporting*
Area:	*Quality*
Document Types:	*Plan*

Quality Improvement & Patient Safety Plan (QAPI)

PURPOSE

The Quality Improvement & Patient Safety Plan, as equivalent to CMS' Quality Assurance 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.

ORGANIZATION OVERVIEW

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, California and a 143-bed acute hospital in Los Gatos, 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, 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, Spinal Fusion and as a "baby friendly hospital" by WHO/UNICEF.

The ECH Medical Staff includes 1189 active, provisional and consultant, 259 affiliate physicians, and 259 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.

EI CAMINO HEALTH MISSION

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

EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

EI 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.

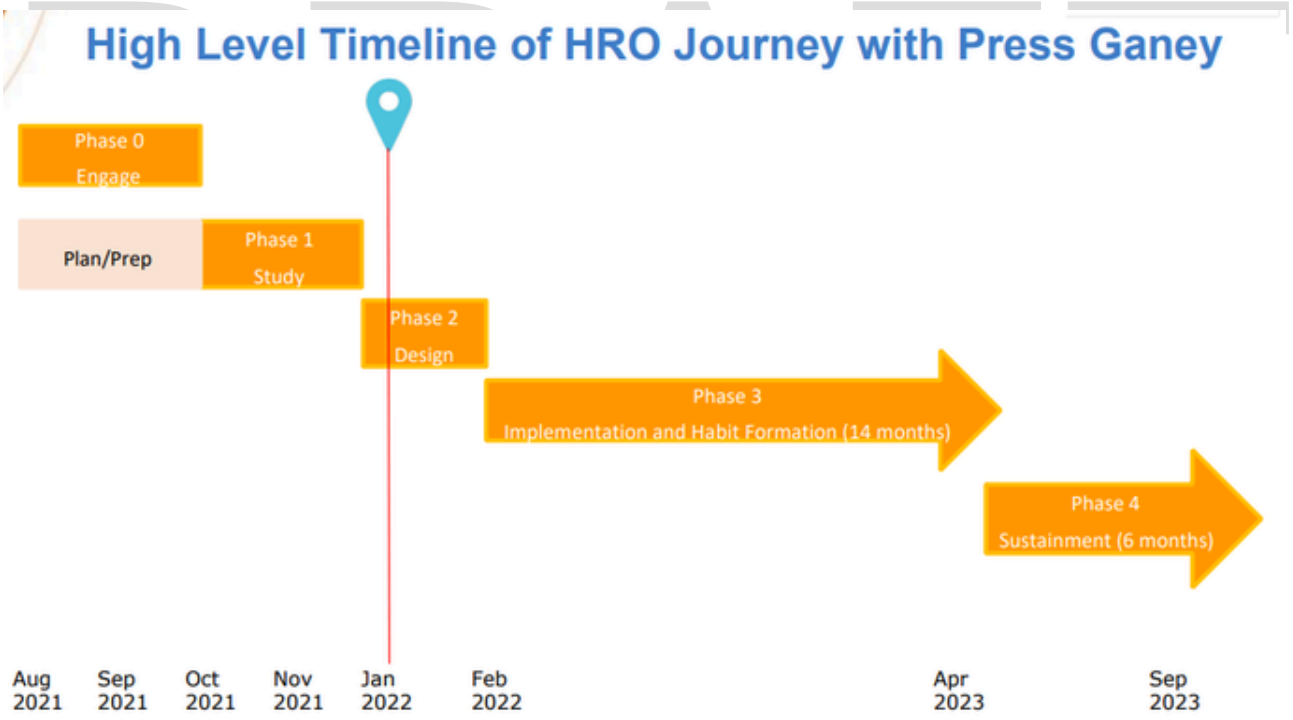
Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

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

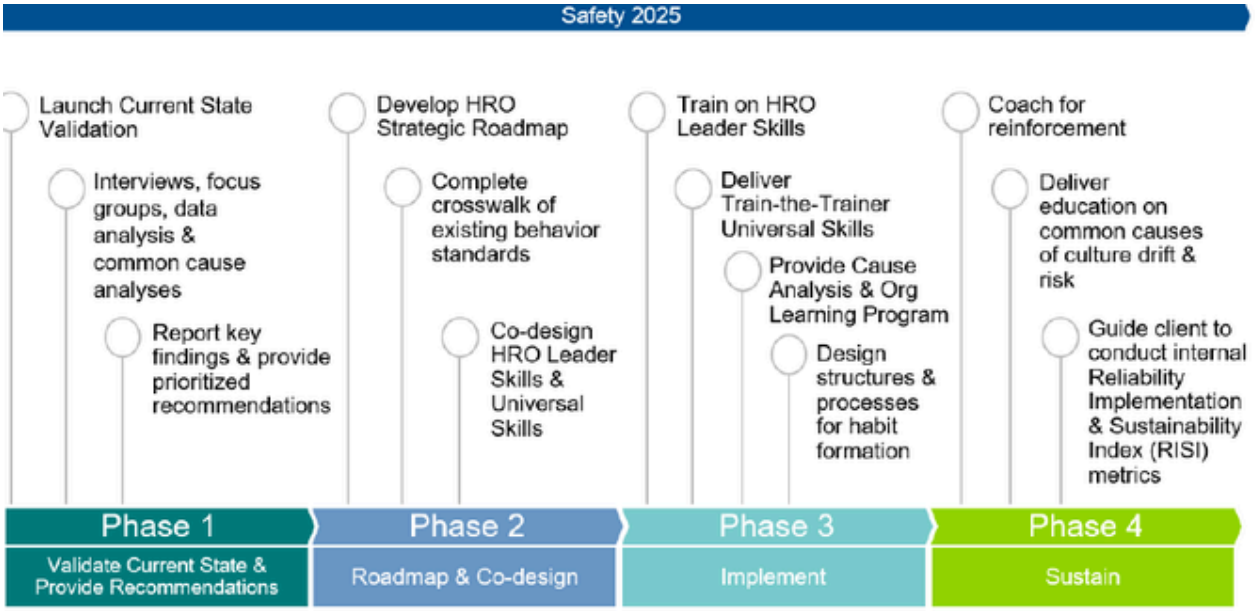
Accountability: We take responsibility for the impact of our actions has on the community and each other.

HIGH RELIABILITY

El Camino's 2021 vision for quality includes becoming a high reliatibility organization to achieve zero preventable harm. Safety is a well-defined science and can be improved through attention to reliability culture (expectations, behaviors, teamwork, etc.) and processes (intuitive design, mistake proofing, etc.). A High Reliability Steering Committee provides guidance and direction toward the implementation of high reliability practices. The HRO brand, SAFETY FIRST MISSION ZERO, has been adopted and will be used to enhance communication and understanding of high reliability. To date, El Camino Health has completed the first two phases of its HRO jounrey and will be launching focused leader and universal skill training this calendar year.



Phases of the HRO Journey above are defined here:



El Camino will develop a tool kit for all executive and medical staff leaders, provide training, and monitor use. The toolkit will include techniques to lead the safety journey (e.g., how to encourage reporting, educating for safety, having a moment for safety in each meeting, sharing lessons learned), build accountability (e.g., rounding to influence, 5:1 feedback, fair and just culture), and finding and fixing problems (e.g., top 10 work list, action planning).

El Camino physician and executive leaders will work to decrease power gradients and improve interpersonal communication. In addition to the daily Safety Huddle, El Camino will develop a series of communication tools to allow for immediate frontline communication and education to decrease the risk of preventable harm.

Using the newly implemented iSAFE incident reporting system data, all safety events are now classified by a team of experts trained in the HPI classification system. The classified events are then subjected to a common cause analysis. This allows for identification of recurrent safety events so that interdisciplinary teams can be formed to address the gaps in generally accepted performance standards.

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

OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. 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.
5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.

7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. 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.
9. 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.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

Governing Board

As described in the Governing Board Rules and Regulations, 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 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 for implementing the Quality Improvement & Patient Safety Plan to the medical staff and hospital administration.

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, cause 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:

1. Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered

to patients in the hospital;

2. 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
3. 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:

1. 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
2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. 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
4. Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff
5. 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

6. Assure that staff are trained in quality and safety improvement approaches and methods and receive education that focuses on safety, quality, and high reliability
7. Continuously measure and assess the effectiveness of quality and safety improvement activities, and implement improvements for these activities

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 & Patient Safety Committees: Enterprise Quality Council and Patient and Employee Safety Committees

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 co-chaired by the past chief of staff 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 2022 is reduction of the Readmission Index and 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 21 Quality Council report schedule.

The **Enterprise Patient and Employee Safety Committee** 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), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Medication Errors, Employee Injuries, and the Grievance Committee. (See Attachment C: Patient and Employee Safety Dashboard) The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital administration to develop action plans in response to the results. Failure Mode Effects Analysis (FMEA) are done for new or changed hospital services or for areas that are high-risk/problem-prone. The Director of Risk Management provides data on incident reports (iSafe– ECH's Online System for – event reporting) the adequacy of the reporting process, including updates on the number and type of iSafe reports, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Serious Safety Events Procedure to outline the process for categorizing patient safety events, including serious safety events, performance of a root cause analysis for serious safety events, compliance with regulatory requirements for mandated reporting of adverse events and process of notification of ECH leadership of serious safety events.

The **Root Cause Analysis (RCA) Steering Committee** is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). The RCA Steering Committee meets monthly focuses on events that an RCA has completed and thus has the senior leadership with the involved departments reporting on actions taken and the continuous improvement until the process change has been sustained. This process also includes the SSE's and investigation process.The **Enterprise Patient Safety Oversight Committee (PSOC)** is also a subcommittee of the Quality Council Committee and is described in the *Management of Adverse Events/Sentinel Events Procedure* (Administrative). The Patient Safety Oversight Committee is a committee that meets weekly to review and categorize iSafeReports, serious patient safety events, behavior, safety and operational issues. The Committee is comprised of the Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Medical Director for Quality Assurance, Associate Chief Medical Officer, Sr. Director Quality, Director of Risk Management/Patient Safety Officer, Director of Accreditation/Public Reporting, Director of Medical Staff Services and a representative of the Medical Staff. These leaders provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

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 the teams addressing the organizational quality, ERAS 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:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. 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 D and E.
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment F for Data Registries in use)
5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
6. Collaborates with the Director of Risk Management on efforts to manage and reduce risk through Root Cause Analyses and Intense Analyses as responses to adverse events and near misses
7. Collaborates to facilitate failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting
   Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"

8. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
9. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
10. Providing data as requested to external organizations, see data provided in Appendix B
11. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list
12. 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
13. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health to improve the quality of care and safety of care provided to our patients.

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(s) 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:

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of quality improvement, patient safety and risk reduction activities
3. 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)
4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.

Performance Processes

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.

1. **Patient Safety**
   ECH strives to prevent errors and adverse effects to patients that are associated with complex patient care. While patient safety events may not be completely eliminated, harm to patients can be reduced and our goal is always zero harm. To promote the goal of zero harm, ECH adopted a new logo and phrase: "Safety First Mission Zero" in 2020. To learn from and to make changes to reduce harm, all hospital-acquired conditions, infections and complications of care are reviewed and results shared with involved departments and providers. Root cause analyses and intense analyses are conducted to more clearly understand the factors involved in a near miss or untoward event. The purpose is to develop and sustain a culture of safety. The leadership, risk management and quality staff work to promote a "just culture" that focuses on the systems involved in care and to create a trust-report-improve cycle to promote reporting of all event and near misses.

   a. iSafe reports, surgical site infections, MRSA infections, evidenced-based bundle failures and other events that result in patient harm are reported and evaluated weekly by the Safety Event Classification Team. This team determines if there were defects in care or deviations from generally accepted performance standards (GAPS) and the level and type of patient harm. This information is translated and reported as the Serious Safety Event Rate.

   b. SSE diagrams:

   c.

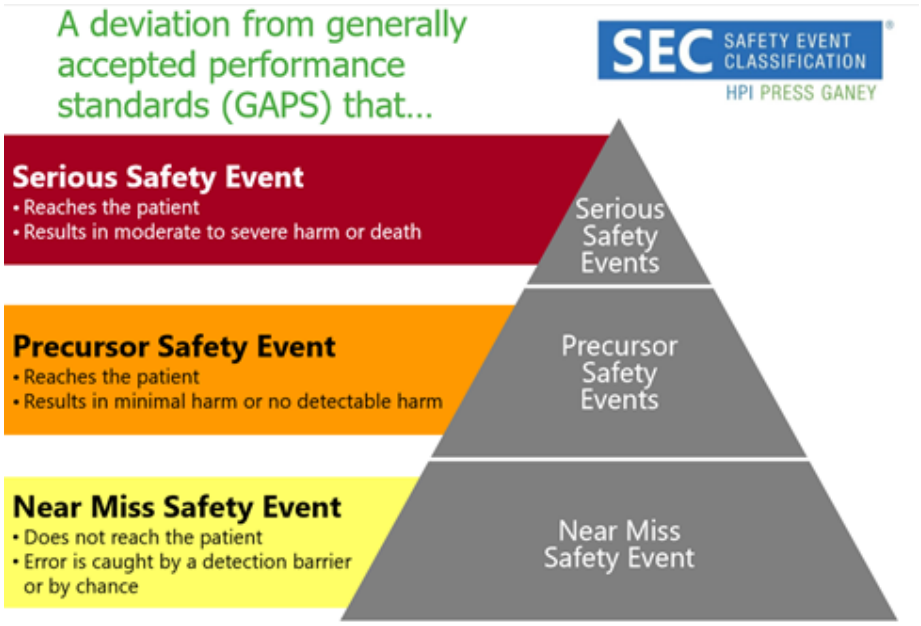
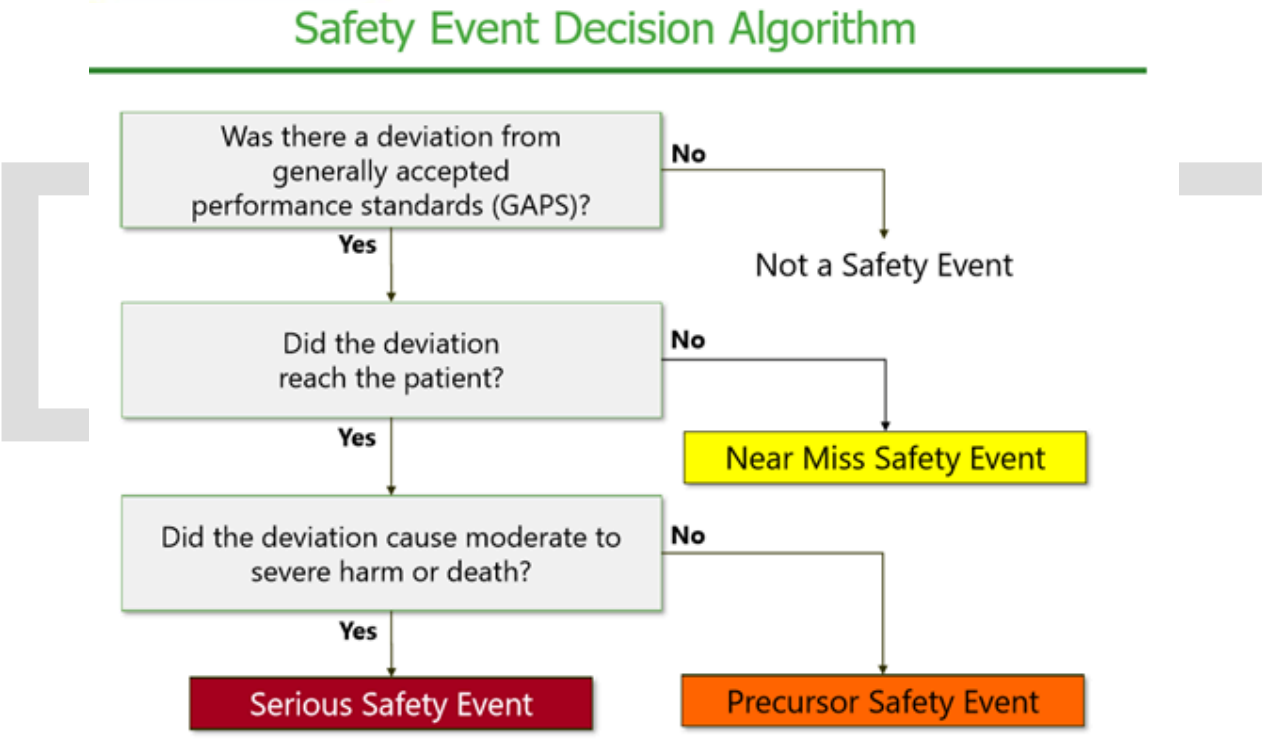


Table 1. HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch



2. **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. 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:

a. Consistent with the organization's mission, vision, goals, objectives, and plans;

b. Meeting the needs of individuals served, staff and others;

c. Clinically sound and current;

d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;

e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;

f. Incorporated into the results of performance improvement activities.
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:

g. Establish a performance baseline;

h. Describe process performance or stability;

i. Describe the dimensions of performance relevant to functions, processes, and outcomes;

j. Identify areas for more focused data collection to achieve and sustain improvement.

3. **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.
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.
ECH requires an intense analysis of undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;

b. Performance varies significantly and undesirably from recognized standards;

c. When a sentinel event occurs;

d. Blood Utilization to include confirmed transfusion reactions;

e. Significant adverse events and drug reactions;

f. Significant medication errors, close calls, and hazardous conditions;

g. Significant adverse events related to using moderate or deep sedation or anesthesia;

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:

1. ***Three fundamental questions, which can be addressed in any order.***
    - What are we trying to accomplish?
    - How will we know that a change is an improvement?
    - 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.
2. ***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:

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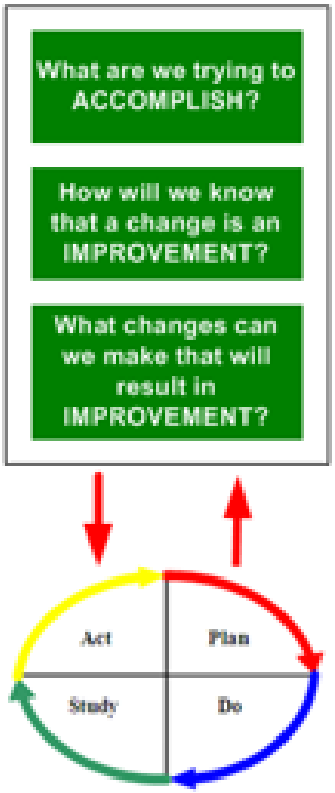


3. ***Goal Setting and Auditing Methodology***
    - S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, 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 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.

- 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:
  - Sample all cases for a population size of fewer than 30 cases
  - Sample 30 cases for a population size of 30–100 cases
  - Sample 50 cases for a population size of 101–500 cases
  - Sample 70 cases for a population size of more than 500 cases
  - 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.

Performance Improvement and the El Camino Health Operating System

ECH is on a journey of continuous improvement and operational excellence. Performance 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. High Reliability Organizations deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Performance Improvement department has been in existence since 2012, and has adopted the use of Lean methodology and principles as the foundation for our interventions. We also use tools from Six Sigma, Change Management, and PDCA, to support our transformation in becoming a High Reliability Organization.

We do this by focusing on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the base.

The Performance Improvement department provides resources to the organization for problem solving, as well as deploying ECHOS, our El Camino Health Operating System. The dedicated team is comprised of Program 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.

Systems critical to the success of Performance Improvement include robust education and training programs. We recently established the PI Academy, a 90 day project based training program designed to encourage and support all staff to be problem-solvers, and to engage in continuous improvement. We also provide ad hoc training sessions for Lean/PI throughout the enterprise, and assisted 20+ departments with project completion.

The PI 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

An operating system is a term that is commonly used in reference the computer system that runs other programs and applications. When we talk about the El Camino Health Operating System, we are talking about the processes and tools that we use to run the various functions of our work. The ECH Operating System is the way that we lead and do work at EL Camino Health Care. At the top is our True North; our mission, vision and values, as well as our True North pillars. Our foundation represents our Operating system, which is made up of all the process improvement concepts, methods and tools, along with our Management System.

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

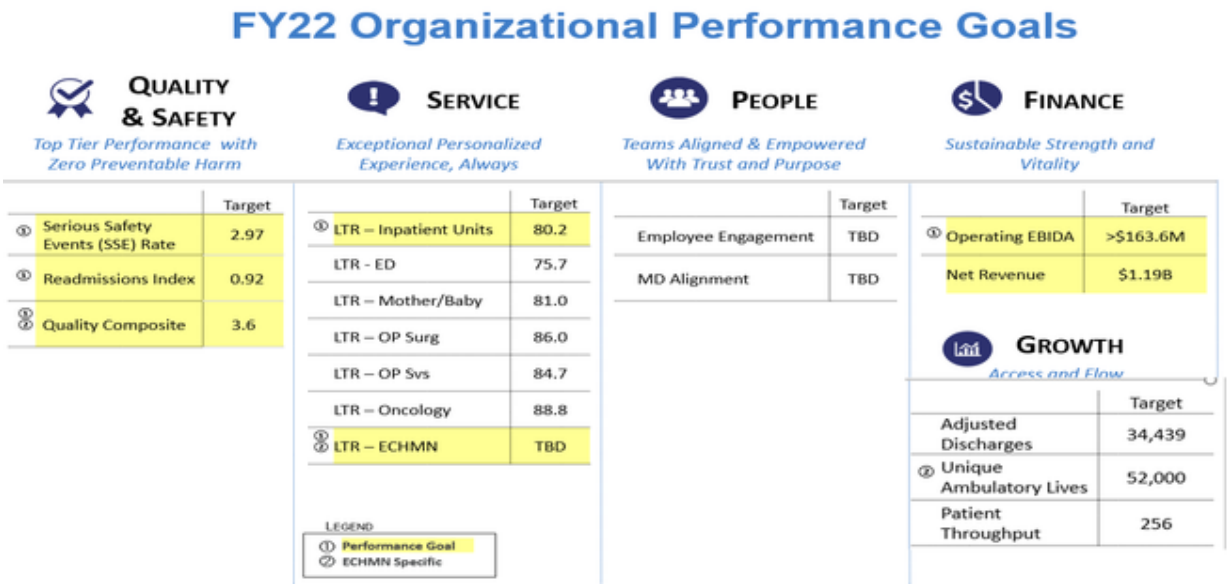
1. **Align** the goals of the organization from the Executives to the Front Line with annual *Strategy Deployment*
2. **Engage** our people in daily front line problem solving daily through the *Daily Management System* using Tiered Huddles, Linked Visual Systems, Gemba, Standard Calendar, and Leader Standard Work
3. **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 & Patient Safety Plan focuses on specific quality measures in three areas: quality/safety, service and finance. See below for the Fiscal Year 2022 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 Quality goal Readmission Index, ECH formed five teams to address issues with Readmissions at the beginning of the fiscal year and who meet bi-weekly: Heart Failure team, Cancer Care

team, Weekly Readmission Review team, Hospital-acquired Pneumonia (HAP) team, and the Enhanced Recovery After Surgery (ERAS) team. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.



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.

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 Services Department, the Medical Staff Services Department 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 Sr. Director, Quality Services Department or the Compliance Officer.

Annual Evaluation

The Sr. Director of Quality Services, shall coordinate the annual evaluation of the program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address the program's effectiveness in improving patient care, patient 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.

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.

Cross References:

1. Management of Adverse Events and Sentinel Events Procedure
2. Medical Staff Peer Review Policy

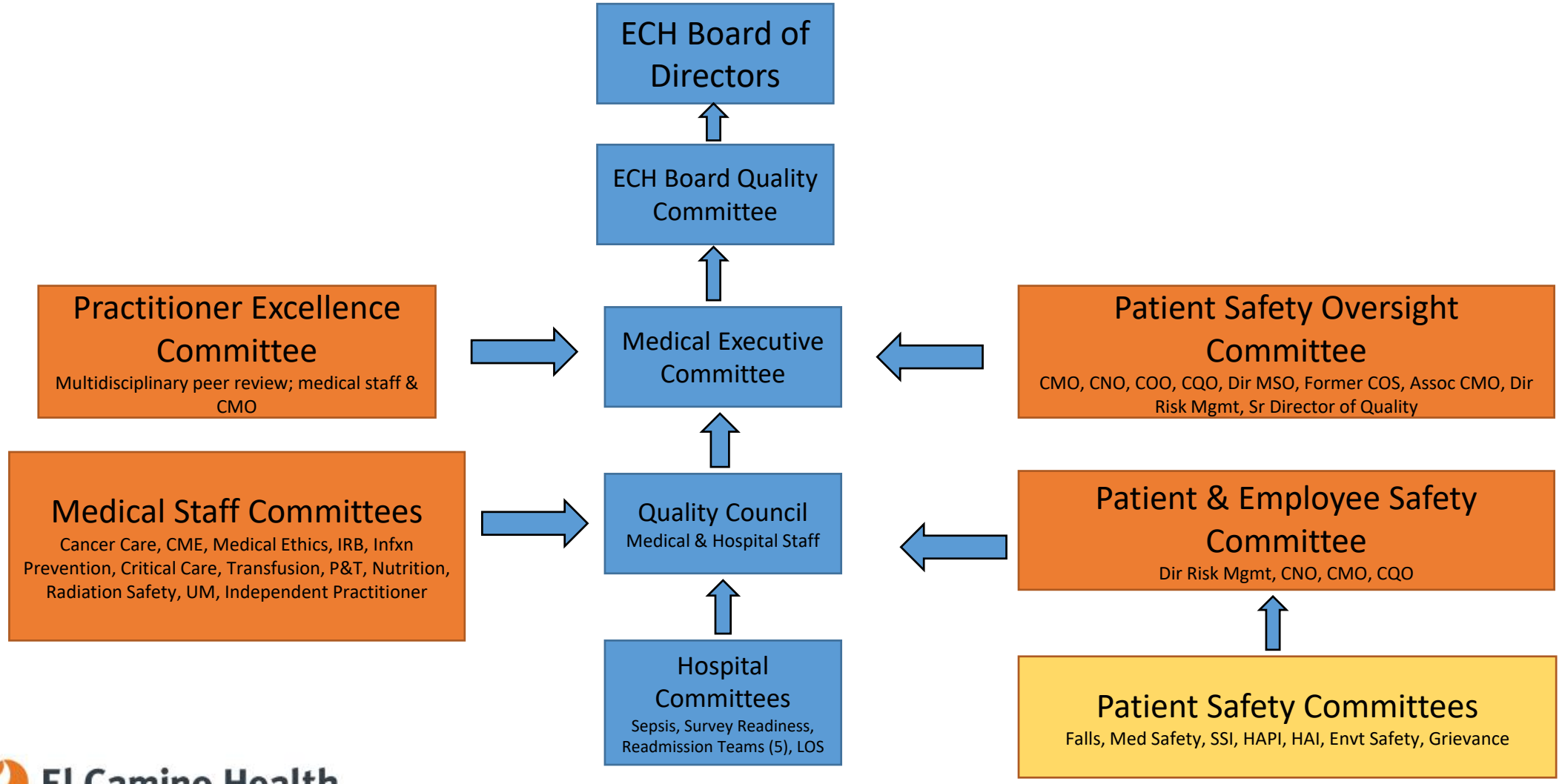
NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this

document, the electronic version prevails.

Attachments

Att A Governance Information Flow.pdf
Att B FY22 Combined Quality Council Reporting Calendar rev 1.25.22.pdf
Att C Patient and Employee Safety Dashboard FY22.pdf
Att D Org Goals and Quality FY22.pdf
Att E Board Quality and Safety Dashbaord FY22 end of December final.pdf
Att F Abbrev Registries List.pdf
Att G EXTERNAL REGULATORY COMPLIANCE INDICATORS 2022.pdf

Quality Assurance and Performance Improvement—Governance Information Flow FY22



El Camino Health

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY 22 Quality Council

Annual Performance Improvement Reporting Calendar for Hospital Departments/Programs/Service Lines*

1st Wednesday – 7:00 am to 9:00 am

2021	**July 7, 2021**	**August 4, 2021**	**September 1, 2021**
		▪ MV Emergency Dept. ▪ LG Emergency Dept. ▪ ED Physician Service Contract Evaluation ▪ Information Services	▪ Antibiotic Stewardship ▪ Health Information Management ▪ Orthopedics Service Line ▪ Patient Experience (HCAHPS)
	October 6, 2021	**November 3, 2021**	**December 1, 2021**
	▪ Nutrition Services ▪ Pharmacy ▪ Heart/Vascular Institute ▪ Care Coordination	▪ Cancer Service Line ▪ Human Resources ▪ Maternal Child Health Service Line ▪ Performance Improvement (Value Streams)	▪ Urology Service Line ▪ Sleep Center ▪ Respiratory Care Services ▪ Spine Service Line
2022	**January 5, 2022**	**February 2, 2022**	**March 2, 2022**
	▪ Rehab Service Line ▪ Mental Health & Addiction Service Line ▪ Environmental Services	▪ Infection Prevention ▪ Acute Dialysis ▪ Critical Care ▪ Organ Donation/Donor Network	▪ Sepsis ▪ Acute Rehab ▪ Patient Blood Management ▪ Quality/Performance Improvement /Patient Safety Plan (QAPI)
	April 6, 2022	**May 4, 2022**	**June 1, 2022**
	▪ Imaging Services / Radiology ▪ Contract Services ▪ Value Base Purchasing ▪ Sterile Processing	▪ Core Measures ▪ CPR ▪ Laboratory & Pathology	▪ Palliative Care ▪ MV Peri-Operative Services ▪ LG Peri-Operative Services ▪ Stroke Program

Revised 1/25/22

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

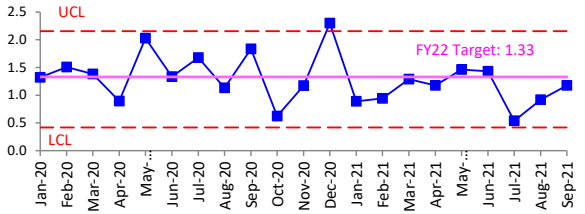
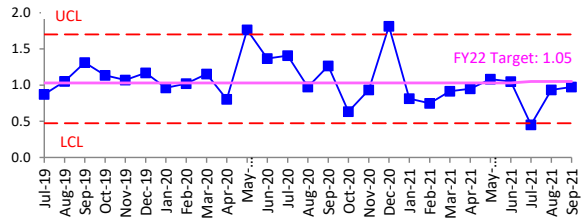
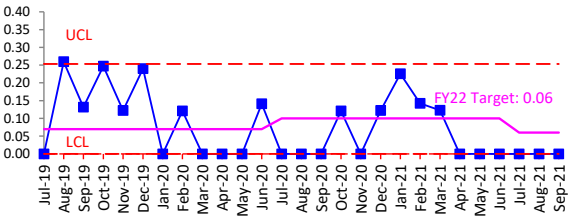
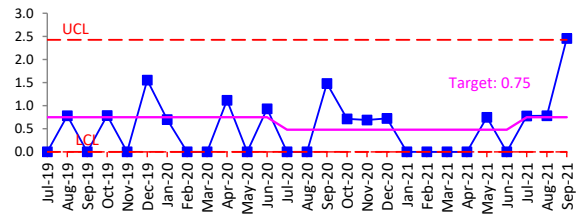
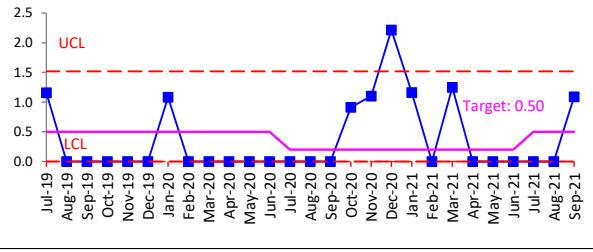
Annual (A) Reports		Standing Items (As Appropriate)
▪ Acute Inpatient Dialysis ▪ Acute Rehab ▪ Antibiotic Stewardship ▪ Cancer Service Line ▪ Care Coordination ▪ Contracted Services ▪ Core Measures ▪ Critical Care ▪ CPR ▪ Emergency Dept.(MV & LG) ▪ Environmental Services ▪ Health Information Management (HIM) ▪ Human Resources ▪ Heart/Vascular Institute ▪ Imaging Services/Radiology ▪ Infection Prevention ▪ Information Services ▪ Laboratory & Pathology ▪ Maternal Child Health Service Line ▪ Mental Health & Addiction Service Line ▪ Nutrition Services ▪ Organ Donation/Donor Network	▪ Orthopedic Service Line ▪ Palliative Care ▪ Patient Blood Management ▪ Patient Experience (HCAHPS) ▪ Peri-Operative Services MV & LG ▪ Performance Improvement ▪ Pharmacy ▪ Quality/Performance Improvement/ Patient Safety Plan ▪ Rehab Services ▪ Respiratory Care Services ▪ Sepsis ▪ Sleep Center ▪ Spine Service Line ▪ Sterile Processing (separate from Peri-Op Svs) ▪ Stroke Program ▪ Urology Service Line ▪ Value Based Purchasing	▪ Regulatory Update

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY22 End of Q1**

Report updated: 10/24/2021

	SAFETY EVENTS	Performance FY22, Q1	Performance FYTD 22	Baseline FY21 Actual	Target FY22 Target/ Goal	Trend *Displaying at least the last 24 months of available data*	Comments
1	**IP Units - Patient Falls Reported to NDNQI - *new method*** *(effective FY22)* *per 1000 Patient Days (NDNQI reported)* *excludes ED, L&D, and intentional falls* *Reporting period: Jul - Sep 2021*	0.88 (25/28480)	0.88 (25/28480) (old/retired method = 1.45)	1.33 (old/retired method = 2.34)	1.33 (<= FY21 performance)		FY22, Q1 NDNQI falls = 25 New definition used to calculate the fall rate for FY22, which aligns with NDNQI. Baseline calculated based on the new definition, which is = 1.33 (old/retired method = 2.34)
2	**All Patient Fall Rate - Internal (ECH licensed facilities)** *All patient falls per 1000 Adjusted Patient Days (EPSI report)* *Reporting period: Jul - Sep 2021*	0.79 (42/53335)	0.79 (42/53335)	1.05	1.05 (<= FY21 performance)		FY22, Q1 total All Patient Falls = 42 2 Moderate Injury and 1 Major injury in external area (non- NDNQI)
3	**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (HAPI) Rate** (excludes skin failure and expired pts) *per 1000 Total Patient days* *Reporting period: Jul - Sep 2021*	0.0 (0/27157)	0.0 (0/27157)	0.06 (6/98205)	<=0.06 (10% reduction from FY21 outcome, 6 HAPIs)		FY22, Q1 = '0' (1 HAPI, reportable for FY22 end of Q1, however it is not counted for safety dashboard because the patient expired)
4	**HAI- Catheter Associated Urinary Tract Infection (CAUTI)** *per 1000 Urinary Catheter days* *Reporting period: Jul - Sep 2021*	1.32 (5/3790)	1.32 (5/3790)	0.37 (6/16280) MV: 5 LG: 2	SIR <= 0.75 MV = 6 LG Main = 1 LG Rehab = 1		July: 1, 3AP Aug: 1, 3AC Sep: 3 - 3AP:1 and 3AC: 2
5	**HAI- Central Line Associated Blood Stream Infection (CLABSI)** *per 1000 Central Line Days* *Reporting period: Jul - Sep 2021*	0.35 (1/2862)	0.35 (1/2862)	0.53 (6/11352) MV: 5 LG: 1	SIR <= 0.50 MV = 5 LG Main = 0 LG Rehab = 0		Sep: MV = 1, NICU

El Camino Health

Definitions and Additional Information

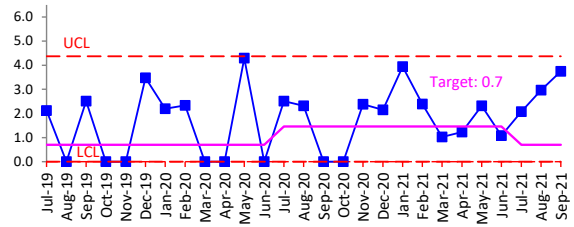
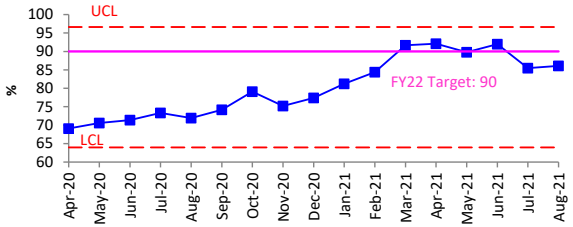
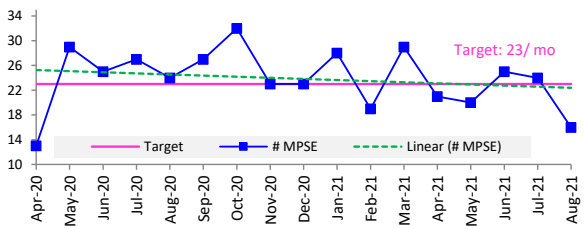
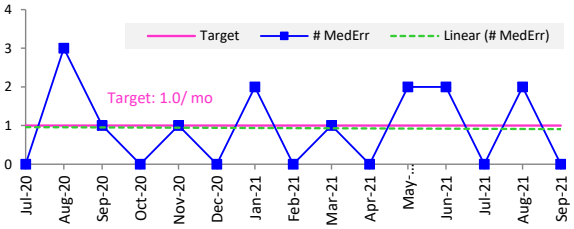
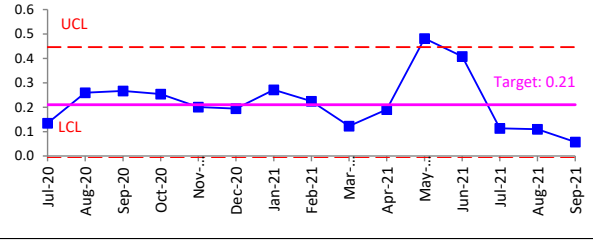
		Data Owner	Work Group	Definition	Data Source
SAFETY EVENTS					
1	**IP Units - Patient Falls Reported to NDNQI - *new method*** *(effective FY22)* *per 1000 Patient Days (NDNQI reported)* *excludes ED, L&D, and intentional falls* *Reporting period: Jul - Sep 2021*	Jane Truscott/ Andria Mills	Falls Committee/PESC Committee	All IP falls including Med/Surg/CC/MBU/ IPBHS reported to NDNQI per 1,000 patient days (includes short stay days + NICU days). Excludes L&D and intentional falls. ED falls are also reported to NDNQI but calculated the fall rate separately. NDNQI Fall Definition: patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Includes Assisted Falls (when staff attempts to minimize the impact of the fall). Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included in CALNOC fall. FY22 Target = 1.33, which is calculated using the new method. Baseline data received from Dee. *Upper Control Limit (UCL) and Lower Control Limit(LCL) are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports and Staff Validation/iSafe
2	**All Patient Fall Rate - Internal (ECH licensed facilities)** *All patient falls per 1000 Adjusted Patient Days (EPSI report)* *Reporting period: Jul - Sep 2021*	Jane Truscott/ Andria Mills	Falls Committee/PESC Committee	All reported falls that occur in ECH licensed facilities including IP, OP, and ED Fall Rate calculated per 1000 Adjusted Patient Days (EPSI report). This is an internal report. Non- patient falls are excluded FY Target: Achieve fall rates less than the FY21 actual, which was 1.05, Target email received from Sheetal/Andria, 8/17/21 *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports and Staff Validation/iSafe
3	**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (HAPI) Rate** (excludes skin failure and expired pts) *per 1000 Total Patient days* *Reporting period: Jul - Sep 2021*	Anna Aquino	Regulatory/ PIPSC Committee	Stage 3, Stage 4 and Unstageable Hospital Acquired Reportable Pressure Injury Rate per 1000 patient days. Data reported by date of discovery, excludes expired patients. Reportable HAPIs is defined as Stage 3, Stage 4 and Unstageable. We report all "reportable HAPIs" to CDPH but for the purposes of our Quality dashboard reporting, we exclude patients who developed reportable HAPIs that qualify as "Skin Failure or Kennedy Pressure Ulcer". Exclusion: Patients diagnosed with Skin Failure (Formerly know as Kennedy Pressure Ulcer). Data verification and comments received from Anna A. FY22 Target: Achieve less than the FY21 actual performance, which was 0.06 (6 HAPIs). Target email received from Anna on 8/30/21. *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Regulatory/PIPSC
4	**HAI- Catheter Associated Urinary Tract Infection (CAUTI)** *per 1000 Urinary Catheter days* *Reporting period: Jul - Sep 2021*	Catherine Nalesnik	HAI Committee/ Anna Aquino	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP *Target data received from Sheetal on 8/24/21 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero.*	CDC NHSN database - Inf. Control
5	**HAI- Central Line Associated Blood Stream Infection (CLABSI)** *per 1000 Central Line Days* *Reporting period: Jul - Sep 2021*	Catherine Nalesnik	HAI Committee/ Anna Aquino	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP *Target data received from Sheetal on 8/24/21 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero .*	CDC NHSN database - Inf. Control

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY22 End of Q1**

Report updated: 10/24/2021

	SAFETY EVENTS	Performance FY22, Q1	Performance FYTD 22	Baseline FY21 Actual	Target FY22 Target/ Goal	Trend *Displaying at least the last 24 months of available data*	Comments
6	**HAI- Clostridium Difficile Infection (C.diff)** *per 10,000 Patient Days* *Reporting period: Jul - Sep 2021*	2.88 (8/27775)	2.88 (8/27775)	1.78 (19/106990) MV: 15 LG: 4	SIR <= 0.70 MV: 20 LG Main = 4 LG Rehab = 2		Jul: 2 - 1: 4A and 1: 3C Aug: 3 - 2: 3C and 1: 4B Sep: 3 - 1: 3C, 1: 4A, and 1: L04 (LG)
7	**Documentation of Vital Signs within 10-20min of Transfusion Initiation** **Reporting period: Jul - Aug 2021*	85.8%	85.8%	81.9%	>=90% (same as FY21)		Data available up to August. Target same as FY 21, because it did not meet Target in FY21
8	**Actual # of Medication Precursor Safety Events (MPSE) per month** FYTD rolling 12 month average *Reporting period: Jul - Aug 2021	40 (20/ month)	23.9/ mo (12 month rolling average)	320 (25/month) *(April 2020 to April 2021*	304 (23/month) *(5% reduction from baseline)*		Total events: July = 24 Aug: 16
9	**Actual # of Incorrect Medication Errors that Reached Patient per month** *Reporting period: Jul - Sep 2021*	2 (<1 per month)	2 (<1 per month)	12 (1/ month) (out of 16 incorrect meds 12 reached patient)	11 (1/ month)		FY22, Q1 = 2 out of 6 incorrect medication events did reach patients but did not cause harm. First error reached an outpatient, where incorrect test strip was dispensed that was incompatible. Both had similar names but different sensors. Second error occurred due to lack of barcode scanning done for all medications including maintenance IV Fluids.
10	**Employee Falls** *per 10000 Adjusted Patient Days* ***(excludes volunteers, visitors, MDs and patients)*** *Reporting period: Jul - Sep 2021*	0.09 (5/53335)	0.09 (5/53335)	0.25 (total 48 falls)	0.21 (15% reduction from baseline)		Total falls: July: 2 Aug: 2 Sep: 1 Comments: These 5 injuries had a combined 3 days of loss time and 120 restricted duty days. One of these injuries resulted in a fracture.

El Camino Health

Definitions and Additional Information

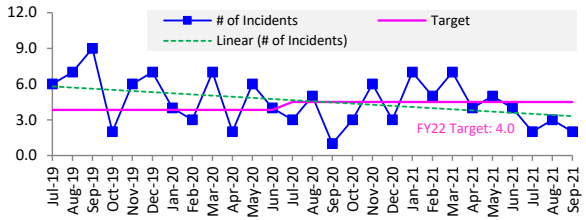
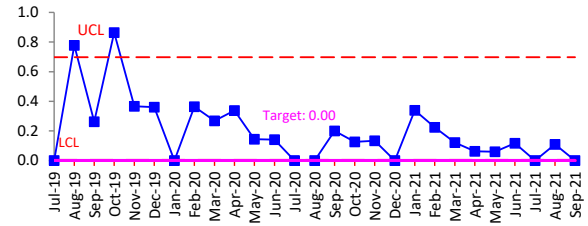
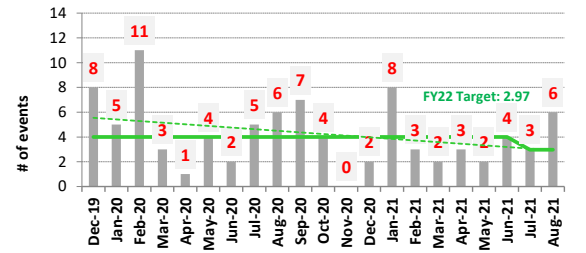
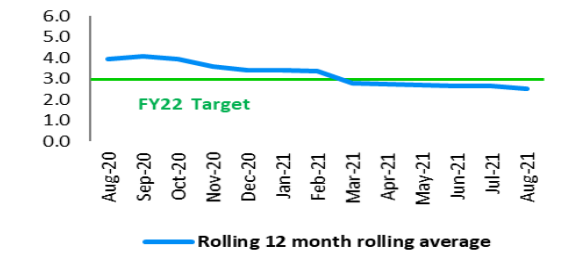
		Data Owner	Work Group	Definition	Data Source
SAFETY EVENTS					
6	**HAI- Clostridium Difficile Infection (C.diff)** *per 10,000 Patient Days* *Reporting period: Jul - Sep 2021*	Catherine Nalesnik	HAI Committee/ Anna Aquino	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only 1. Based on NHSN defined criteria 2. ALL positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization. Exclusion criteria: Out-patients and ED patients *Target data received from Sheetal on 8/24/21 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	CDC NHSN database - Inf. Control
7	**Documentation of Vital Signs within 10-20min of Transfusion Initiation** **Reporting period: Jul - Aug 2021*	Franz Encisa	Transfusion Safety Committee	Definition: During the first 15 minutes, nurse is required to remain at the patient's bedside as most transfusion reactions occur during the first 15 minutes of transfusion. This measure will assess nursing staff's compliance in checking and recording patient's vital signs within 10-20min of initiation. The measure value is the average value of 4 required elements of vital signs – blood pressure, temperature, respiratory rate, and pulse. Target: 90% of compliance rate *Baseline and Target data received from Jeong/ Sheetal on 8/17/21 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.*	EPIC Report and Staff Validation
8	**Actual # of Medication Precursor Safety Events (MPSE) per month** FYTD rolling 12 month average *****Reporting period: Jul - Aug 2021	Deep Mattapally	Medication Safety Committee	All medication events classified as precursor safety events by Safety Event Classification Team EPSI report used for Patient days and # of events provided by Deep M. *Target data received from Sheetal on 8/12/21 via email - 5% reduction from baseline* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports / EPSI Report / Safety Event Classification
9	**Actual # of Incorrect Medication Errors that Reached Patient per month** *Reporting period: Jul - Sep 2021*	Deep Mattapally	Medication Safety Committee	Incorrect Medication Errors that Reached patients. Includes all patients including IP, OP and ED. Data displayed as an actual # of events per month. New measure added to the dashboard in FY 21 July. *Baseline and Target data received from Deep M. on 7/27/20 via email*	Incident Reports and Staff Validation/iSafe
10	**Employee Falls** *per 10000 Adjusted Patient Days* ***(excludes volunteers, visitors, MDs and patients)*** *Reporting period: Jul - Sep 2021*	Mari Numanlia-Wone	Central Safety Committee/ PESC	The definition of Employee Falls is a slip/trip/fall with significant injury (OSHA recordable). Data only includes ECH employees does not include volunteers, MDs, visitors, patients. *Baseline and Target data received from Mari on 8/20/21 via email*	EWHS Systems- Employee enter data in this system. EMR System Agility- EWHS data are entered in Agility after staff review.

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY22 End of Q1**

Report updated: 10/24/2021

		Performance		Baseline	Target	Trend	Comments
SAFETY EVENTS		**FY22, Q1**	**FYTD 22**	**FY21 Actual**	**FY22 Target/ Goal**	*Displaying at least the last 24 months of available data*	
11	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* *Reporting period: Jul - Sep 2021*	7 (2/ mo)	7 (2/ mo)	53 (4/ mo)	<=49 (10% reduction from FY21 performance) (4/ mo)		7 total events, 4 with reported minor injuries and 3 with no injuries. The FY-22 goal for WPV events is 49 events, a 10% reduction over the FY-21 total of 53.
12	**Never Events Reported to CDPH Rate** *per 1000 Adjusted Patient Days* *Reporting period: Jul - Sep 2021*	0.04 (2 events)	0.04 (2 events)	0.11 (21/185541)	0		2 HAPI (Unstageable from Stage 2, MV-4B, coccyx & Stage 3, MV-CCU, penile corona from COVID19 proning pressure) 2 RFO (LG-OR, missing cottonoid from lumbar fusion & MV-OR, broken k-wire from right foot cuniform fusion)
13	***Organizational Goal** **Serious Safety Event Rate (SSER) per month** # of events/ FYTD = rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* Reporting period: *Jul - Aug 2021*	9	2.54 (44/173340)	3.13	2.97		FY22 total events: July = 3 Aug = 6 FY22 Target: 2.97
	Serious Safety Event Rate (SSER) Graph *Rolling 12 month average - graph*						NA

**data available up to August only*

El Camino Health

Definitions and Additional Information

		Data Owner	Work Group	Definition	Data Source
SAFETY EVENTS					
11	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* *Reporting period: Jul - Sep 2021*	Steve Weirauch/ Matthew S.	Safety/ Security	Every general acute care hospital, shall report any incident involving the use of physical force against an employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury. This includes any incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury. -Cal/OSHA - Title 8, § 3342. Violence Prevention in Health Care. *Target data received from Sheetal and Matthew S.on 8/17/21 via email*	WPV Reporting Log, data based on reported incidents
12	**Never Events Reported to CDPH Rate** *per 1000 Adjusted Patient Days* *Reporting period: Jul - Sep 2021*	Franz Encisa	PESC Committee	Never Events is Identified patient incident as defined in and pursuant to Health and Safety Code Section 1279.1 as well as Title 22, California Code of Regulations, Section 70737 (the "unusual occurrence" reporting requirement). Data collected by CDPH reported date. Includes expired patients. *Target data received from Sheetal via email on 8/19/21* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports and Staff Validation
13	***Organizational Goal** **Serious Safety Event Rate (SSER) per month** # of events/ FYTD = rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* Reporting period*: Jul - Aug 2021*	Sheetal Shah	PESC Committee	Serious Safety Event (SSE) is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient Inclusion is events determined to be serious safety events per Safety Event Classification team. Denominator is Acute Adjusted Patient Days which defines as 'Acute Patient Days adjusted by factor to adjust IP activity to include OP activity' (per EPSI definition, email Mary W. 9/14/20) New measure added to the dashboard in FY 21 July. Started monitoring in December 2019. *Target data received from Catherine via email 8/20/21, which is 2.97*	HPI Systems
	Serious Safety Event Rate (SSER) Graph *Rolling 12 month average - graph*	Sheetal Shah	PESC Committee	Serious Safety Event (SSE) is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient Inclusion is events determined to be serious safety events per Safety Event Classification team. Denominator is Acute Adjusted Patient Days which defines as 'Acute Patient Days adjusted by factor to adjust IP activity to include OP activity' (per EPSI definition, email Mary W. 9/14/20) New measure added to the dashboard in FY 21 July. Started monitoring in December 2019. *Target data received from Catherine via email 8/20/21, which is 2.97*	HPI Systems

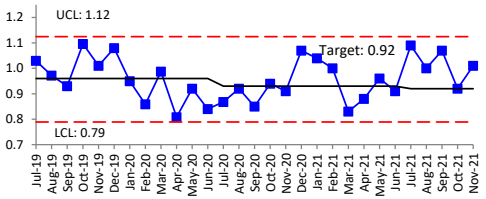
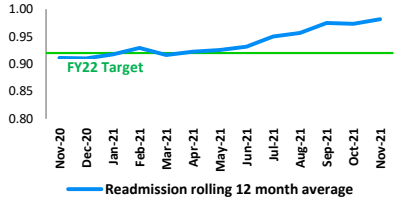
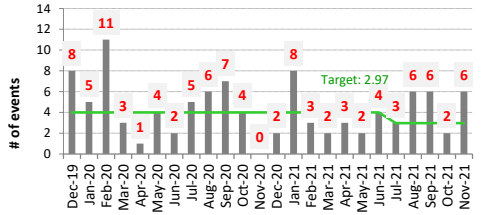
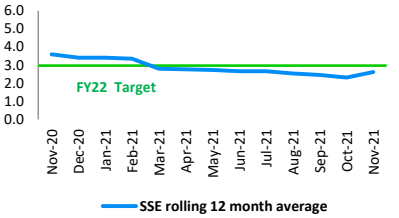
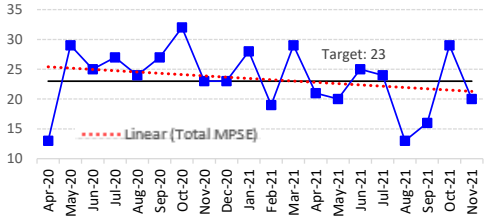
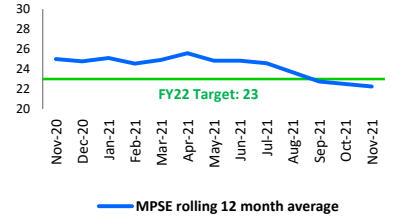
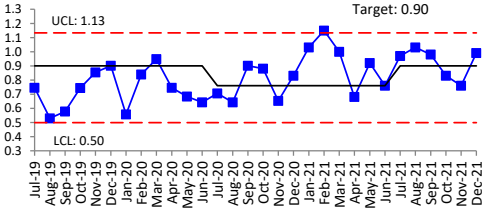
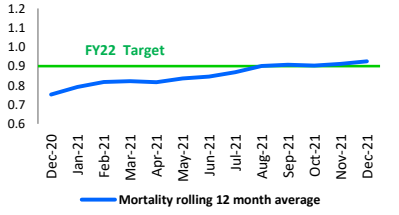
**data available up to August only*

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2021 (unless otherwise specified)

Month to Board Quality Committee:
February, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: November 2021*	1.01 (8.29%/8.21%)	1.01 (8.56%/8.44%)	0.93	0.92		
2	*Organizational Goal **Serious Safety Event Rate (SSER) per month** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ***Latest data month: November 2021*	6	2.62 (47/179649)	3.13 (Dec 2019 - Jun 2021)	2.97		
3	**Actual # of Medication Precursor Safety Events (MPSE) per month/** FYTD rolling 12 month average ***Latest data month: November 2021*	20	22.3/ mo. (12 month rolling average)	320 (25/month) *(April 2020 to April 2021)*	304 (23/month) *(5% reduction from baseline)*		
4	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: December 2021*	0.99 (2.29%/2.31%)	0.92 (1.71%/1.85%)	0.86	0.90		

Definitions and Additional Information

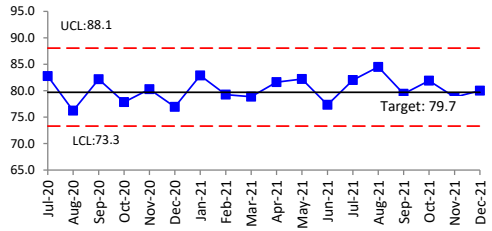
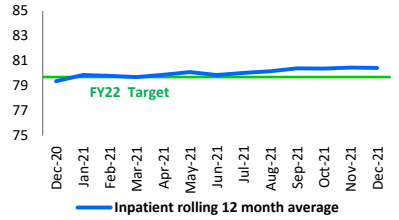
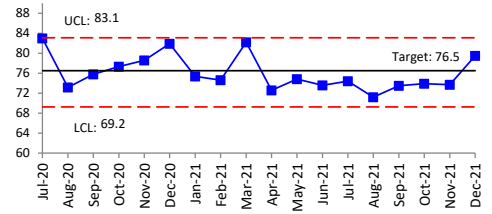
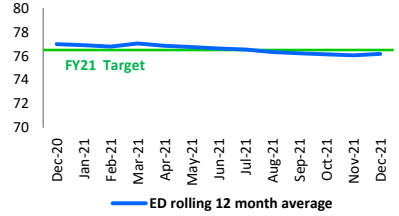
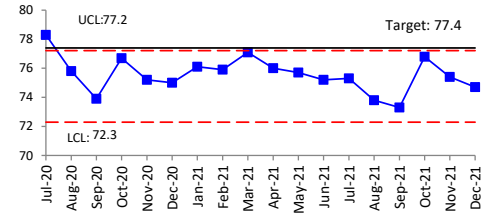
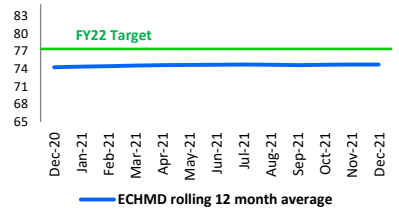
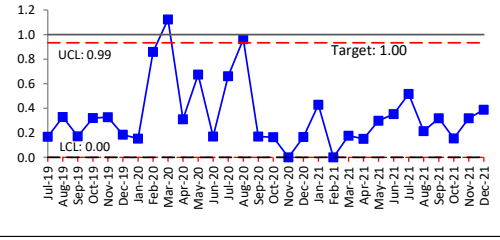
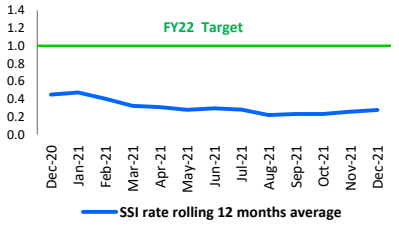
Measure Name	Comments	Definition Owner	Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)	The number of readmissions dropped from 235 in October to 212 in November. The most frequent were due to Heart Failure @ 16, Sepsis @ 15, Alcoholic Cirrhosis @ 7, and pre-eclampsia @ 4. The Heart Failure Quality Team will begin additional post-discharge phone calls, 4 in addition to the first one after 48 hours, in February to discover issues with heart failure patients that are causing readmissions.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). Includes Inpatient Units *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)	For Nov there were 6 SSE: 1- SSI, 3 - HAPI, 1 - ROF (broken needle), 1- Delay in treatment	Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI Systems**
3. Actual # of Medication Precursor Safety Events per month	A total of 20 precursor medication safety events were identified for November 2021. These errors had reached patients but did not cause harm. Top 3 trends include 1. Incorrect time (7) 2. Incorrect dose (6) and 3. Omitted medication(4). These errors resulted from staff not following physician orders and delayed or retiming of dose administration. A total of 20 precursor medication safety events were identified for November 2021. These errors had reached patients but did not cause harm. Top 3 trends include 1. Incorrect time (7) 2. Incorrect dose (6) and 3. Omitted medication(4). These errors resulted from staff not following physician orders and delayed or retiming of dose administration.	Deep Mattapally	All medication events classified as precursor safety events by Safety Event Classification Team EPSI report used for Patient days and # of events provided by Deep M. *Target data received from Sheetal on 8/12/21 via email - 5% reduction from baseline*	iSafe Reports / EPSI Report / Safety Event Classification
4. Mortality Index (Observed/Expected)	45 deaths in December, of which 16 (35%) were due to Sepsis, 5 were due to strokes, and 4 due to malignancies.	Catherine Carson	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	Premier Quality Advisor

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2021 (unless otherwise specified)

Month to Board Quality Committee:
February, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: December 2021*	80.0	87.0	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: December 2021*	79.5	74.5	76.1 (2347)	76.5		
7	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Adjusted** *Latest data month: December 2021*	74.7	74.8	76.0 (n=15,330)	77.4		
8	**Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: December 2021*	0.39 (1/258)	0.31 (10/3210)	0.30 (21/7016)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

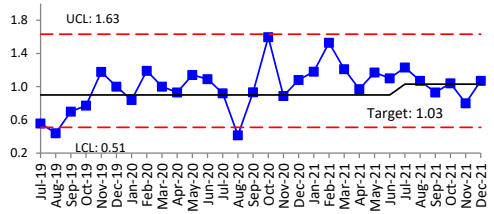
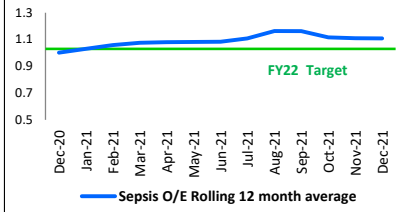
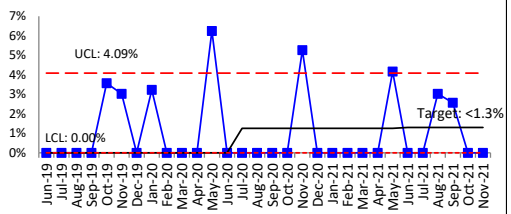
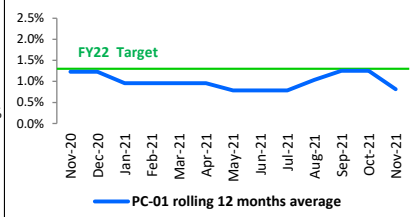
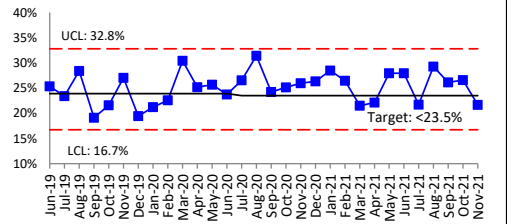
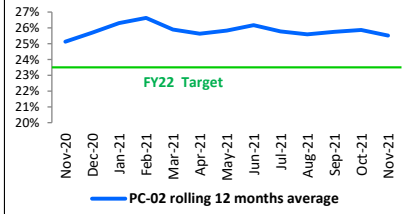
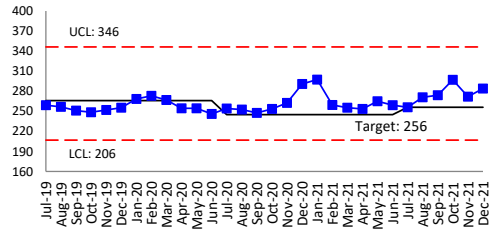
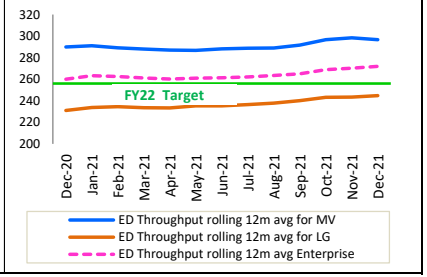
Measure Name	Comments	Definition Owner	Definition	Source
5. Inpatient Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted	Inpatient units continue to be strong despite the dip in Mountain View due to Omicron affecting our staffing in many areas. We continue to focus on our efforts and improvements in our "Power of 3" best practices; i.e. nurse leader rounding, bedside shirt report and purposeful (hourly) rounding despite these challenges. In addition, we are conducting post discharge phone calls on this group and are following up with all patients that have a question, issue or negative experience.	Christine Cunningham	IP Units only, Excludes MCU. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Adjusted' *New FY22 Target received from Christine 10/18/2. Criteria changed to Adjusted score for Board reports/ external reports* *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey**
6. ED - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.'%, Adjusted	Although the ED continues to struggle with increased volumes, staffing and increased demand for testing, we still outperform California and National top box scores and we were in the 88th percentile for the month of December! We continue to focus on patient flow, intercampus transfers, early discharge and patient communication.	Christine Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' *New FY22 Target received from Christine 10/18/2. Criteria changed to Adjusted score for Board reports/ external reports* *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey**
7. ECH MD/ ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted	Our clinics struggled this month with increased volume and decreased staffing. We continue to work on developing plans to address these issues.	Christine Cunningham	ECHMD – does not have HCAHPS – we use only one data point that is NPS (net promotor score), which is a likelihood to recommend care provider (SVMD only). Switching Vendor NRC to PressGaney in January 2022. Data run criteria, 'Top Box, Received Date, and Adjusted' *New FY22 Target received from Christine 10/18/2. Criteria changed to Adjusted score for Board reports/ external reports* *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**NRC**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	1) 49 y/o female admitted for rt. Total hip arthroplasty using minimal invasive anterior approach. Pt w/chronic pain, morbid obesity. Readmitted after 11 days w/rt hip infection requiring 2 surgical procedures, I&D and then total revision of hip arthroplasty.	Catherine Carson/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable. FY22 Target, Ent = same as last year =< 1.0 (SIR) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average . Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

December 2021 (unless otherwise specified)

Month to Board Quality Committee:
February, 2022

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: December 2021*	1.07 (15.28%/14.29%)	1.03 (11.10%/10.83%)	1.08 (12.86%/11.87%)	1.03		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: November 2021*	MV: 0.0% (0/17) LG: 0.0% (0/7) ENT: 0.0% (0/24)	MV: 0.7% (1/135) LG: 2.9% (1/35) ENT: 1.2% (2/170)	MV: 0.41% (1/244) LG: 1.32% (1/76) ENT: 0.63% (2/320)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: November 2021*	MV: 23.5% (40/170) LG: 12.1% (4/33) ENT: 21.7% (44/203)	MV: 26.3% 209/795) LG: 19.9% (36/181) ENT: 25.1% (245/976)	MV: 27.58% (422/1530) LG: 20.69% (72/348) ENT: 26.30% (494/1878)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psych patients, patients expired in the ED, Newborns, and transfer between sites)* *Latest data month: December 2021*	MV: 307 min LG: 261 min Ent: 284 min	MV: 302 min LG: 247 min Ent: 275 min	MV: 288 min LG: 239 min Ent: 264 min	MV: 263 min LG: 227 min Ent: 256 min		

** Readmission, SSE, MPSE, PC-01 and PC-02 data are available up to November only

Report updated: 1/26/22

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Definition	Source
9. Sepsis Mortality Index, based on ICD-10 codes *(Observed over Expected)*	The incidence of sepsis increases in the winter months, and with the COVID surge, the sepsis mortality is up to the same as it was in December 2020. The expected of 14.29% is high reflecting the severity of these sepsis cases.	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	Zero early elective deliveries across the Enterprise in November.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed FY22 Target, Ent. = 1.3% (same as FY21) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Fewer C/Sections on both campuses in December.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation FY22 Target, Ent. = 23.5% (same as FY21) *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput-Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns, excludes transfer between sites	The Patient Throughput Value Stream for FY22 continues to focus on stabilizing the Capacity Management Center (CMC) and improving the discharge process. A multidisciplinary discharge process pilot with Team Health will be implemented February 2022. Epic tools for creating efficiency in the care coordination discharge process are in the final phase of optimization and will be moved to sandbox for testing and validation by end of January. The Predictive Model tool is on-track to go live for end users by January 31, 2022. The Nursing Assignment Wizard will be a part of the next Epic update scheduled for March 2022.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, newborns and transfer between sites FY22 Target, Ent. = 256 mins (same as FY21) Arrival: Patient Arrived in ED ED Departure: Departed ED *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

El Camino Health

Month to Quality Committee of the Board: February 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FY22 end of December (unless otherwise specified)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 21	FY 22	FY22, Q1	FY22, Q2	FY22, Q3	FY22, Q4	FYTD22 Total
Safe Care	Serious Safety Events Rate (Rolling 12 month)	3.13	2.97	2.44	2.46			2.62
	Surgical Site Infections (SSI)	0.30	1.0 (SIR)	0.36	0.29			0.31
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.37	<= 0.75	1.32	0.79			1.07
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.53	<= 0.50	0.35	0.00			0.18
	Modified PSI-90 CMS HAC Reduction Program (composite)	0.919	0.90	0.846	0.873			0.807
Timely	HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes	100%	100%	100% (13/13)	NA (available only up to Q1)			100%
	Patient Throughput - Median Time Arrival to ED Departure	264 min	256 min	267 min	284 min			275 min
	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	57.5% (14/23)	50%	25% (1/4)	10% (1/10)			14.3%
	Stroke: Door-to-Groin <= 75 minutes	16.7% (3/18)	50%	50% (1/2)	14.3% (1/7)			22.2%
	Stroke: Door-to-Groin <= 90 minutes	50% (9/18)	NA	50% (1/2)	28.6% (2/7)			33.3%
Effective	Risk Adjusted Readmissions Index	0.93	0.92	1.07	*0.96			1.01
	Risk Adjusted Mortality Index	0.86	0.90	0.99	0.87			0.92
	Sepsis Mortality Index	1.08	1.03	1.06	0.97			1.03
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.63%	1.3%	1.8%	*0%			1.2%
	PC-02 NTSV C-Section	ENT: 26.3%	23.5%	25.8%	*24.1%			25.1%
	ECHMN: CMS 165 Controlling High Blood Pressure	59.0%	>= 59%	60.0%	59.0%			59.0%
	ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	30.0%	<= 30	24.0%	26.0%			25.0%
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.29	1.30	1.35	1.33			1.34
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 19)	<=1	0.99	1.0 (CA: 1.0, NA: 0.99)			0.99
Equitable	Hospital Charity Care Support	$19.7 mil	NA	7.2 mil	11.5k			18.7 mil
	Clinic Charity Care Support	$14.9k	NA	7.5k	3.0k			10.5k
	Language Line Unmet Requests	0.72%	<1%	0.62%	0.36%			0.50%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.0	NA	4.3	4.03			4.15
		White: 3.89		3.77	3.88			3.83
		Asian: 3.57		3.59	3.67			3.63
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.6	79.7	82.0	80.2			81.2
	ED - Likelihood to Recommend (PG)	76.1	76.5	73.1	75.7			74.5
	ECHMN - Likelihood to Recommend Care Provider (NPS)	76.0	77.4	74.1	75.6			74.8
	MCH - HCAHPS Likelihood to Recommend	81.8	82.0	79.4	80.5			80.2
	OAS - HCAHPS Likelihood to Recommend	85.7	86.1	85.5	87.6			86.5

Report updated 1/25/2022

*data available up to November only

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

El Camino Hospital Data Registries - February 2022 Attachment F

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	CathPCI Registry®	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90' . Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all	HVI	Quarterly
2	Chest Pain-MI Registry®–(old ACTION)	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI/ACS process performance: Overall AMI performance composite; STEMI performance composite; NSTEMI performance composite	HVI	Quarterly
3	STS/ACC TVT RegistryTM	STS (Society of Thoracic Surgeons) ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)–Median Post Procedure (days) and outcome (TAVR & MitraClip): In Hospital, 30 day observed and 3-year risk adjusted mortality. Risk adjusted Stroke rate	HVI	Quarterly
4	LAAO RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per CMS indications; Proportion of LAAO procedures successful and medication stredegy and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
5	AFib Ablation RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures.	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
76	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for isoCABG, isoAVR and MV procedures. Composite quality rating (star rating) for isoCABG, isoAVR and MV procedures	HVI	Quarterly
7	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly
8	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDIF; MRSA; CRE; VRE Device Associated Surveliace: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP	Quality; Nursing EW&HS	monthly Yearly
9	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
10	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
11	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality indicators	Quality; Neuro	quarterly
12	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
13	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
14	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
15	California Maternity Quality Care Collaborative (CMQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
16	California Perinatal Quality Care Collaborative (CPQCC)	Hospital Collaborative	Neonatal Outcomes	Outcomes	Neonatal	Monthly

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
17	California Alliance for Nursing Outcomes	CALNOC	Actionable information and reearch on nursing sensitive quality indicators	Nursing indicators	Nursing	Quarterly
18	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit leel	Nursing indicators	Nursing	Quarterly
19	American Joint Replacement Registry	American Association of Orthopedic Surgeons	Hip and Knee Replacement Case Profile data, Risk Assessment data, and Outcomes data	Case data including implants, comorbidities, hospital complications. Patient reported outcomes Survey data fro HOOS JR, KOOS JR, and PROMIS-10	Ortho Director	Rolling submission with PRO data drawn quarterly
20	The Joint Commission - Disease-Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years
21	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	Outcome (part of STS) risk adjusted mortality and stroke rate. Comparison with all other CA hospitals	HVI	biannually
22	Santa Clara County-AMI and Cardiac Arrest	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome. Biannually County meeting	HVI	Quarterly
23	National Cancer Data Base/RCRS	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Registry	Monthly and Annually
24	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Registry	Monthly
25	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
26	Hospital Based Inpatient Psychiatrics Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
27	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
28	Parkinsons Registry	California Department of Public Health	CPDR captures and stores informatin on all Parkinson's disease cases dagnosed or receiving treatment in California. The informaton is used to expand the understanding of Parkinson's disease to ultmately imporove thel lives of those affected.	The prohect is not a study, the enhanced data and informaiton available to better prevent, diagnose and treat Parkinson's disease.	IT Business Applications	Every month
29	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly
30	ICAEl certification	Intersocietal Accreditation Commission	Adult Echocardiography facility standard and guidelines	Ongoing practice requirements: volume, experience, staff educations	HVI?	yearly

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
31	VQI (Vascular Quality Initiative)	VQI (Vascular Quality Initiative) is a collaboration of the Society of Vascular Surgery	Demographic, clinical, procedural and outcomes data for Carotid Endaarterectomy, Endovascular AAA repair and Peripheral Vascular Intervention procedures	Quality and outcome benchmarks including risk adjusted mortality with follow-up	HVI	Biannually
32	Transcatheter Valve Center Certification	American College of Cardiology	Provides external review that assists hospitals in meeting standards for multidisciplinary teams, formalized training, and shared decision-making with a focus on TVT Registry metrics and outcomes.	Process and Quality: In-Hospital, 30 day, and 1 year mortality and/or readmission, stroke rate, and bi-monthly M&M	HVI	Weekly, Quarterly, and Annual submissions
33	American Heart Association (AHA) Resuscitation Registry	Get with the Guidelines (GWTG)	GWTG-Resuscitation facilitates the efficient capture, analysis and reporting of data that empowers and supports the implementation of current guidelines, creation and dissemination of new knowledge, and development of next generation, evidence-based practice in resuscitation science.	Resuscitation Services Quality Indicators	Quality	Quarterly

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2022 REPORTING PERIOD ATTACHMENT G

Indicator Name	Indicator Description	Regulatory/Accreditation source
Chart-Abstracted Clinical Core Measures **Hospital Inpatient and Outpatient:** * Measures Required to Meet Hospital IQR Program APU Requirements		
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital Outpatient Quality Reporting (OQR) Program
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke	
PCB-05	Exclusive Breast Milk Feeding	TJC ORYX Performance Measurement Program
PCB-06.0	Unexpected Complications in Term Newborns - Overall Rate	
PCB-06.1	Unexpected Complications in Term Newborns - Severe Rate	
PCB-06.2	Unexpected Complications in Term Newborns - Moderate Rate	
PCM-02a	Cesarean Birth	
PCM-01 *	Elective Delivery	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
SEP-1*	Early Management Bundle	Hospital Inpatient Quality Reporting (IQR) Program
SEP-3T	Sepsis Treatment 3-Hour Window	
SEP-6T	Sepsis Treatment 6-Hour Window	
SHK-3T	Septic Shock Treatment 3-Hour Window	
SHK-6T	Septic Shock Treatment 6-Hour Window	
HBIPS – Hospital-based Inpatient Psychiatric Services		
IMM-2	Influenza Immunization	TJC ORYX Performance Measurement Program
HBIPS-2	Physical Restraint	
HBIPS-3	Seclusion	
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate	
SUB-2	Alcohol Use Brief Intervention Provided or Offered	
SUB-2a	Alcohol Use Brief Intervention	
SUB-3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	
SUB-3a	Alcohol and Other Drug Use Disorder Treatment	
TOB-2	Tobacco Use Treatment Provided or Offered	
TOB-2a	Tobacco Use Treatment	
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	
TOB-3a	Tobacco Use Treatment at Discharge	

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2022 REPORTING PERIOD ATTACHMENT G

2022 Electronic Clinical Quality Measures (eCQM): Requirement includes three self-selected eCQMs and the Safe Use of Opioids measure for three self-selected quarters. Name and description:	**Regulatory/Accreditation source**
eVTE-1 Venous Thromboembolism Prophylaxis	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis	
eSTK-2 Discharged on Antithrombotic Therapy	
eSTK-3 Anticoagulation Therapy	
eSTK-5 Antithrombotic Therapy by the End of Hospital Day Two	
eSTK-6 Discharged on Statin Medication	
ePC-05 Exclusive Breast Milk Feeding	
eED-2 Admit Decision Time to ED Departure-Admit	
eOPI-1 Safe Use of Opioids	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: June 6, 2022
Subject: FY23 Organizational Goals

Recommendation:

To approve Fiscal Year 2023 Organizational Goals for the enterprise Quality, Service and People pillars.

Summary: El Camino Health and the Quality, Patient Care and Patient Experience Committee of the Board tracks greater than 200 performance measures to ensure we provide high quality and safe care to our patients. Each year, the leadership team identifies areas where there are notable opportunities for focused improvement. The measures used to monitor our performance in these opportunity areas are selected to be "Organizational Goals" for the enterprise. Whilst the organizational goal measures receive focused attention, the enterprise continues to track and manage to excellent performance for every one of the > 200 measures. We will continue to do so in FY23.

1. Situation: The quality organizational goal, "The Hospital Acquired Condition Index" was discussed at the April 2022 and May 2022 Quality Board Committee Meetings. For the June 2022 meeting I will additionally share the FY23 targets for the Service and People pillars with the goal of having the committee members review, discuss and approve the proposed FY23 organizational goals in these 3 domains.

2. Authority: This is an area of concern for the governing board as the performance in these areas directly affects the quality and safety of the care delivered to El Camino Health patients**.**

3. Background: The proposed strategic goals for FY23 are intended to align focus across the entire enterprise on performance areas, which affect the experience, quality and safety of our patients. The methodology for measuring the performance areas has been defined and will be reviewed at this committee meeting. The actual numerical targets will be determined once the final data is available for FY22 that will not be complete until October of FY23.

4. Assessment: The following four strategic goals have been selected for adoption in FY23.

   A. Quality and Safety Pillar—**Hospital Acquired Condition Index.** This index is a new measure. The rationale for adopting this index is twofold. First, there is an increase in occurrences of patient harm events such as clostridium difficile infection and patient falls in FY22. Second, having a quality and safety goal focused on the aim of zero harm aligns with our enterprise deployment of High Reliability behaviors and culture. The HAC Index includes; C. difficile infection, Surgical Site Infections (SSI), non-ventilator hospital acquired pneumonia (nvHAP), hospital acquired pressure injuries (HAPI) and patient falls.

   B. Service Pillar-**Likelihood to Recommend (LTR).** The survey results received from patients who have received care at El Camino Health will be used to measure our

service performance for both the inpatient and ambulatory settings. These are different surveys, both from Press Ganey, designed to appropriately assess the experience of patients in the outpatient setting when seeing an El Camino Health Medical Network provider, and, in the inpatient setting.

i. Likelihood to Recommend Impatient, Press Ganey Survey Top Box

ii. Likelihood to Recommend El Camino Health Medical Network, Press Ganey Survey Top Box.

C. People Pillar-**Culture of Safety Survey Results**. The culture of safety survey is administered by Press Ganey. A subset of questions related to safety is compiled into a culture of safety index based on three themes; **prevention and reporting**, **resources and teamwork, pride and reputation**. For example, the questions in the prevention and reporting theme domain are;

i. I can report patient safety mistakes without fear of punishment.

ii. Providers will freely speak up if they see something that may negatively affect patient care.

iii. Mistakes have led to positive change here.

iv. When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person.

v. Where I work, providers and management work together to ensure the safest possible working conditions.

vi. I feel free to raise workplace safety concerns.

vii. In my department, we discuss ways to prevent errors from happening again.

viii. We are actively doing things to improve patient safety.

5. Other Reviews: None

6. Outcomes: The Quality Committee will recommend to the board that these four organizational goals are adopted for FY23.

List of Attachments: None