El Camino Health

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

Monday, June 5, 2023 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 925 5802 1997#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Health (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**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	*public comment*	**possible motion 5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 5:33 – 5:34**
4.	**PUBLIC COMMUNICATION**	Carol Somersille, MD Quality Committee Chair		**information 5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 5:37 – 5:52**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (05/01/2023) ***Information*** b. Report on Board Actions c. Progress against FY2023 Committee Goals d. FY23 Enterprise Quality Dashboard e. Leapfrog f. QC Follow-Up Items g. Quality Committee Survey Results			
6.	**CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair		**information 5:52 – 5:57**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:57 – 6:07**
8.	**HEALTH CARE EQUITY**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:07 – 6:27**

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 (QAPI)**	Holly Beeman, MD, MBA, Chief Quality Officer	*public comment*	**motion required 6:27 – 6:42**
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:42 – 6:43**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 6:43 – 6:44**
12.	**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 (05/01/2023) ***Information*** *Health and Safety Code Section 32155* b. Quality Council Minutes (05/03/2023)	Carol Somersille, MD Quality Committee Chair		**motion required 6:44 – 6:49**
13.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:49 – 6:59**
14.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Holly Beeman, MD, MBA, Chief Quality Officer		**discussion 6:59 – 7:04**
15.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:04 - 7:05**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		**information 7:05 – 7:06**
17.	**ROUNDTABLE**	Carol Somersille, MD Quality Committee Chair		**discussion 7:06 – 7:09**
18.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:09 – 7:10 pm**

Next Meeting: August 7, 2023, September 5, 2023, November 6, 2023, December 4, 2023, February 5, 2024, March 4, 2024, May 6, 2024, June 3, 2024

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, May 1, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Pancho Chang
Philip Ho, MD
Jack Po, MD
Krutica Sharma, MD
Melora Simon
John Zoglin

Members Absent
Prithvi Legha, MD

Others Present
Holly Beeman, MD, MBA, CQO
Dan Woods, CEO**
Mark Adams, MD, CMO
Meenesh Bhimani, MD, COO
Deb Muro, CIO**
Cheryl Reinking, DPN, RN, CNO
Shahab Dadjou, President, ECHMN
Shreyas Mallur, MD, ACMO
Ute Burness, RN, VP of Quality and Payer Relations
Lyn Garrett, Senior Director, Quality**
Daniel Shih, MD**
Tracy Fowler, Director, Governance Services
Nicole Hartley, Executive Assistant II

**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at 5:32 pm by Chair Carol Somersille. A verbal roll call was taken. Dr. Sharma joined at 5:33 pm and Ms. Simon joined at 5:35 pm. Dr. Legha was absent. All other members were present at roll call and participated in-person. A quorum was present.	
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Ms. Hartley shared that we have no members of the Committee participating remotely due to Just Cause.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Mr. Zoglin pulled items 5b – FY24 Committee Goal and 5e – FY23 Enterprise Quality Dashboard. Chair Somersille requested to pull item 5h – QC Follow-Up items. Mr. Zoglin asked about the FY24 Committee Goals that refer to actions in FY23 and if these are placeholders until we identify the numbers more. Ms. Fowler confirmed these are placeholders. Chair Somersille addressed the QC Follow-Up items, asking about the Health Equity follow-up item and if in the future, Quality Council minutes can include details when Health Equity is discussed. Dr. Adams shared that Quality Council is a management committee and we cannot present requests to them. Ms. Fowler shared that the staff present can speak to any questions the Committee has regarding the Quality Council meeting minutes when questions arise. The Committee discussed the Quality Council process and leadership encouraged Committee members to attend a Quality Council meeting. Mr. Zoglin addressed the FY23 Enterprise Quality Dashboard and asked about the Readmissions Index. He asked if we know what is affecting the changes/improvements with the Readmission Index. Before responding to the question, Dr. Beeman shared that this would be discussed during agenda item 7 (Review of the STEEEP Dashboard). For process going forward, would the committee prefer a single memo describing measures which appear in either or both of the dashboards; the monthly Enterprise dashboard, and the quarterly STEEEP dashboard. Currently there are two memos covering the same content. The committee supports this suggestion. Going forward, when both STEEEP and Enterprise are paced to be reviewed at the committee, the Chief Quality Officer will compose one memo encompassing the contents of both dashboards. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (04/03/2023), (b) FY24 Committee Goals; For information: (c) Report on Board Actions, (d) FY23 Pacing Plan, (e) FY23 Enterprise Quality Dashboard, (f) CDI Dashboard, (g) Core Measures, (h) QC Follow-Up Items **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Consent Calendar Approved***

6. PATIENT STORY	Cheryl Reinking, CNO presented the Daisy Award winners over the past year in honor of nurses' week. Cheryl reviewed what the daisy award is in the memo and shared that it occurs on a monthly basis. Each month they receive between 40-50 nominations to review and select one winner. This is a highly coveted award and a special ceremony is completed each month on the unit where the Daisy Award is presented by the CNO.	
7. Q3 FY23 STEEEP DASHBOARD REVIEW	Dr. Holly Beeman, CQO presented the Q3 FY23 STEEEP Dashboard and highlighted the following: **Readmissions:** 4 areas of focus are one-day length of stay, vulnerable population, high utilizers, and patients with sepsis. The improvement in decreasing readmissions is a result of progress in each of these areas. A theme that affected all readmissions work was a complete disruption of home health and skilled nursing facilities from the pandemic. We are collaborating with skilled nursing facilities to focus on specific interventions and address opportunities with them. Our sepsis coordinator went to every skilled nursing facility and created an educational tool kit for them. This process has helped build relationships and create an opportunity to identify gaps early on. One day length of stay has been reduced by 30%. There is a correlation between care coordination coverage and the time the patient was admitted. Management has expanded coverage of social work in the ED to help with the 11:00 pm – 4:00 am window when patients are being admitted for 'social' not medical indications. Cheryl also shared that substance abuse patients are another factor in readmissions and highlighted our Bridge Program designed to provide care navigation to patients with substance abuse. Dr. Po asked about the mortality index and whether we are concerned that it is trending up. Dr. Beeman shared that the mortality index rise is related to our sepsis mortality index rising. Dr. Beeman confirmed this is a concern and this is being addressed. The committee discussed imaging turnaround time regarding the processes in place currently and potential options to help in the future.	
8. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Ute Burness, RN, VP of Quality and Payer Relations provided an overview to supplement the materials in the packet for the El Camino Health Medical Network Report and highlighted the following:	

	• Clinical Excellence Domain: FYTD 23 Performance and current status on the opportunities for better performance. • Quality Trends on diabetes management, colorectal cancer, medication reconciliation, breast cancer, blood pressure control, and annual flu vaccination • Mitigation plan for clinical excellence domain • Dependable, Convenient, and Experience Domain and the mitigation plan for the third next available (3NA) • Patient Experience FYTD23 and the processes in place to continue improvement The committee discussed the dependable, convenient, experience measures, and the forecasted future for the results. Mr. Dadjou shared current updates on the recruitment and hiring efforts.	
9. REVIEW & RECOMMEND FY24 ENTERPRISE ORGANIZATIONAL GOALS	Dr. Holly Beeman, CQO presented the FY24 Enterprise Organizational Goal and highlighted the following: • Last meeting the committee discussed having the HAC 2.0 index with C Diff, CAUTI, and CLABSI as the quality organizational goal for FY24 • Non-ventilator hospital acquired pneumonia (nvHAP) will stay as a goal again for FY24 • We do not have an update at this time regarding the Patient Experience goals. This will be provided once available. **Motion**: To recommend to the Board the FY24 Enterprise Organizational Goals **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***FY24 Enterprise Organizational Goals Approved***
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 7:00 pm. **Movant**: Chang **Second**: Po **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned to closed session at 7:00 pm***
11. AGENDA ITEM 17: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:28 pm. Agenda items 11-16 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (04/03/2023), the Quality Council Minutes	

	(04/05/2023), and the Credentialing and Privileges Report by unanimous vote by all committee members present.	
12. AGENDA ITEM 18: ROUNDTABLE	Tracy Fowler, Director of Governance Service shared with the committee the Quality Committee Assessment and where to locate it.	
13. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:33 pm **Movant**: Po **Second**: Simon **Ayes**: Somersille, Chang, Ho, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha **Recused**: None	***Adjourned at 7:33 pm***

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

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Nicole Hartley, Executive Assistant, II

Prepared by: Nicole Hartley, Executive Assistant, II
Reviewed by: Tracy Fowler, Director of Governance Services

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Tracy Fowler, Director Governance Services
Date: June 5, 2023
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 since the last Quality, Patient Care and Patient Experience Committee meeting.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	May 10, 2023	- Credentialing and Privileges Report - Policies, Plans and Scopes of Services: • Emergency Management – Pandemic Plan • MERP – Medication Error Reduction Plan • Scope of Service – Health Library & Resource Center • Scope of Service Spiritual Care
ECHD Board	May 16, 2023	- Response to Santa Clara County Civil Grand Jury Report "Know What's On Your Ballot" - Community Benefits Mid-Year Update - ECHD Board Officer Election Process
Compliance and Audit Committee	No meetings	- No approvals to report
Executive Compensation Committee	No meetings	- No approvals to report
Finance Committee	No meetings	- No approvals to report
Quality Committee	N/A	- N/A

El Camino Health

FY23 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences 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.

STAFF: **Holly Beeman, MD, MBA,** Chief Quality Officer (Executive Sponsor)

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY22 Achievement and Metrics for FY22 (Q1 FY23) - Review FY23 Incentive Goal recommendations for Quality, Safety and Patient Experience measures	Review management proposals; provide feedback and make recommendations to the Board
2. Review the milestones and outcome metrics of the ECH High Reliability implementation.	HRO Journey in process currently with classes underway April 2022 with plans for ongoing education throughout FY22 and FY23.	HRO: Serious Safety Event Rate and Culture of Safety Survey.
3. Reducing health care disparities is a quality priority for the enterprise	Biannual report to Quality Committee FY23	Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Review Quality, Patient Care and Patient Experience reports and dashboards	- Review reports per Pacing Plan timeline.	Explanation of measure methodology and benchmarks included with each report.
5. Review Board Quality STEEEP Dashboard and propose changes as appropriate	Quarterly	Review Dashboard and Recommend Changes to the Board
6. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Using closing wrap up time, review quarterly at the end of the meeting	- Attend 2/3 of all meetings in person - Actively participate in discussions at each meeting

Chair: Dr. Carol Somersille
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

El Camino Health

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

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: June 5, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through April 2023

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience measure performance through April 2023 (unless otherwise noted).

Summary:

1. Situation: The Fiscal Year 2023 Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics were selected based on a review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization. This memo and the attached dashboard provide the Committee with a snapshot of the FY 2023 metrics monthly with trends over time and compared to the actual results from FY2022 and the FY 2023 targets.

2. Assessment:

Quality Measures

a. **Hospital Acquired Condition Index** (lower is better). This metric is a composite of the weighted rates of 5 component measures:

FY22 Baseline					
Metric	Num.	Den.	Rate	Weight	Weighted Rate
C. Difficile Infection	37	patient days	xxx	0.10	0.355
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06
nvHospital Acquired Pneumonia	115	patient days	xxx	0.20	0.365
Falls	153	patient days	xxx	0.20	0.265
Hospital Acquired Pressure Injury	8	patient days	xxx	0.25	0.022
HAC Index				Sum »	1.066

During April, the index was 0.817, which is favorable to target of 0.986. Year to date the HAC Index is 0.954, favorable to the FY23 target of 0.986.

b. **C. Difficile Infection:** There was one hospital acquired C. Diff infection in April. The hospital wide focus on hand-hygiene combined with optimization of the standard procedure and education of our teams has made an impact. We continue to focus on environmental and hand hygiene. The one case of C. Diff in April was likely due to exposure to C. Diff from a team member who did not

comply with appropriate hand hygiene, or, suboptimal cleaning of the room in between patients. Consistent with being a highly reliable organization, we continue to focus our efforts on LEARNING from these events, and not BLAMING or shaming individuals or units where we still have opportunities. We are very encouraged by the progress and commitment to patient safety demonstrated by our teams.

c. **Surgical Site Infection:** No new surgical site infections in April.

d. **Non-ventilator Hospital Acquired Pneumonia (nvHAP)**—Fifteen patients developed nvHAP in April. This is the second highest (worst) month year to date. Compliance with elements shown to decrease nvHAP is poor. Examples of interventions which are not being followed consistently are;

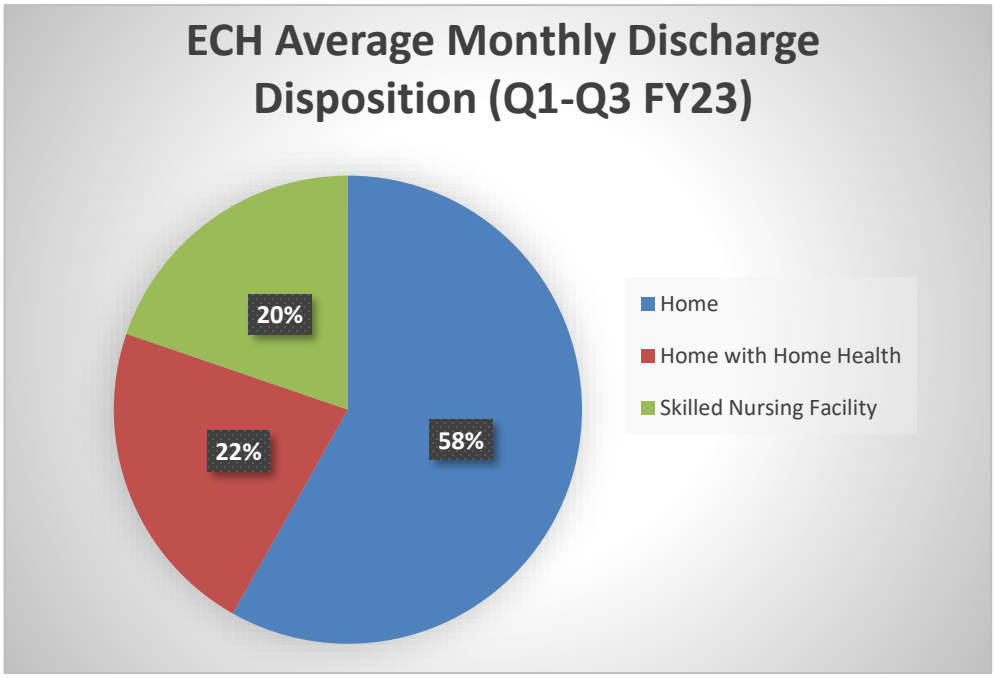
- Oral Care 3 x a day
- Raising head of bed so patients are not flat and at increased risk of aspiration
- Ambulation and mobility

Multidisciplinary teams including front line nurses, certified nurse assistants, and respiratory therapists are working closely together with nursing leadership, quality and process improvement teams to update the current standard protocol for nvHAP prevention. Because improvement is not yet demonstrated, the current (high) rate of nvHAP underscores why this hospital acquired infection needs to be an ongoing area of improvement focus for FY24

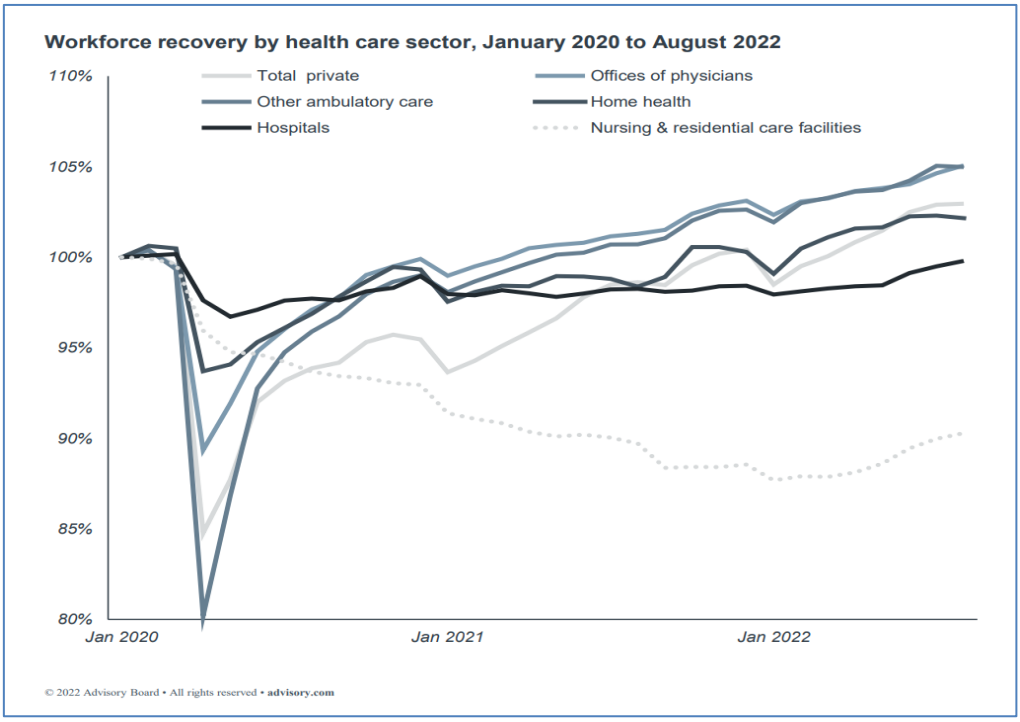
e. **Patient falls on inpatient units—**April performance is favorable to target again. Year to date, we have had 121 patient falls, favorable to our FY23 target of having ≤ 142 patient falls.

i. **Readmission Index.** March 2023 readmission index (0.99) is again favorable to target (1.00). Significant and sustained improvement has been achieved in avoiding unnecessary 'social' admissions by increasing social work staffing coverage in the ED. Optimized inter-facility care coordination between Skilled Nursing Facility (SNF) and ECH for sepsis patients has decreased readmission rates for patients with Sepsis. Areas of focus are:

1. Ensuring patients have a post discharge follow up appointment with their primary care provider (PCP) within 7 days of discharge. This is challenge due to inadequate availability of primary care providers/appointments. We are coordinating with SVMD operations leadership to implement better systems for 'unassigned' ECH patients to be scheduled with a SVMD PCP within 7-days of discharge.
2. Post-acute care-coordination and alignment with Skilled Nursing Facilities is critical to successful post-acute care for ECH patients to avoid preventable readmission. One in five patients is discharged to a SNF from ECH on any given month.

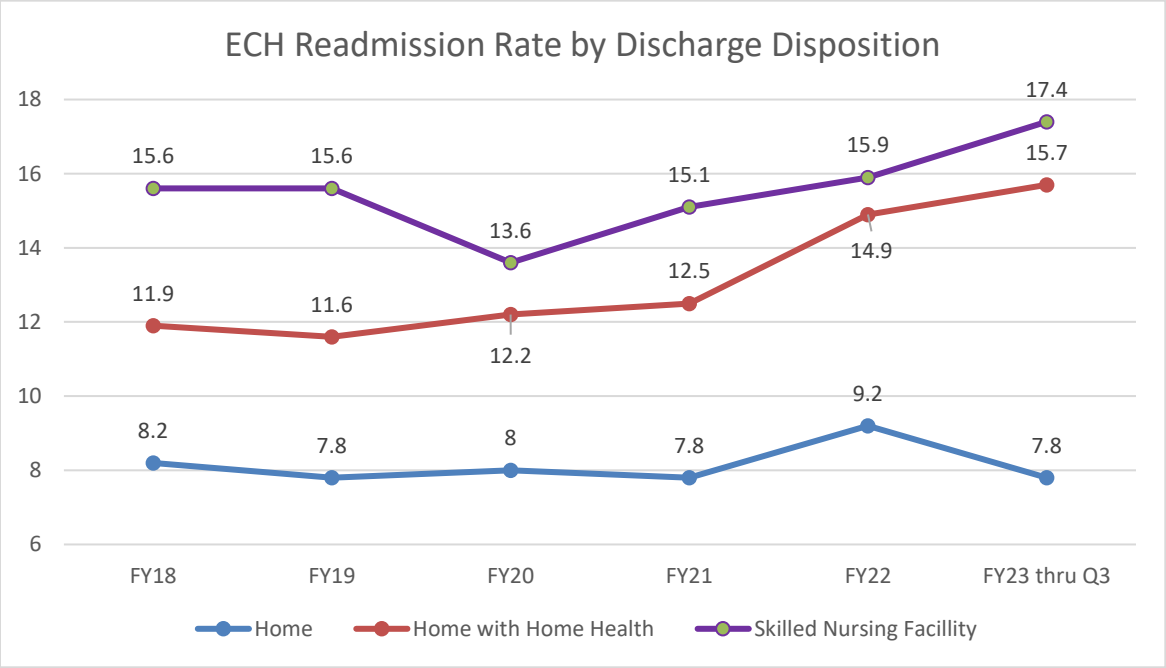


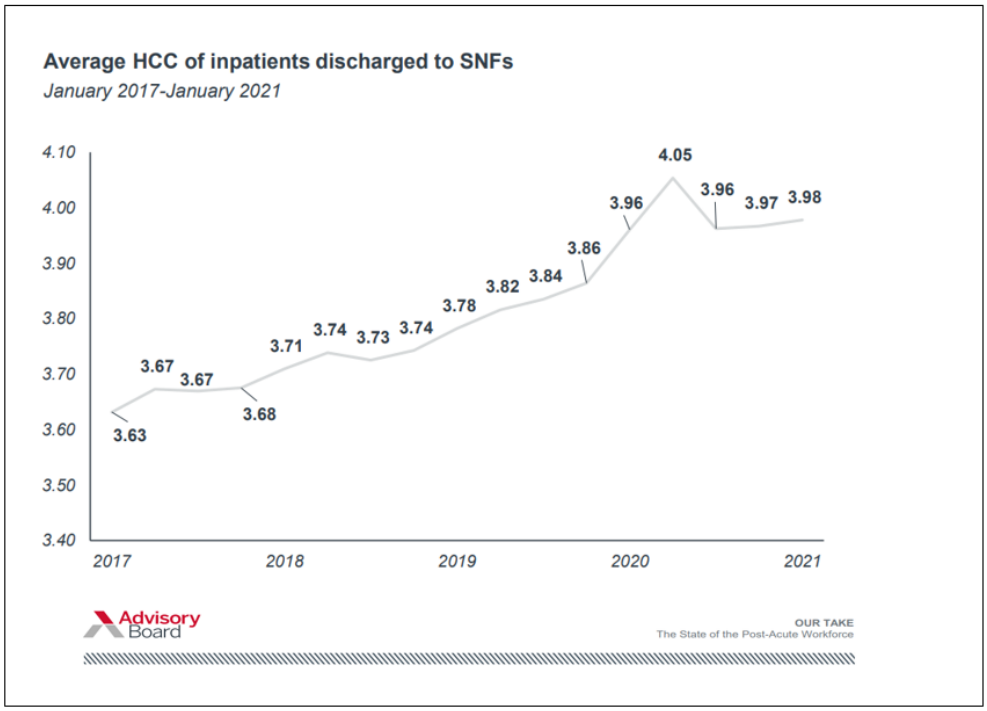
3. Skilled nursing facilities have been hardest hit of all health care employers due to the pandemic. “SNF Staffing shortages are so severe as to be existentially threatening. And, perhaps more troubling: these shortages are driven not only by the trauma of the pandemic, but by the many structural workforce challenges present before March of 2020.” (Advisory Board, 2022)



Source: “Delays In Transitions to Post-Acute Care”. Advisory Board Feb 2023

4. A review of our ECH data demonstrates our experience is consistent with that of the rest of the country, SNF readmission rates are at an all-time high. This is due to staffing exodus at all levels of licensure, and, the increased complexity of patients in skilled nursing facilities.





f. **All-Cause Mortality and Sepsis Mortality Index:** Both improved from prior month. Process improvement is focused on improving compliance with the sepsis bundle for patients in the ED, particularly for those patients who are 'boarding' in the ED waiting for a staffed bed in an appropriate inpatient care setting. There is great focus from ED and hospitalist teams on addressing consistent and appropriate care of our patients with sepsis.

g. **PC-O2: Cesarean Birth (NTSV--nulliparous, term, singleton, vertex):** No new data for this report.

h. **Emergency Department Turnaround Time for Pts Discharged from ED:** ED TAT-D (unfavorable): Emergency department turnaround time for discharged patient (ED TAT-D) is currently at a median of 197 minutes enterprise wide and increase from prior month of 171 minutes. Major drivers of the prolonged TAT are 1. Volumes 2. Insufficient inpatient staffed bed capacity and 3. Radiology turnaround times. We are anticipating a deterioration of ED TAT in August when Good Samaritan hospital will have closed its inpatient psychiatry unit. Many patients who previously were cared for at Good Samaritan mental health services will come to ECH ED. We are actively developing counter measures in anticipation of this surge on mental health patients. This is in addition to efforts to shorten length of stay, early discharges, and improved radiology TAT to improve throughput in the ED.

i. **Patient Experience Measures (Comments from Chief Experience Officer)**

   i. **Inpatient Likelihood to Recommend:** April performance (73.5% Top Box Rating) is at an all-time low for FY23. Inpatient units did not meet goal for April despite having very few low scores (goal is based on top box scores only). Environmental issues in Los Gatos (sharing of rooms, room temperature and food) continue to bring down our overall scores and extra focus will be on our LG Orto Unit. Nursing communication improved for April. We continue to emphasize being proactive (nurse leader rounding) and ensuring that bedside shift report is happening.

   ii. **Maternal Child Health Likelihood to Recommend:** April performance is 70.3% Top Box Rating for likelihood to recommend unfavorable to target of 81.5%. Mountain View MCH did not meet target due to high census, however, our Los Gatos campus achieved a top box score of 100! Improvements were seen in environmental categories such as noise, visitor and family accommodations. In addition, staff worked together a key driver, also increased. The team continues to focus on proactive rounding and service recovery due to constructions noise.

   iii. **ED Likelihood to Recommend:** April performance (74.7) is improved from prior month and just shy of FY23 target of 75.0. The overall ED target was not achieved for April but our very busy Mountain View campus did exceed target! We continue to have delays due to volume and the team is working tirelessly on systems and operation issues to

remedy the issues. A lot of work is being done to improve the efficiency of the lower acuity patients to ensure we decrease their wait times.

iv. **ECHMN Likelihood to Recommend Care Provider:** Performance in April (83.8) is favorable to FY23 target of 83.4. We exceeded our target for the third month in a row as we are starting to see our hard work pay off. Our Urgent Care Clinics also exceeded target for April, exceeding target 3 out of the last 4 months. We are seeing strong improvements in our access and appointment scheduling due to our template re-design and new online scheduling processes. We are working with our high volume, lower performing providers and clinics and have developed a coaching/training plan.

Attachments:

1. Enterprise Quality Safety and Experience Dashboard through April 2023

2. Optional Reading. Article of Interest—The State of the Post-Acute Workforce, Advisory Board May 2022

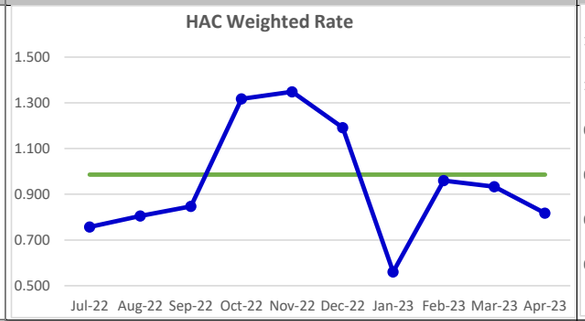
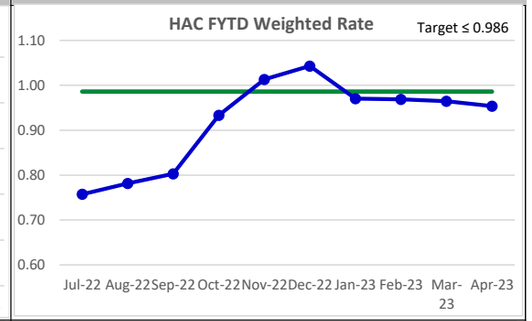
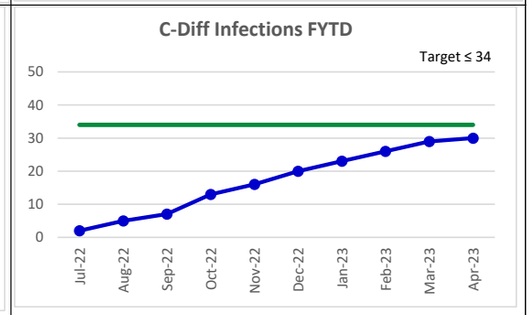
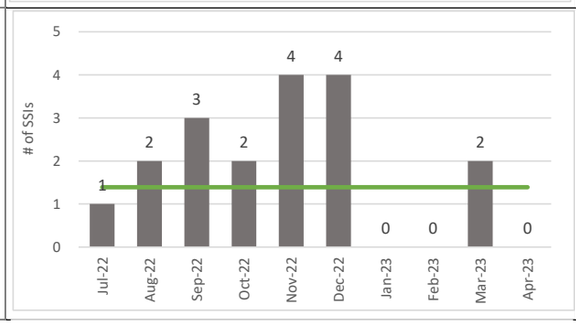
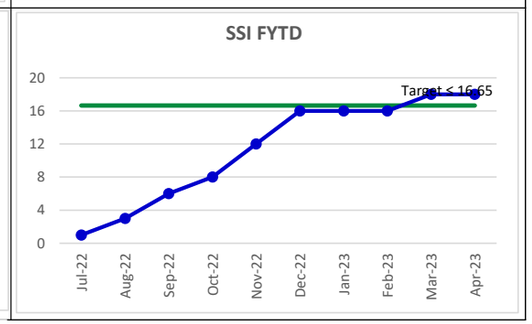
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

April 2023 (unless otherwise specified)

Month to Board Quality Committee:

June, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index** *Latest data month: Apr, 23*	0.817	0.954	1.066	0.986 (7.5% ↓)		
2	**HAC component** **Clostridium Difficile Infections (C-Diff)** *Latest data month: Apr, 23*	1	3.00 / month	3.08 / month	2.85 / month		
3	**HAC component** **Surgical Site Infections (SSI)** *Latest data month: Apr, 23*	0	1.80 / month	1.50 / month	1.39 / month		

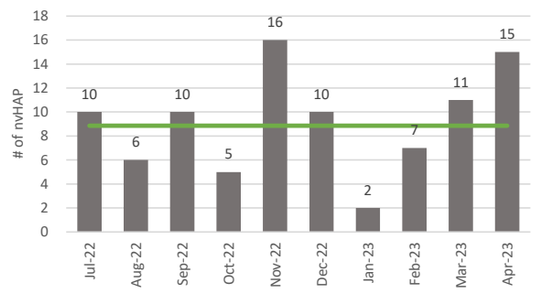
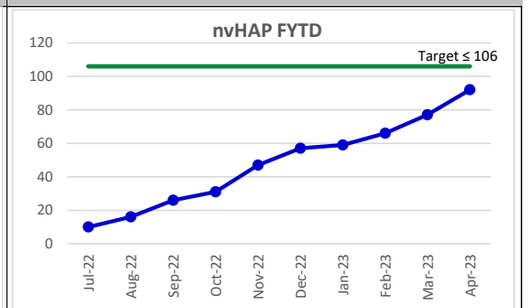
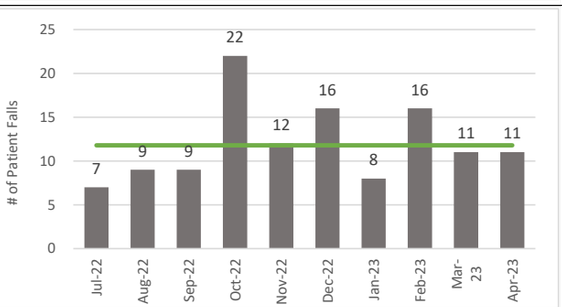
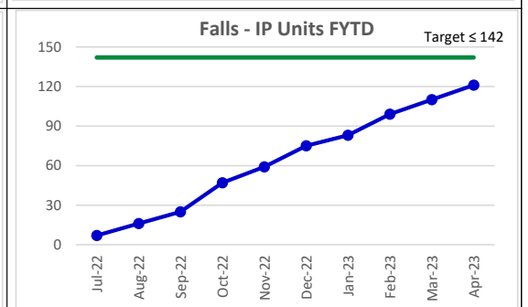
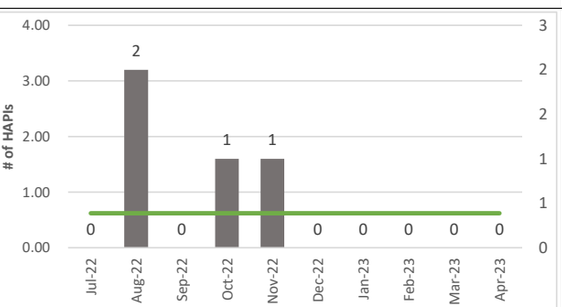
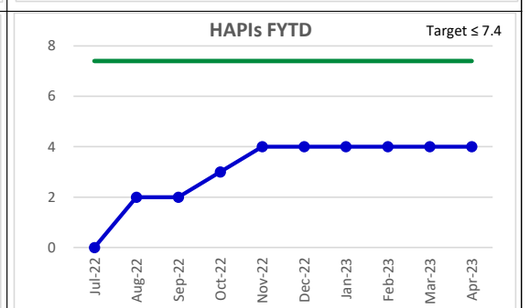
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

April 2023 (unless otherwise specified)

Month to Board Quality Committee:

June, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Apr, 23*	15	9.20 / month	9.58 / month	8.86 / month		
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Apr, 23*	11	12.10 / month	12.75 / month	11.79 / month		
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Apr, 23*	0	0.40 / month	0.67 / month	0.62 / month		

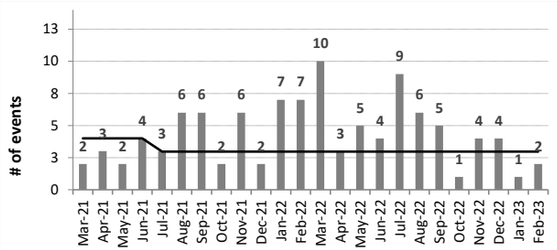
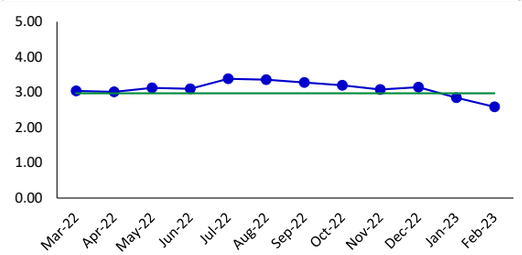
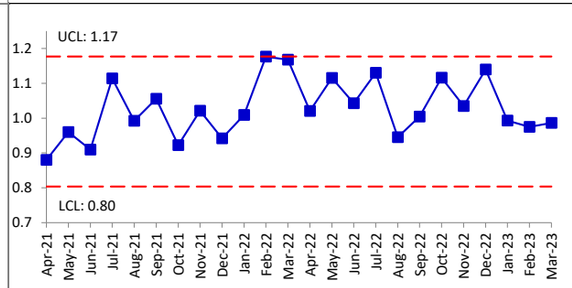
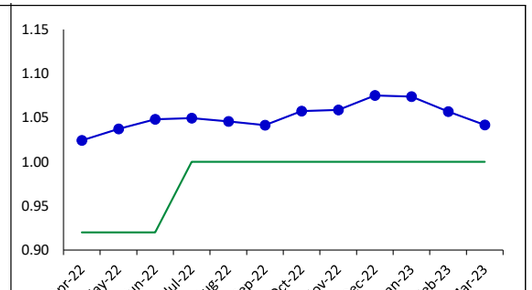
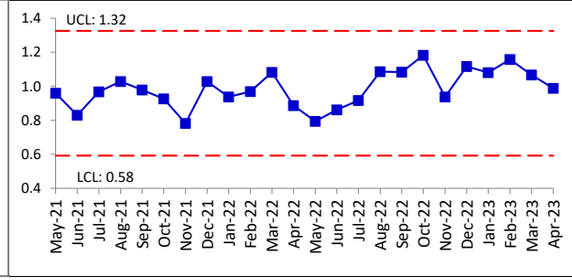
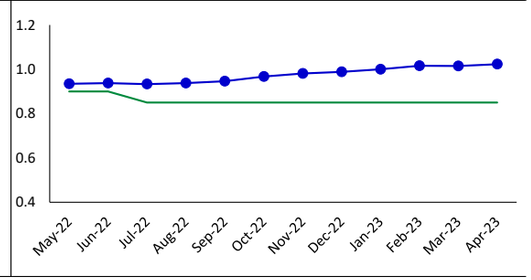
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

April 2023 (unless otherwise specified)

Month to Board Quality Committee:

June, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Serious Safety Event Rate (SSER)** **Latest data month: Feb, 23*	2	2.59 (54/208731)	3.10 (Jul, 21 - Jun, 22)	n/a		
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Mar, 23*	0.99 (9.12%/9.24%)	1.04 (9.19%/8.87%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Apr, 23*	0.99 (1.98%/2.01%)	1.07 (2.19%/2.05%)	0.94	0.85		

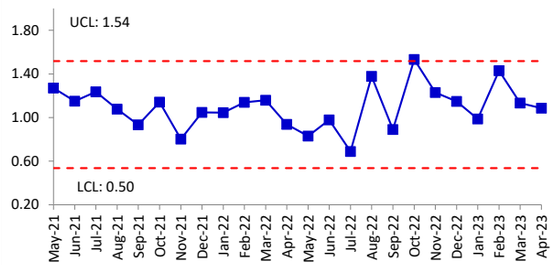
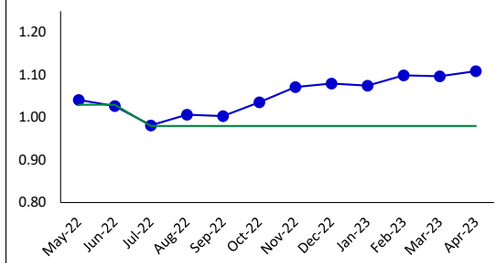
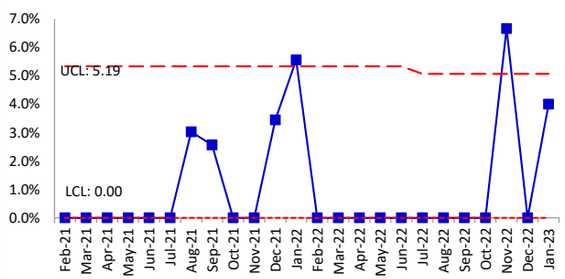
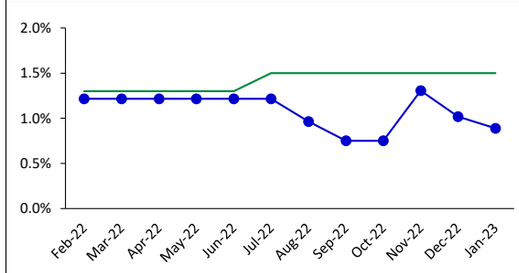
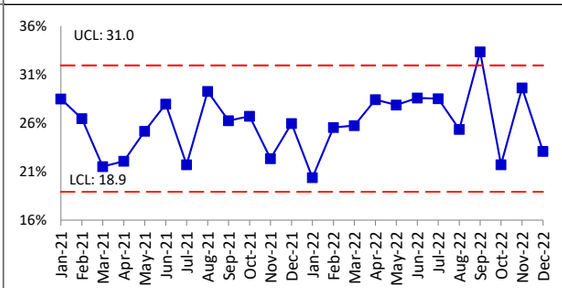
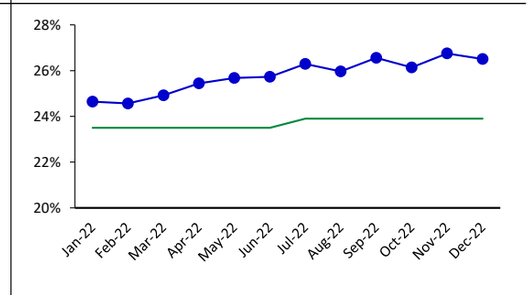
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

April 2023 (unless otherwise specified)

Month to Board Quality Committee:

June, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Apr, 23*	1.08 (13.73%/12.65%)	1.15 (14.07%/12.27%)	1.03	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Jan, 23*	MV: 5.6% (1/18) LG: 0.0% (0/7) ENT: 4.0% (1/25)	MV: 1.3% (2/155) LG: 0.0% (0/50) ENT: 1.0% (2/205)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	1.5% (FY23 Target)		
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Jan, 23*	MV: 25.8% (39/151) LG: 9.5% (2/21) ENT: 23.8% (41/172)	MV: 27.5% (305/1110) LG: 20.6% (41/199) ENT: 26.4% (346/1309)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	23.9% (FY23 Target)		

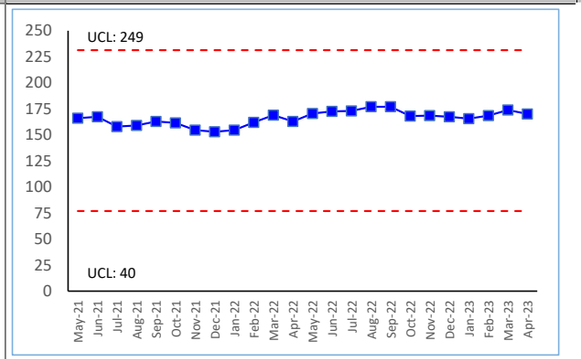
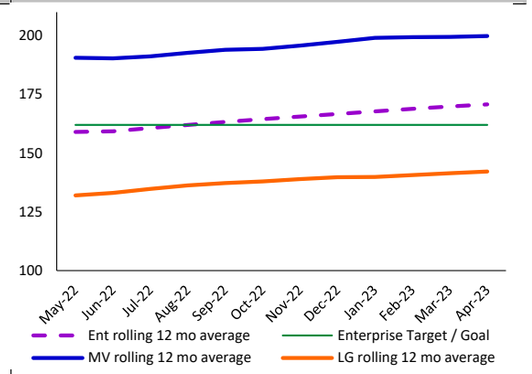
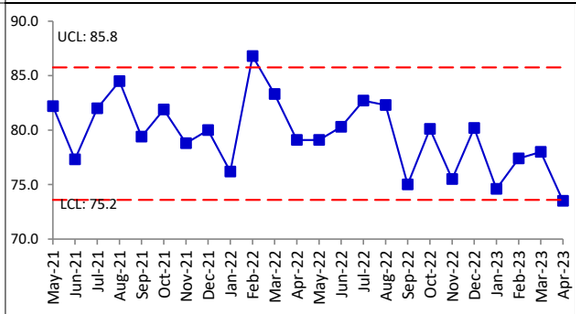
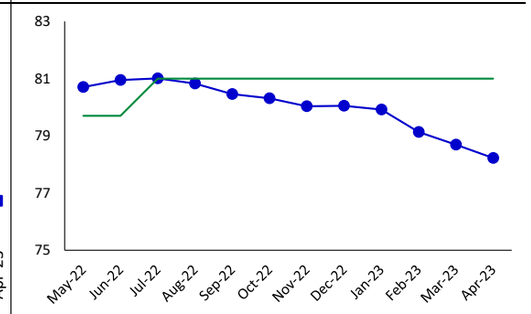
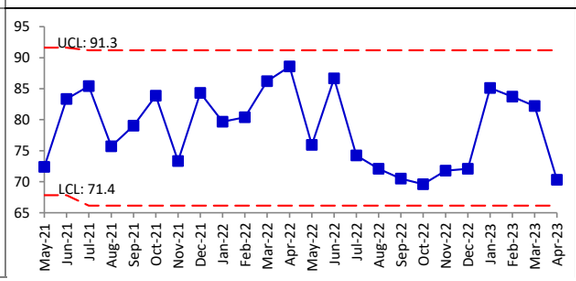
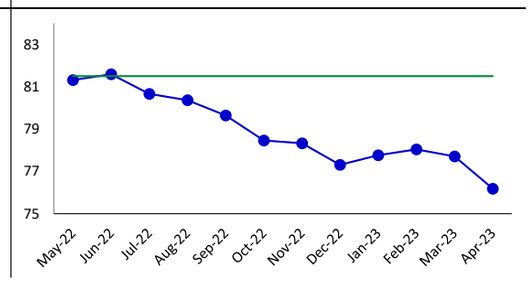
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

April 2023 (unless otherwise specified)

Month to Board Quality Committee:

June, 2023

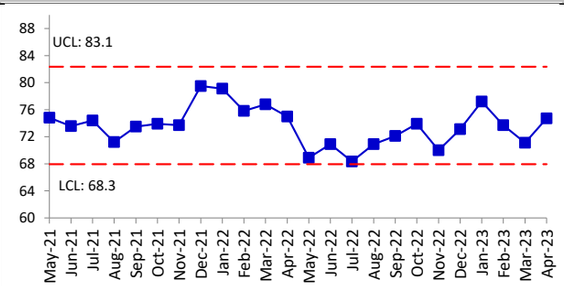
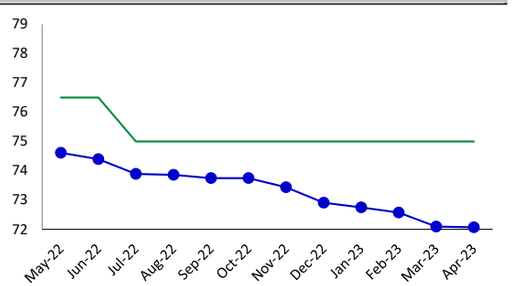
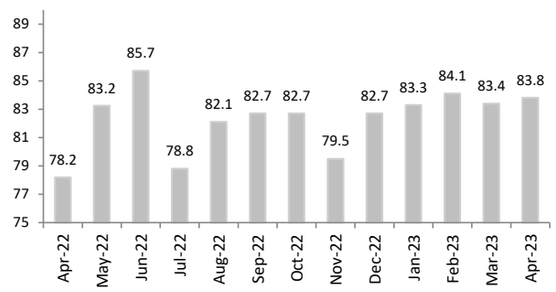
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Apr, '23*	MV: 197 mins LG: 143 mins ENT: 170 mins	MV: 199 mins LG: 143 mins ENT: 171 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins		
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Apr, 23*	73.5	78.0	80.8	81.0		
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Apr, 23*	70.3	75.0	81.3	81.5		

El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

April 2023 (unless otherwise specified)

Month to Board Quality Committee:
June, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Apr, 23*	74.7	72.4	68.4	75.0		
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Apr, 23*	83.8	82.4	83.2	83.4		NA

Notes:

1) SSER through Feb, 23
2) Readmissions through Mar, '23
3) PC-01 & PC-02 results available up to January 2023
4) ECHMN: reflect new vendor (PG) survey results
5) Updated 5/22/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Apr, 23*		H. Beeman, MD	New for FY23, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (5) key inpatient safety events. The elements of the composite are weighted as noted: Falls 20%, hospital-acquired Pressure Injuries (HAPIs) 25%, non-ventilator hospital-acquired pneumonia (nvHAP) 20%, Clostridium difficile infections (C-Diff) 10%, and surgical site infections (SSIs) 25%.	See below
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Apr, 23*		C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Apr, 23*		C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Apr, 23*		C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Apr, 23*		Nursing	1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'. 2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports. 3) Numerator exclusions: L&D, intentional falls. 4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU 5) Formula: (# falls/patient days) * 1,000 6) Latency: rare; corrections may change previously reported results.	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Apr, 23*		A. Aquino	1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries 2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & proned Covid-19 patients 3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	Numerator: EPIC Report and staff validation Denominator: EPSi patient days

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Serious Safety Event Rate (SSER)** **Latest data month: Feb, 23*		S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** * Latest data month: Mar, 23		H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** Latest data month: Apr, 23		H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Apr, 23*		J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *****Latest data quarter: Jan, 23*		H. Beeman, MD	1) Numerator: Patients with elective deliveries 2) Denominator: Delivered newborns with gestation weeks >/= 37 to 39 weeks For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): The FY23 target for PC-01 1.5% (top 25th %ile for MDC). MCH needs to retain some ability to do medically indicated, yet not meeting criteria, early deliveries.	IBM CareDiscovery Quality Measures
12	**PC-02: Cesarean Birth** (reported quarterly) *****Latest data quarter: Jan, 23*		H. Beeman, MD	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): FY23 target for PC-02 NTSV is 23.9%. Given our population (Asian average in CA was 25.2% from 07/2021-06/2022 for same nursery level CA MDC, + have significantly older population than CA), we think this is pretty aggressive.	IBM CareDiscovery Quality Measures

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
13	**Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Apr, '23*		J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. **Time stamp is used for this calculation:** ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Apr, 23*		C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Apr, 23*		C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

El Camino Health

Definitions and Additional Information

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

Notes:

1) SSER through Feb, 23
2) Readmissions through Mar, '23
3) PC-01 & PC-02 results available up to Jan
4) ECHMN: reflect new vendor (PG) survey
5) Updated 5/22/23

OUR TAKE

for post-acute leaders

The State of the Post-Acute Workforce

How to stabilize the exodus of clinical staff—while addressing long-standing workforce challenges

Published - May 2022 • 15-min read

Workforce challenges are among the most difficult threatening health care providers today. Nursing turnover, vacancies, and premium labor use are at their highest peaks in 15 years. Meanwhile, the frontline workforce continues to struggle with the personal and systemic impacts of the pandemic.

But this pain is not felt evenly across health care employers. Many post-acute providers, particularly SNFs, are facing staffing shortages so severe as to be existentially threatening. And perhaps more troubling: these shortages are driven not only by the trauma of the pandemic, but by the many structural workforce challenges present before March of 2020.

This report will explore those long-standing challenges and how they intersected with the pandemic. It will also detail where post-acute leaders have the best opportunity to address them—and chart a course to workforce stability and growth.

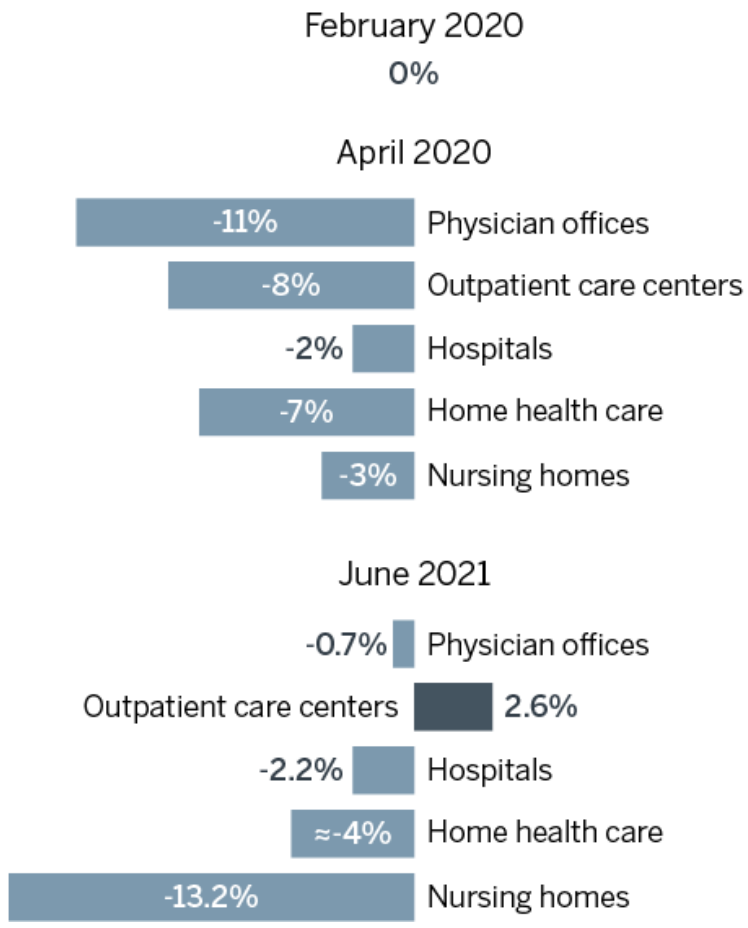
Advisory Board

Table of contents

The conventional wisdom

Staffing is one of the most significant challenges facing post-acute providers—specifically, a shortage of nursing staff including RNs, LPNs, CNAs, and other aide roles. But while most care settings have seen some rebound in employment since the early days of the Covid-19 pandemic, SNFs,[1] and to a lesser degree home health agencies,[2] lag the rest of the industry.

Change in U.S. total nurse employment in major health care sectors, relative to February 2020



1. Employment data is calculated using BLS definition of "nursing care facilities," which does not include CCRCs. Data can be accessed here: https://www.bls.gov/news.release/empsit.t17.htm
2. Employment data is calculated using BLS definition of "home health care services." Data can be accessed here: https://www.bls.gov/news.release/empsit.t17.htm

Source: "Nurse Employment During the First Fifteen Months of the COVID-19 Pandemic," *Health Affairs*, Jan 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01289.

THE CONVENTIONAL WISDOM

Provider leaders and industry experts typically cite three causes behind the unique severity of post-acute shortages, all triggered by the pandemic.

1. **Many clinicians endured intense emotional and physical burdens during the pandemic, and those burdens were particularly hard on people working in long-term care facilities**. Despite leaders' best efforts, environmental factors inherent to long-term care—specifically a patient population particularly vulnerable to infection and negative outcomes from the virus, and a lack of necessary infection control supports (such as negative pressure spaces, private rooms, and sufficient PPE)—made it arguably the most difficult setting in which to work during the pandemic. Yet while nursing home employees suffered the highest proportion of health care worker infections and deaths, the stigma surrounding these outbreaks excluded staff from receiving the widespread (and deserved) public recognition that many hospital staff received as "health care heroes."

2. **Post-acute sites primarily employ the nursing roles with the largest exodus from the workforce**, including nursing assistants/aides. While RN turnover is creating widespread shortages across the care continuum, only 1% of RNs left the workforce from April 2020 to June 2021. In contrast, 10% of CNAs left the workforce during that same time. So, in addition to experiencing the rising turnover seen throughout the industry, providers (especially SNFs) are also competing for a smaller number of CNAs. While the drivers of this exodus are not fully understood, part of the explanation lies with broader labor market changes. Nursing assistants and aides have had significant incentive to leave health care entirely for better pay and hours offered by industries that were also suffering severe staffing shortages, including manufacturing, hospitality, retail, and order fulfillment.

Change in U.S. total employment for select nursing roles from April 2020-June 2021

20% Decrease in LPNs

10% Decrease in nursing assistants and aides

1% Decrease in RNs

Source: "Nurse Employment During the First Fifteen Months of the COVID-19 Pandemic," *Health Affairs*, Jan 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01289.

3. **Acute care RN turnover rose to 18% in 2021**, the highest recorded rate in Advisory Board's 15 years of collecting benchmarks. This turnover impacted post-acute organizations in two ways. First, hospital leaders are increasingly turning to other sources of talent to fill their nursing ranks—including LPNs, who have historically been employed largely by SNFs. Second, sky-high starting bonuses at hospitals and lucrative travel opportunities draw RNs from both SNFs and home health.

Today, shortages in post-acute care pose a nearly existential threat to financial stability—especially for nursing home and assisted living facilities. In September 2021, 58% of surveyed nursing home leaders reported limiting new admissions due to workforce shortages. And 35% of those leaders were "very concerned" their facility would close if those challenges persisted. While shortages are comparatively less dire for home health agencies, nearly 80% of home care leaders cite staffing shortages as the primary driver of declining client growth rates.

SNF staffing shortages will likely be exacerbated by minimum staffing requirements proposed in February 2022 amid a bundle of federal nursing home reforms. While CMS won't issue their proposed rule until February 2023, the mandate will likely increase the number of nursing staff the average SNF needs to employ—compounding a projected increase in demand for LPNs and CNAs.[1]

Source: "2021 Advisory Board hospital turnover and vacancy benchmarks," Advisory Board, Mar 2022, https://www.advisory.com/Topics/Retention-and-Recruitment/2022/01/Hospital-turnover-and-vacancy-benchmarks?msclkid=cb721c46b60b11ec9df42380f550a8d4; State of the Long Term Care Industry," AHCA/NCAL, Sept 2021, https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/Workforce-Survey-September2021.pdf; "'A Huge Victory': Home Care Turnover Remains Stable at 65.2%," *Home Health Care News*, May 2021, https://homehealth carenews.com/2021/05/a-huge-victory-home-care-turnover-remains-stable-at-65-2/; "FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes," The White House, Feb 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/; "Nursing Assistants and Orderlies," Bureau of Labor Statistics, Sept 2021, https://www.bls.gov/ooh/health care/nursing-assistants.htm; "Licensed Practical and Licensed Vocational Nurses," Bureau of Labor Statistics, Sept 2021, https://www.bls.gov/ooh/health care/licensed-practical-and-licensed-vocational-nurses.htm.

1. The Bureau of Labor Statistics projected that CNA and LPN demand will grow by 8% and 9% respectively from 2020-2030.

Our take

There is no question that the pandemic disproportionally impacted post-acute providers and clinicians. Covid-19's effect on older adults and the staff who care for them, especially in residential facilities, left emotional and financial scars that will linger for years to come.

Yet while the severity of staffing shortages is new, staffing instability is not. A study of SNF staffing in 2017-18 estimated average turnover rates for RNs and CNAs at well over 130%. Home health turnover clocked in at 64.3% in 2019, far above the 2019 U.S. national turnover rate of 22%. Even if post-acute employers were able to return to pre-pandemic staffing levels, they would likely still not have enough workers to position for growth.

> "If I didn't have staffing problems,
> **I wouldn't have any problems."**
>
> Matt Bourque, Administrator
> Chateau Senior Living
> January 2020

In short, the pandemic didn't introduce new staffing challenges. It exacerbated pernicious challenges within the workforce that have left post-acute employers at a disadvantage in an increasingly competitive labor market. And it is essential post-acute employers focus their efforts on these legacy pain points if they are to make any progress on today's staffing shortages.

Source: "High Nursing Staff Turnover In Nursing Homes Offers Important Quality Information," *Health Affairs,* March 2021, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00957; "'A Huge Victory': Home Care Turnover Remains Stable at 65.2%," *Home Health Care News,* May 2021, https://homehealthcarenews.com/2021/05/a-huge-victory-home-care-turnover-remains-stable-at-65-2/; "North American employee turnover: trends and effects," Mercer, Jan 2020, https://www.imercer.com/articleinsights/North-American-Employee-Turnover-Trends-and-Effects?msclkid=316957d3b3c211eca2f437cf25526a94.

Three challenges to post-acute workforce stability

The rest of this report explores how the following structural challenges evolved during the pandemic. We will also detail the approach workforce leaders should take stabilize their workforce, with the goal of addressing both the historical pain points and those introduced or exacerbated by Covid-19.

01

CHALLENGE

Stagnant wage growth

02

CHALLENGE

Burnout

03

CHALLENGE

Limited career growth and development

01 Stagnant wage growth

Compensation has long been a barrier to recruiting and retaining clinical staff to post-acute organizations. Low reimbursement rates, driven by Medicare Advantage and Medicaid, in addition to an increasingly financially unfavorable payer mix, make for razor-thin profit margins. Those profit margins in turn have made it difficult for employers to increase their labor costs, resulting in staff compensation often not being competitive with other settings.

But today's intense competition has finally made compensation increases possible. Since March 2020 providers have been pushed to increase baseline compensation,[1] in addition to offering retention and sign-on bonuses, to stem the exodus of clinical staff.

These increases were particularly noticeable at SNFs and assisted living facilities, which raised total compensation for all employees at a much faster pace (6%) across 2021 than the health care sector more broadly (4.6%)[2].

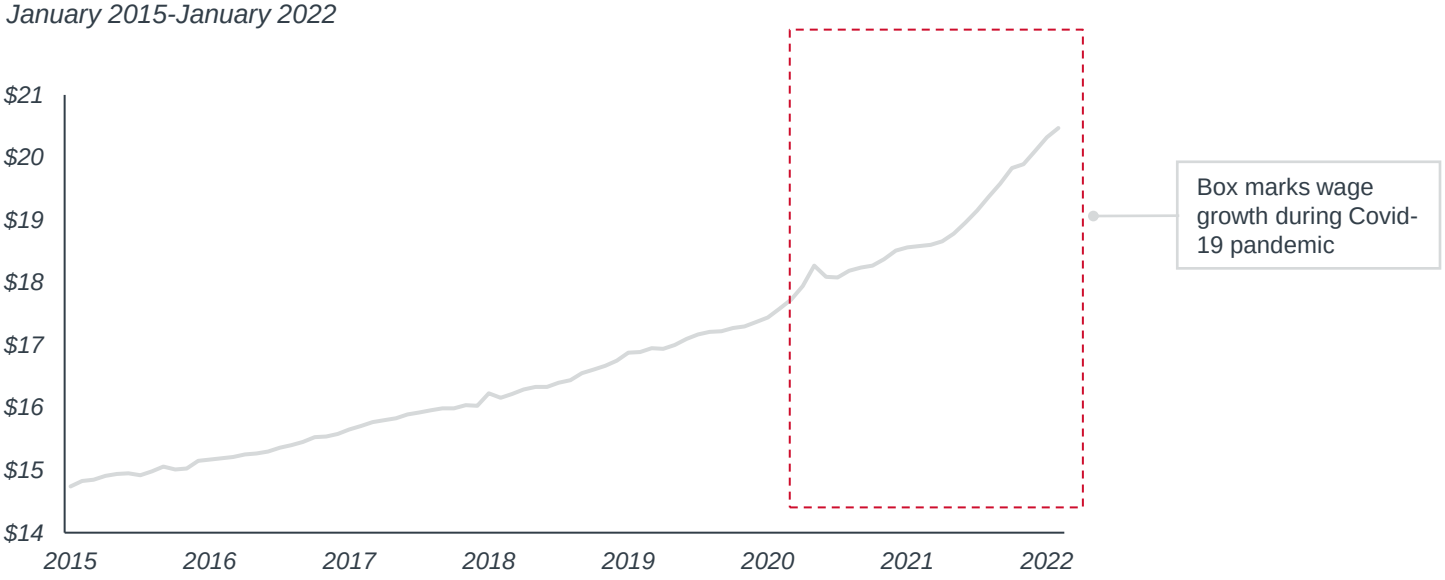
1. Nursing homes raised average hourly wages by 5.5% per year from 2020-2022, compared to the average increase of 2.97% per year from 2015-2020. Home health agencies raised average hourly wages by 8.26% per year from 2020-2022, compared to the average increase of 3.67% per year from 2015-2020. Hourly wages are calculated using the Bureau of Labor Statistics' average hourly wages, seasonally adjusted.
2. According to the Bureau of Labor Statistic's Compensation Cost Trends survey.

Source: "Nursing and Residential Care Facilities: NAICS 623," *Bureau of Labor Statistics, April 2022*, https://www.bls.gov/iag/tgs/iag623.htm; "Health Care and Social Assistance: NAICS 62," Bureau of Labor Statistics, April 2022, https://www.bls.gov/iag/tgs/iag62.htm.

1. STAGNANT WAGE GROWTH

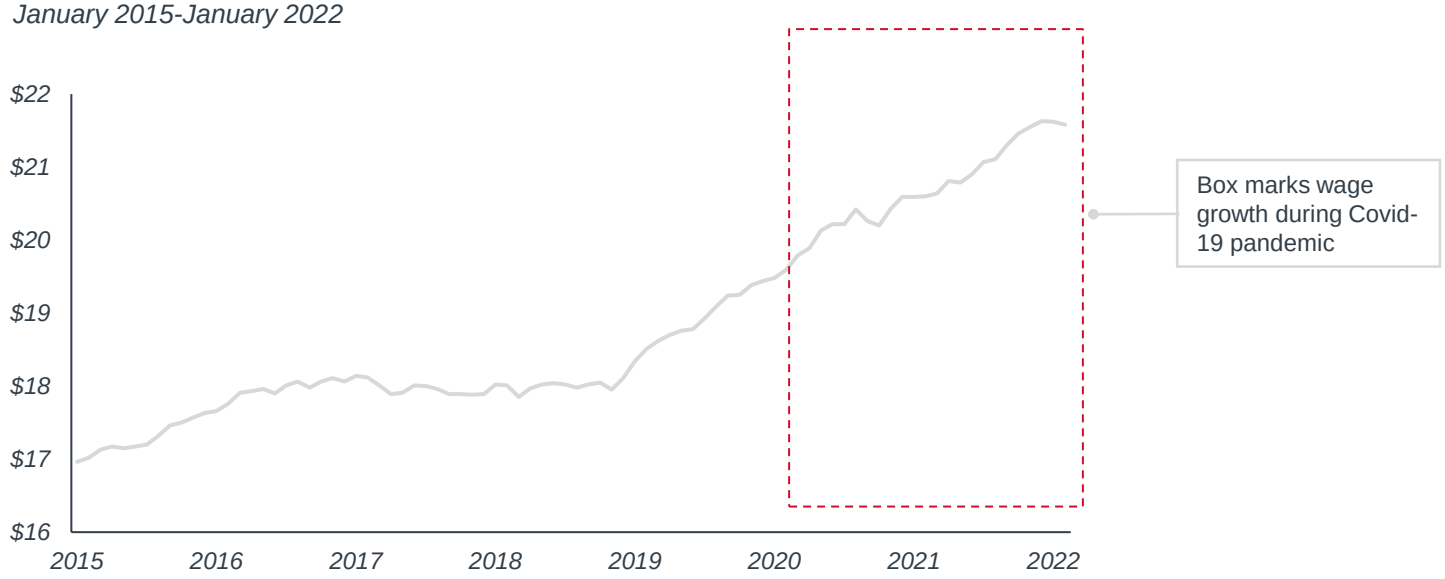
Average hourly earnings of all U.S. production and nonsupervisory employees in nursing and residential care facilities[1]

January 2015-January 2022



Average hourly earnings of all U.S. production and nonsupervisory employees in home health care services[1]

January 2015-January 2022



1. Seasonally adjusted.

Source: "Nursing and Residential Care Facilities: NAICS 623," Bureau of Labor Statistics, April 2022, https://www.bls.gov/iag/tgs/iag623.htm; "Health Care and Social Assistance: NAICS 62," *Bureau of Labor Statistics, April 2022*, https://www.bls.gov/iag/tgs/iag62.htm.

1. STAGNANT WAGE GROWTH

Leaders of post-acute organizations focused this rise in employee compensation primarily on unlicensed staff, including CNAs and home health aides, for two reasons:

- While wages did keep pace with inflation, average hourly wages for both nursing homes and home health organizations are far below the U.S. national average of $31.56 in January 2020.[1] This highly motivates staff to leave roles for relatively small increases in base compensation, creating a compensation arms race between employers that accelerates staff turnover.
- Both SNFs and home health agencies employ primarily aide-level staff who may not be required to hold licenses, who can switch between industries with relative ease (and without feeling the opportunity cost of not using education they invested significant time and money to get). Because many post-acute sites operate on tighter margins than both other care settings and out-of-industry competitors, they are at a disadvantage to match competing offers.

Despite the rapid growth in base compensation over the past two years, many post-acute leaders believe that these increases are reaching a ceiling given current reimbursement rates.

1. According to the Bureau of Labor Statistic's Compensation Cost Trends survey, average hourly wages for nursing homes were $20.32 in January of 2022 and $21.62 for home health organizations.

Source: "Nursing and Residential Care Facilities: NAICS 623," Bureau of Labor Statistics, April 2022, https://www.bls.gov/iag/tgs/iag623.htm; "Health Care and Social Assistance: NAICS 62," Bureau of Labor Statistics, April 2022, https://www.bls.gov/iag/tgs/iag62.htm.

1. STAGNANT WAGE GROWTH

Opportunities for post-acute employers to address workforce challenges

HISTORICAL CHALLENGE

Pay all employees a competitive market rate …

Prior to the pandemic, the labor market was employer-centric enough for post-acute organizations to mostly sustain staffing levels even with deflated base compensation. Though staff turnover was high, employers were able to recruit and train enough individuals to keep beds open.

Today, paying market rate (and ideally a living wage) is nonnegotiable. Any post-acute organization that isn't matching market rates for this labor pool risks losing their workforce entirely.

EMERGING CHALLENGE

... while defining the post-acute employee value proposition beyond competitive compensation

But even a market-competitive wage won't be sufficient to retain staff in the long term, especially in a tight labor market. Nor can post-acute employers outcompete Amazon, Target, Starbucks, and other out-of-industry employers with large profit margins.

To retain staff in the long term, post-acute providers should communicate and reinforce the unique (or at least differentiated) qualities that their top talent values in a work environment, including a connection to mission, team environment, and flexible scheduling.

02 Burnout

It's hard to overstate the toll that the Covid-19 pandemic had on health care workers, particularly those in post-acute care. Infection control measures, such as halting visitation in facilities and time spent donning and doffing PPE, increased the already high workload of clinicians. Many in post-acute settings cared for patient populations most vulnerable to severe complications from Covid. Staff in post-acute settings who were not accustomed to significant infection control measures often didn't have adequate PPE on site. In addition, many patients and residents of post-acute facilities have cognitive challenges and are difficult to keep masked or separated, leading to moral distress among staff who felt unable to protect their charges. And nursing home employees died from Covid at nearly twice the rate as hospital employees.

Source: "12 Months of Trauma: More Than 3,600 US Health Workers Died in Covid's First Year," *Kaiser Health News*, Apr 2021, https://khn.org/news/article/us-health-workers-deaths-covid-lost-on-the-frontline/ .

2. BURNOUT

Recent data indicates that over 50% of nursing home and home health workers are burned out, especially those who worked directly with Covid patients and had patients die of Covid.

Excerpt of results from 2021 KFF/Washington Post Frontline Health Care Workers Survey

	Hopeful	Optimistic	Motivated	Burned out	Anxious	Angry
Total frontline health care workers	76%	67%	62%	55%	49%	21%
Where they work						
Hospitals	72%	66%	63%	55%	50%	26%
Nursing homes / assisted care facilities	71%	66%	60%	56%	47%	21%
Doctor's office / outpatient clinic	76%	67%	62%	54%	46%	20%
Patient in-home care	80%	70%	69%	50%	51%	13%
Worked directly with COVID-19 patients						
Direct care	75%	65%	61%	58%	49%	26%
Had a patient die as a result of COVID-19	75%	66%	61%	62%	52%	32%
No direct care	78%	70%	66%	50%	48%	14%

Source: "KFF/The Washington Post Frontline Health Care Workers Survey," KFF, Apr 2021, https://www.kff.org/report-section/kff-the-washington-post-frontline-health-care-workers-survey-toll-of-the-pandemic/

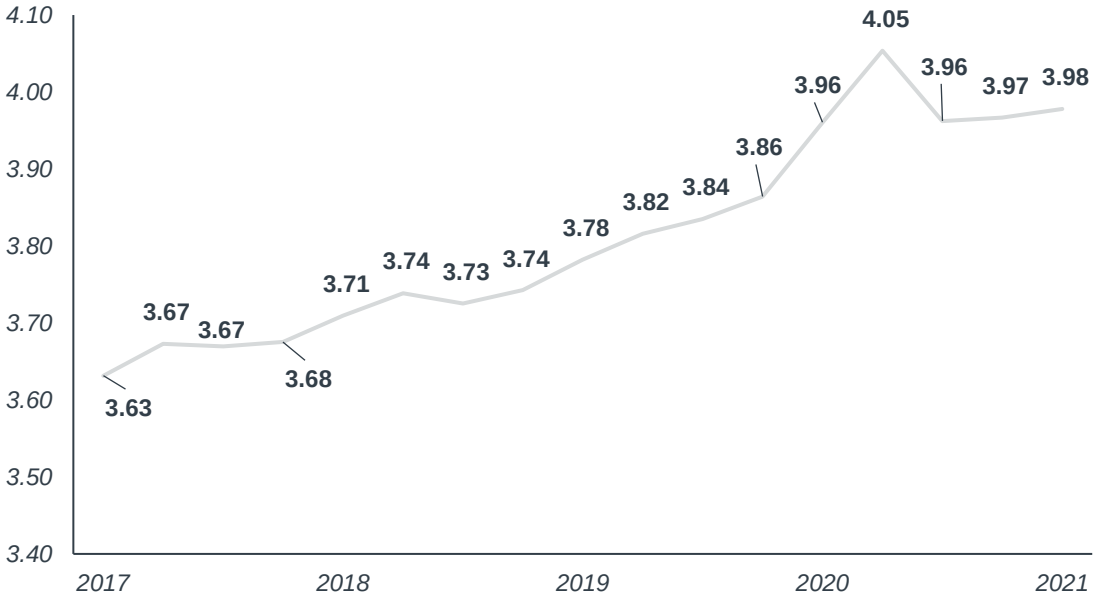
2. BURNOUT

With Covid-19 rates down significantly from their 2020 peaks, employers may expect that the worst of clinician burnout is behind them—and what remains will decrease as staffing levels stabilize.

But rising burnout will stay the rule for the post-acute workforce, not the exception. The work of clinical care delivery itself is becoming more challenging. The pandemic greatly exacerbated a trend that began well before 2019: patients in post-acute care are becoming more complex, while staffing models stay the same.

Average HCC of inpatients discharged to SNFs

January 2017-January 2021



Unless employers intervene, this rising complexity will fall squarely on the shoulders of clinicians struggling to heal from the pandemic—threatening both workforce integrity and patient outcomes.

Source: "The Post-Acute Care Pathways Explorer," Advisory Board, April 2017, https://www.advisory.com/Topics/Retention-and-Recruitment/2022/01/Hospital-turnover-and-vacancy-benchmarks?msclkid=cb721c46b60b11ec9df42380f550a8d4; .

2. BURNOUT

Opportunities for post-acute employers to address workforce challenges

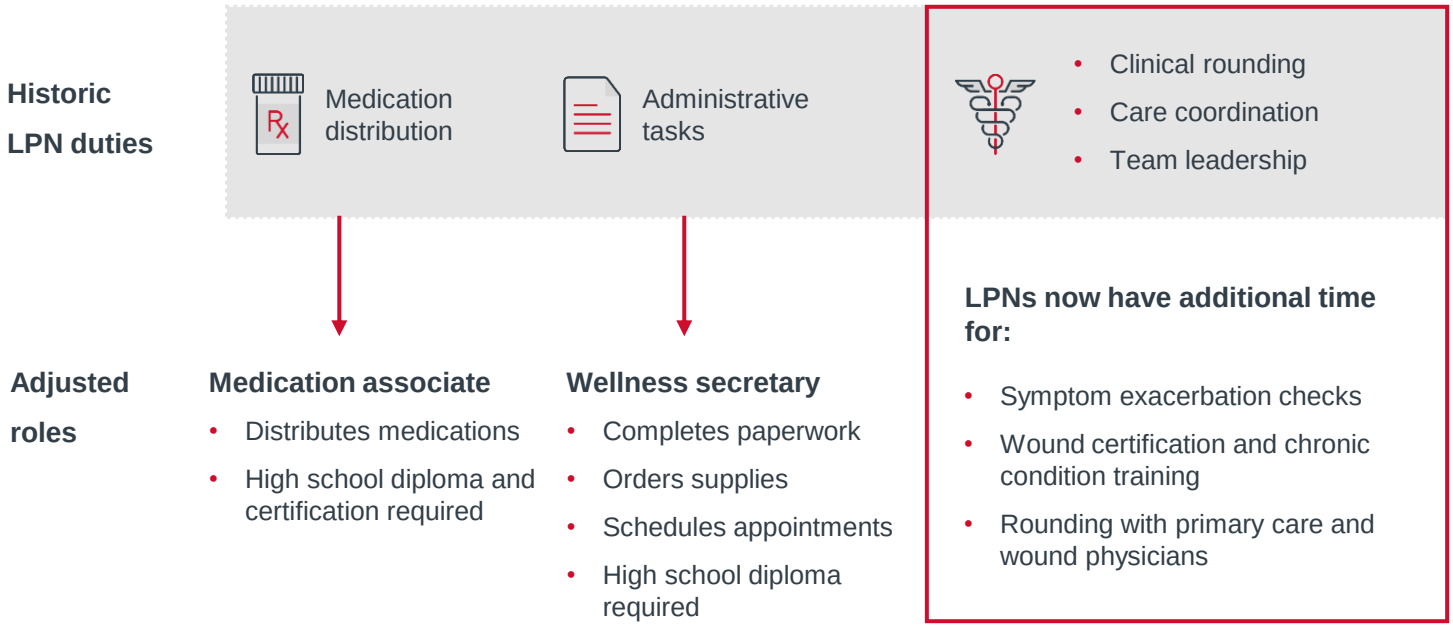
HISTORICAL CHALLENGE

Redesign the care team to reduce clinician burnout …

Rather than attempting to recruit additional clinicians in short supply, leaders should consider re-scoping their existing team to ensure clinicians are practicing at top-of-license—while adding additional roles only as necessary.

For example, LPNs at Country Meadows Retirement Communities in Pennsylvania were overburdened with medication distribution and administrative tasks while their increasingly complex patient population required additional time and attention. To allow LPNs to practice at the top of their licenses, Country Meadows added new staff roles dedicated to medication management and documentation. With a reduced medication and administrative burden, LPNs spend more time on tasks such as rounding, checking for symptom exacerbation, and receiving additional education.

Change in LPN scope of practice at Country Meadows Retirement Communities



Source: Country Meadows Retirement Communities, Hershey, PA.

EMERGING CHALLENGE

… while embedding emotional supports to heal pandemic trauma

Health care organizations have long provided emotional support resources for staff, such as employee assistance programs (EAPs) or debriefs following major emotional events. But staff often don't use these emotional supports, instead relying on individual coping mechanisms so they can prioritize patient needs over their own well-being.

To move beyond this long-standing "I'm fine" culture, organizations need to provide a baseline level of emotional support resources. At a minimum, organizations need to provide at least one formal resource for each of the following:

- Major events that could lead to emotional distress, trauma, grief, or PTSD
- Moral distress
- Routine stress related to frontline care that can contribute to compassion fatigue

For strategies to build baseline emotional support with staff, access our report.

03 Limited career growth and development

Providing frontline career development is uniquely challenging for post-acute employers relative to other care settings. High turnover disincentivizes employers from investing in staff training and skill development. And even if employers were to do so, it isn't always clear what the frontline staff would want them to provide. For example, many staff see CNA and aide roles as a low-barrier opportunity to start their careers, but may not be interested in working as a clinician permanently. Others drawn particularly to health care's mission may be enticed by pathways to licensed roles.

As a result, post-acute care organizations often fail to reward clinicians for additional skills and responsibilities—or motivate employees to grow their careers within the organization.

Maintaining this status quo is a key missed opportunity for employers, for two reasons. First, development provides motivation for staff to acquire the skills necessary to care for the highly complex post-acute population. Second, the promise of future reward can give post-acute employers a much-needed edge over out-of-industry employers wooing staff with compensation bumps.

Sources: Wang G, "Humans in the Loop: The Design of Interactive AI Systems," Stanford Institute for Human-Centered Artificial Intelligence, Oct 2019, https://hai.stanford.edu/news/humans-loop-design-interactive-ai-systems; Advisory Board interviews and analysis.

Opportunities for post-acute employers to address workforce challenges

HISTORICAL CHALLENGE

Create career development opportunities within roles …

To provide career development within roles, employers will need to stratify role responsibilities and rewards (e.g., offer tiers of CNA roles). Ideally, this can support top-of-license practice in addition to engaging employees.

There are two approaches to creating intra-role development. Employers can either stratify roles by skill level and experience, or create a variety of career paths that align with needed areas of specialization (e.g., CNAs trained in caring for patients with behavioral health needs).

EMERGING CHALLENGE

... while creating an interprofessional career ladder

Out-of-industry employers like Amazon are focusing on tuition reimbursement as an in-demand benefit in a competitive labor market. Yet career pathing has always been one of health care employers' greatest opportunities. Most settings of care employ a variety of clinical roles with concrete educational pathways to advance to each one.

But empowering employees interested in these pathways to achieve them will require a more intentional effort by employers. Educational programs may be incompatible with typical shift options or they may be too costly for employees to afford. By strengthening collaboration with local colleges and offering tuition reimbursement benefits, post-acute employers can recruit and retain existing staff in addition to building a future pipeline of quality candidates.

Source: "3 things to know about Amazon's plan to cover 100% of employees' tuition," *Fortune*, Sept 2021, https://fortune.com/education/business/articles/2021/09/10/3-things-to-know-about-amazons-plan-to-cover-100-of-employees-tuition/?msclkid=4fc233bbaa4a11ec8117b37462216a54

Parting thoughts

Providers have never been more committed to attracting and retaining the talent they need—none more so than post-acute care organizations. Yet with limited resources and heightened competition for talent, leaders aren't sure what else can be done. One avenue to achieve both objectives is to build an intentionally differentiated employer value proposition that sets the organization apart from competitors, both within and outside the health care industry.

The key to a successful employer value proposition is outperforming on a small set of compelling values while simply doing "well enough" on the others. But the problem post-acute leaders face won't be indecision around which values to choose. Many leaders are already aware of their organizations' natural workforce strengths (e.g., connection to mission, interprofessional career pathing, flexible hours, and independent practice, among others) and weaknesses (primarily compensation).

The challenge will be highlighting these values in a way that meaningfully inflects retention. Merely communicating them to existing staff or candidates won't be sufficient. Leaders must find intentionally reinforce them within the work environment. By doing this, they can both can both stabilize the current exodus of staff and create long-term solutions to staffing instability.

Related content

Advisory Board resources

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EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, and Senior Quality Director
Date: June 5, 2023
Subject: Leapfrog Hospital Safety Grade Spring 2023

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on Leapfrog Hospital Safety Grade Spring 2023 for both Mountain View (MV) & Los Gatos (LG) Campuses.

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. The two domains of the Leapfrog Hospital Safety Grade are:

1. Process/Structural Measures [12 measures] from the Leapfrog Hospital Survey and
2. Outcome Measures from CMS [10 measures]. Focusing on patient safety through participation in Leapfrog is supportive of our High Reliability aim of achieving zero patient harm.

Assessment:

Leapfrog Survey raises the bar for safer health care by building a movement for transparency. Over 2,000 hospitals voluntarily participate in the Leapfrog Program each year. The support and engagement of our leadership to participate in this survey shows our utmost pursuit for excellent and safe care. Unlike CMS star rating, which assigns one rating for both campuses, Leap Frog views hospitals as separate and each campus receives its own grade.

A. Both Los Gatos and Mountain View Campus earned a letter grade A for the Spring 2023 reporting period. Los Gatos was a letter grade B in the Spring 2022 period. An opportunity identified in Spring 2022 is the ICU Physician Staffing Leapfrog standard with regards to 24/7 onsite coverage at Los Gatos. In collaboration with LG Leadership from Medical Staff, Nursing and Pharmacy, an on-site clinical pharmacist coverage was implemented which improved the LG score from 5 to 50 (out of 100). Of note, for 2022, due to COVID-19, the virtual rounding by the clinical pharmacist on all ICU patients was allowed and earned credits.

B. As with Computerized Physician Order Entry (CPOE) systems and Bar Code Medication Administration (BCMA) systems, Leapfrog anticipates that electronic compliance monitoring technology will improve over time and become an important component of a comprehensive hand hygiene program. Electronic monitoring is a routine component of public safety in other industries where compliance is critical, so health care can and should achieve those standards for its patients.

C. All of the HCAHPS scores fo the Leapfrog Spring of 2023 are above the Average Performing Hospital and are stable or improving for the timeframe 04/01/2021-03/31/2022. Nurse Communication has increased by 1 point; Doctor Communication has remained the same; Staff Responsiveness increased by 2 points; Communication about Medicines has increased by 2 points; and Discharge Information has remained stable.

D. Both Campuses performed below standard in CAUTI and C-Diff. FY2024 will include reduction of HAI/HAC as a goal.

As of: 5/26/23

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
	FY23				
1	9/6/2022	Carol Somersille, MD	4d – Progress Against FY23 Committee Goals. She noted to correct the Chair name to her name and remove Julie Kliger's name.	Nicole Hartley	9/7/2022
2	9/6/2022	Carol Somersille, MD	item dated 06/06/2022 to her name and remove Holly Beeman's name under Committee Member.	Nicole Hartley	9/7/2022
3	11/7/2022	John Zoglin	Agenda Item 7. Follow up items are: Present a 5-year analysis to the Committee and a status update on the deciles.	Nicole Hartley/Christine Cunningham	12/12/2022
4	11/7/2022	Alyson Falwell	stroke patients evaluated and discharged from ED) performance as shared in Core Measure report during the Nov 2022 Quality Committee Meeting.	Dr. Holly Beeman	12/12/2022
5	11/7/2022	Melora Simon	Requests to display both the fiscal year to date and rolling 12 month performance results in future ECHMN quality reports.	Ute Burness	2/6/2023
6	2/6/2023	Krutica Sharma, MD	Requested that we add a monthly threshold or target line to the trend chart on the Enterprise Dashboard	Dr. Holly Beeman	3/6/2023
7	2/6/2023	Krutica Sharma, MD	Request the action plan for complying with the new Joint Commission patient safety goal regarding Health Equity be shared with the committee at a future meeting.	Dr. Holly Beeman	6/5/2023
8	3/6/2023	Melora Simon	Deep Dive on emergency department times and throughput at a future meeting.	Dr. Meenesh Bhimani/Cheryl Reinking	5/1/2023
9	4/3/2023	John Zoglin	Enterprise Quality Dashboard: Dr. Beeman to work with MCH on a timely measure.	Dr. Holly Beeman	
10	4/3/2023	John Zoglin, Melora Simon, Krutica Sharma	FY24 Committee Goals: Initial committee assessment and updated FY24 Goals to be shared with QC at the May meeting by Tracy.	Tracy Folwer	5/1/2023
11	4/3/2023	Melora Simon	**CLOSED SESSION ITEM:** Dr. Beeman will share RCA details at the May meeting from the March Serious Safety/Red Alert Event.	Dr. Holly Beeman	5/1/2023

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality, Patient Care, and Patient Experience Committee
From: Tracy Fowler, Director, Governance Services
Date: June 5, 2023
Subject: FY23 Quality Committee Assessment Baseline Survey

Summary:

The Quality, Patient Care, and Patient Experience Committee (the "Committee") conducted a self-assessment to establish a baseline for performance as part of the Committee's FY24 goals. The responses and comments identify strengths, weaknesses, and areas for improvement, and will allow the Committee to develop a plan to continuously enhance its effectiveness and impact on patient care quality and safety.

The following is a summary of the salient points from the recent Committee Assessment:

Purpose, Scope, Goals, and Objectives: Although the Committee's mandate is clear, there are concerns that the material presented by management doesn't always align with these guidelines. This misalignment needs to be addressed.

Patient Care vs Patient Experience: While our commitment to quality and patient care is clear, there's a consensus that we need to improve our focus on patient experience and how we report it to the Committee. There's a call for more discussions around health equity and the appointment of a C-suite administrator to champion patient experience.

Governance: There's uncertainty regarding the Committee's authority, with some members believing that the executive team doesn't consistently support the committee's role. This confusion also extends to which issues fall within the Committee's purview.

Committee Composition: Adding patients and statistical experts to the Committee could enhance our understanding of patient experiences and provide more depth to our data analysis.

Conflict and Collaboration: Some tensions exist between Committee members and the executive team. Addressing this issue should be a priority, potentially through the engagement of an external facilitator.

Meeting Organization and Materials: Although meetings are well-organized, there's room to improve the focus of our discussions and reduce the time spent preparing reports. Regular reports between less frequent meetings were suggested to maintain familiarity with ongoing data and measures. While some initiatives are SMART (Specific, Measurable, Achievable, Relevant, and Time-bound), others are not. A more consistent approach to goal setting is needed.

Training: While onboarding training is comprehensive, additional resources (e.g., quality improvement articles) and potential further training (e.g., math/controls for caregivers, hospital improvement for non-caregivers) were suggested.

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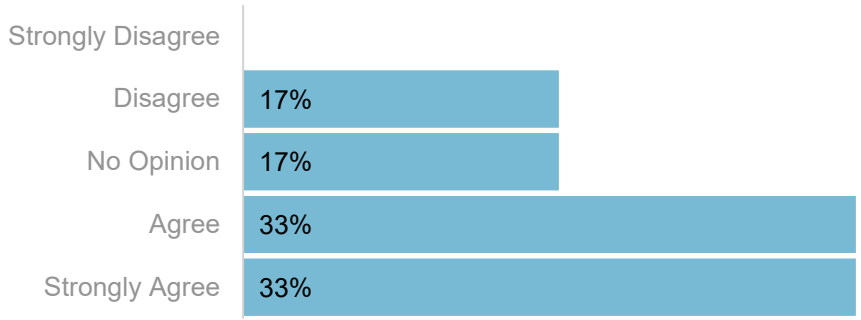
FY23 QC Baseline Survey Results

June 5, 2023

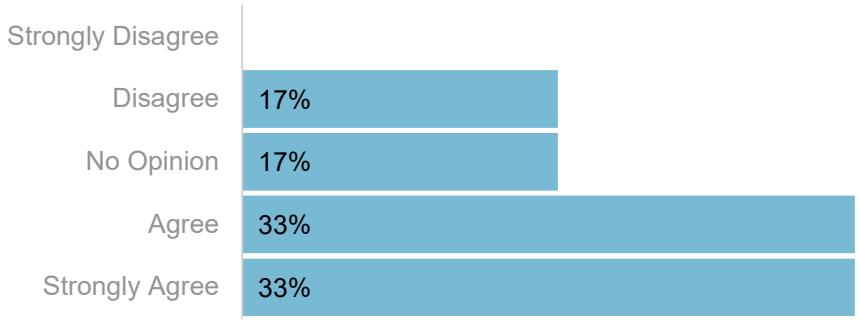
Top Opportunities: Committee Oversight

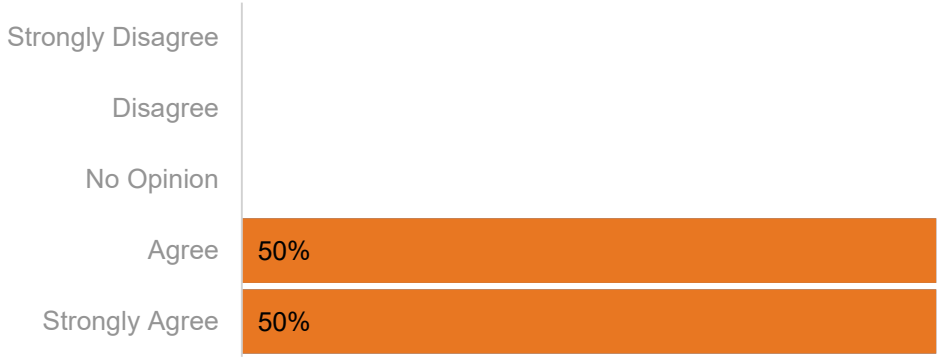
**Committee responses in blue, Staff responses in orange*

Quality improvement initiatives are measurable, achievable, relevant, and time-bound.



The impact of quality improvement initiatives is regularly evaluated and reported.





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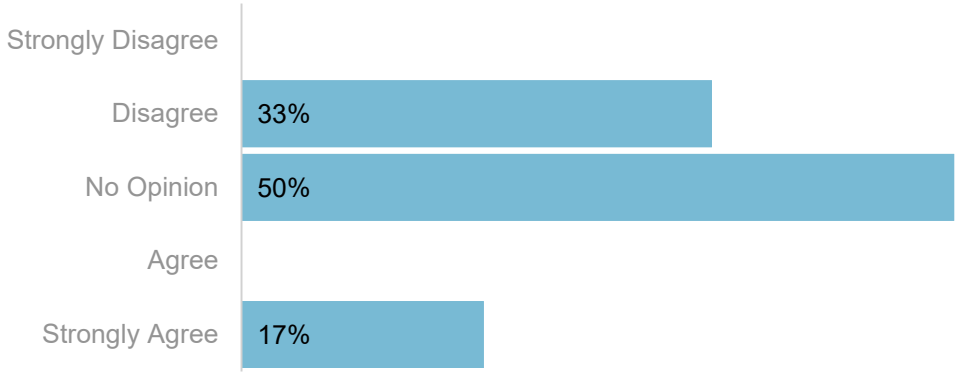
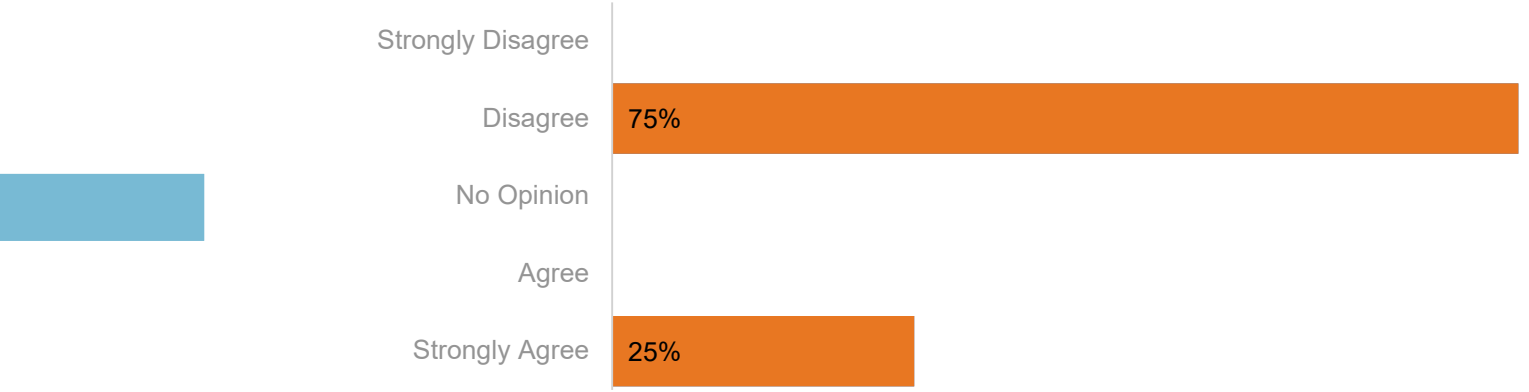
Top Opportunities: Collaboration

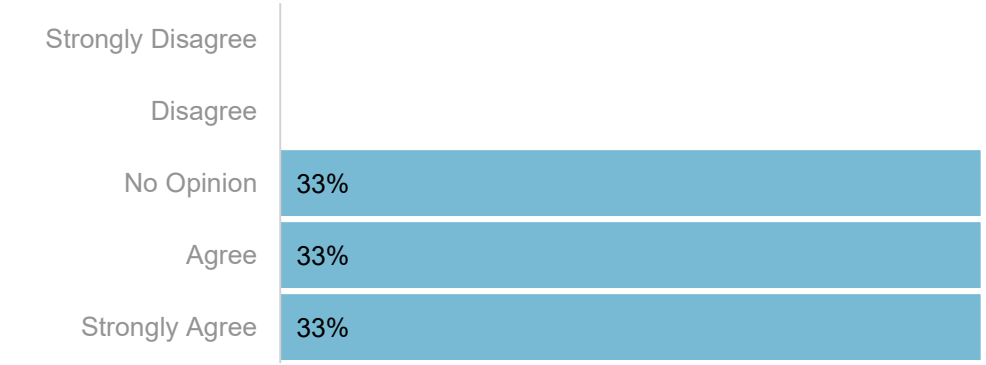
**Committee responses in blue, Staff responses in orange*

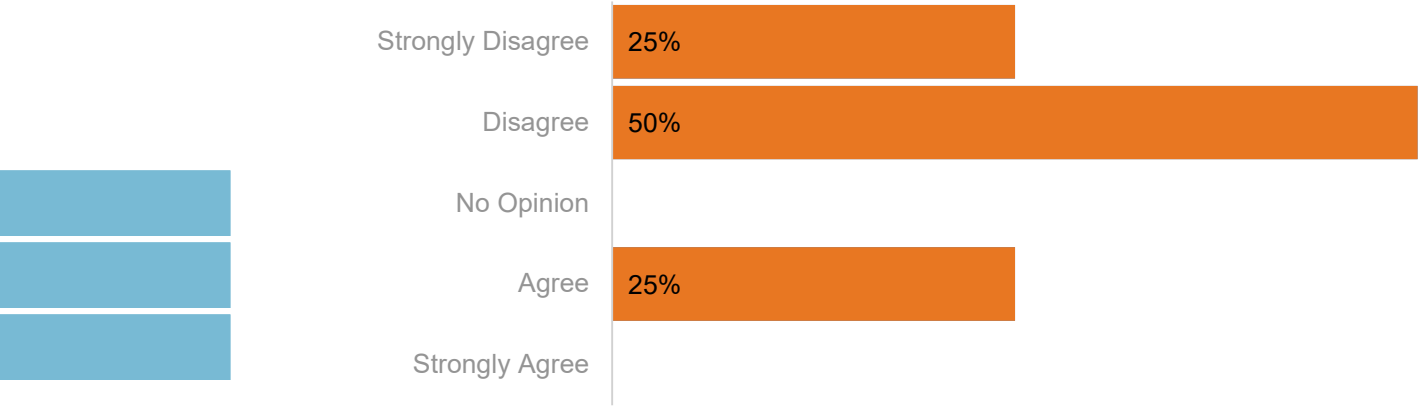
The Quality, Patient Care, and Patient Experience Committee collaborates effectively with other hospital staff, other committees, and/or stakeholders.





The Quality, Patient Care, and Patient Experience Committee understands the role of effective governance and oversight of quality improvement initiatives and serves as an advisor to hospital management.





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Discussion/Questions

Questions for the Committee:

- How can we clarify the committee's authority and role to ensure all members, as well as the executive team, understand and respect its scope and responsibilities?
- How can we foster a healthier relationship between the committee members and the executive team?
- What additional training or resources should we provide to committee members to enhance their capabilities?
- How can we optimize the focus of our meetings and reduce time spent on report preparation? What changes would you suggest for our current reporting procedures?

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FY23 Quality Committee Assessment Baseline Survey Results

Section 1: Purpose and Scope

3 Questions

Question 1 of 3 |

Q1 The Quality, Patient Care, and Patient Experience Committee has clearly defined its purpose, scope, goals, and objectives.

Comments

We are very clearly obsessed w/ quality, but don't really think that much about patient experience.

Still bit of a disconnect between the quality/patient care side emphasis and patient experience side - from board and staffing.

Purpose, scope, goals and objectives are clearly defined - what is brought to us by management is not always perfectly aligned with that.

Question 2 of 3

Q2 The Quality, Patient Care, and Patient Experience Committee's responsibilities and authority are well-understood and documented.

Comments

I think the authority is not well understood, and there are frequently questions about what the staff thinks is outside the scope of the committee, and what the committee believes it has oversight on.

Is this for committee members only or also staff. Don't believe executive team consistently supports/believes in committee's role/authority

By whom? I answered for the committee. Can't speak to the board or the management team of the hospital.

Too early to tell (new member)

Question 3 of 3

Q3 The Quality, Patient Care, and Patient Experience Committee is aligned with the hospital's overall strategic goals and objectives.

Comments

More could be done to connect our activities with the hospital's strategic goals and objectives but it is better than it has been in the past.

Section 2: Membership and Composition

2 Questions

Are the members of the Quality Committee well-qualified, diverse, and representative of the hospital's stakeholders?

Question 1 of 2

Q1 Members of the Quality, Patient Care, and Patient Experience Committee are well-qualified, diverse, and have expertise in the subject matters overseen by the Quality, Patient Care, and Patient Experience Committee.

Comments

We are missing expertise in Patient Experience

I think we are significantly missing the patient experience part at the hospital. Thankfully, most of us don't use the hospital on a frequent basis, but it leads to a gap there.

Adding patients to the Committee could add diversity. Adding statistical experts could add subject matter expertise.

Question 2 of 2

Q2 Members are appointed or elected according to established procedures.

Section 3: Quality, Patient Care, and Patient Experience Committee Oversight

3 Questions

Question 1 of 3

Q1 Quality improvement initiatives are measurable, achievable, relevant, and time-bound.

Comments

They should definitely be measurable, and achievable. But don't have to be time-bound, sometimes the goal is a north star and should be permanent?

Not sure they are time bound -- initiatives selected by exec team - but don't see commitment to solutions with time frames

If there were an option around inconsistency, that would be a better choice than disagree. The recently presented initiative around C-sections was an example of something that was not SMART (Specific, measurable, etc.) whereas work around sepsis and blood management has been. The patient experience approach as presented is not SMART and is one example of the defensiveness of management when we attempt to provide oversight to ask for something that is SMART.

Question 2 of 3

Q2 The impact of quality improvement initiatives is regularly evaluated and reported.

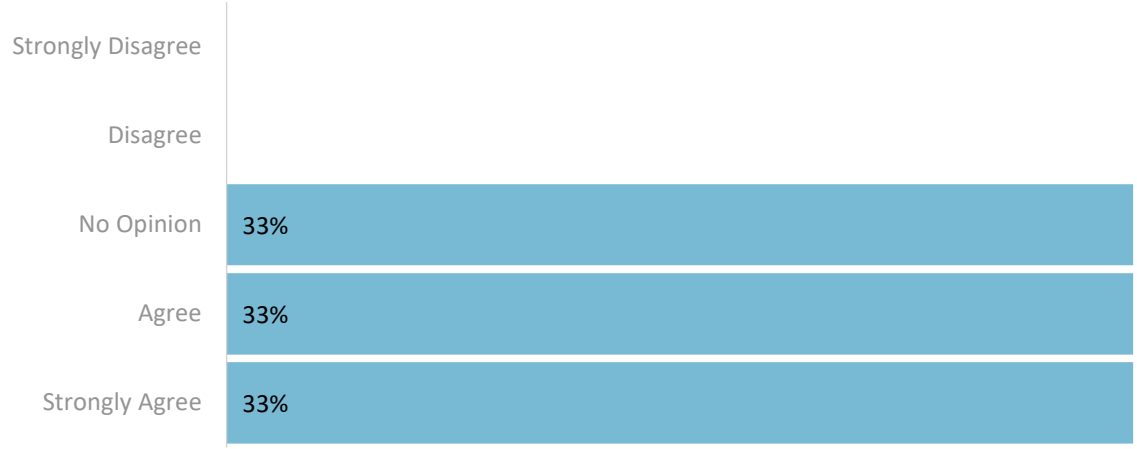
Comments

scorecard is recorded -- doesn't appearr so disciplined about root cause analysis shared and projected result time frames shared

Very rarely

Question 3 of 3

Q3 The Quality, Patient Care, and Patient Experience Committee is aware of and in compliance with relevant regulations, standards, and guidelines related to quality of care.



Comments

I don't believe we aren't in compliance, but I don't think we think about compliance all that much on the committee explicitly.

On the whole, we are aware of relevant standards and guidelines. I don't think it is the committee's job to be in compliance with relevant regulations, but rather to understand the regulations and assess whether the health system is in compliance with them.

A checklist of relevant quality regulations, standards and guidelines would help remind members and align our oversight work.

Section 4: Collaboration and Governance

3 Questions

Question 1 of 3

Q1 The Quality, Patient Care, and Patient Experience Committee collaborates effectively with other hospital staff, other committees, and/or stakeholders.

Comments

Right now there is frequently assumption of ill-intention on both sides, which is making some very innocuous questions and comments immediately triggering on both sides. We really need to deal with this asap.

Don't really spend time aligning/collaborating with other committees.

While smooth for the most part, there have been instances over my time on the committee where hospital exec team might approach committee members' inquiry or questions defensively rather than with a collaborative, educative, clarifying attitude. Great to see the exec team take pride in their work but it is also critically important to remember that the committee members are well within their governing oversight authority to request additional information or clarification on matters directly or indirectly within their purview.

I don't think members of the committee should be asked this one - strikes me it matters more what others think of our collaboration.

New member lacks evidence of effective stakeholder collaborations outside the hospital/health system.

Question 2 of 3

Q2 There are established protocols for resolving conflicts and addressing issues that arise during collaboration.

Comments

Right now it seems to just bubble under the surface, and it explodes randomly at every meeting. I think we actually need a consultant or someone to help here.

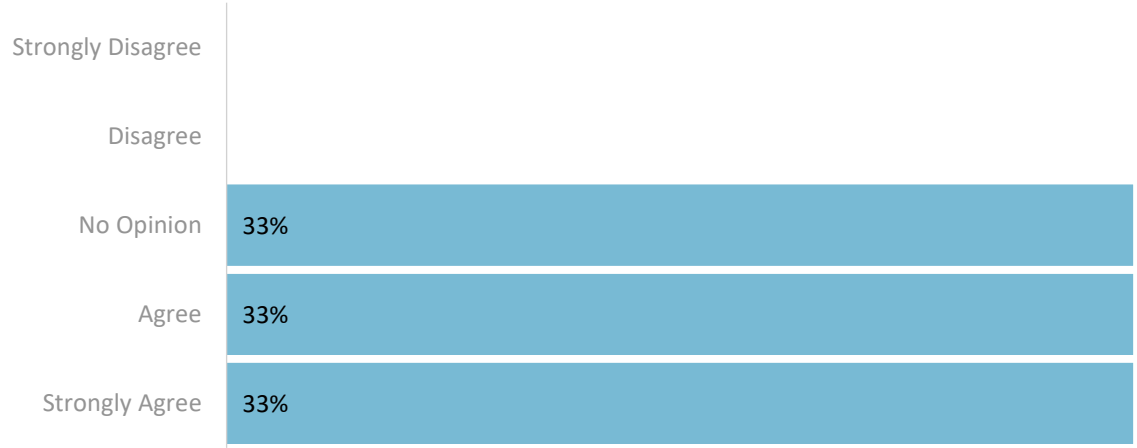
Collaboration within the committee or with other committees. Within committee not always clear we have alignment between executives and committee members on role of the committee

Not really. I feel like sometimes the management team just wears us down with defensiveness until we consent.

Evidence of successful conflict resolution and opportunities for improvement would help new members better understand issues that arise during collaboration

Question 3 of 3

Q3 The Quality, Patient Care, and Patient Experience Committee understands the role of effective governance and oversight of quality improvement initiatives and serves as an advisor to hospital management.



Comments

I think the board and some on the board really is trying to do governance, but the current sentiment is sometimes very defensive from the staff, and then the board members themselves do not help the situation by being very openly aggressive (even though they are rightly trying to do oversight).

Not sure if committee understanding role or exec team understanding committees role - but do not appear to be aligned.

Again, I think this is a question for management, not for the committee

Section 5: Evaluation and Improvement

3 Questions

Question 1 of 3

Q1 The Quality, Patient Care, and Patient Experience Committee regularly evaluates its own performance, processes, and activities.

Comments

I don't think we review ourselves all that much?

Yes, through these surveys and discussions that stem from them.

Excellent baseline work

Question 2 of 3

Q2 Assessment results are used to identify areas for improvement and implement changes.

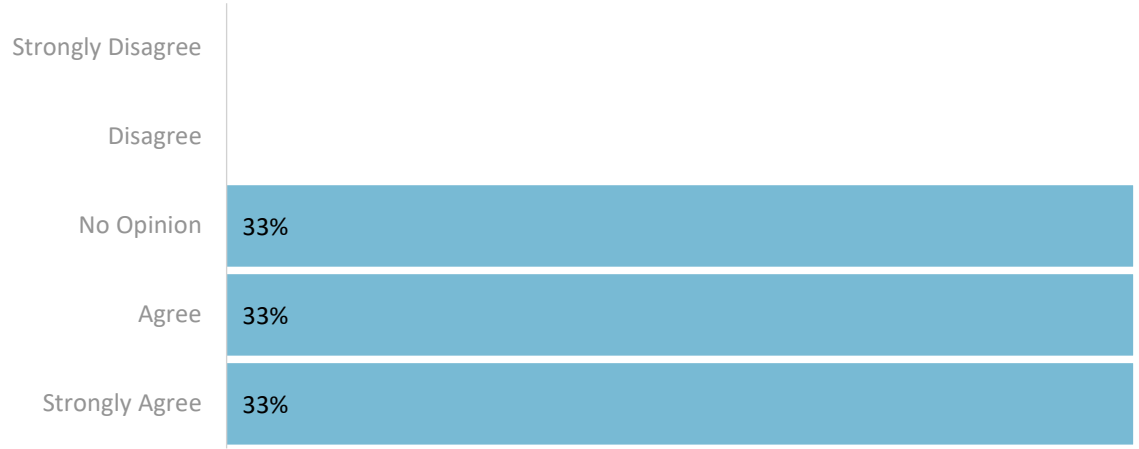
Comments

Haven’t had committee level assessment for a while don't believe.

This has definitely happened in the past to great effect.

Question 3 of 3

Q3 There a culture of continuous improvement within the Quality, Patient Care, and Patient Experience Committee.



Comments

In terms of committee itself improving processes - again not sure exec team fully bought in to committees role/ability to contribute
Working on it - this survey is a good place to start.
Excellent beginning

Section 6: Meetings and Communication

3 Questions

Question 1 of 3

Q1 The Quality Committee meets regularly and as needed.

Comments

Probably too regularly... (i.e. too often).

Question 2 of 3

Q2 Meetings are well-organized, with clear agendas, minutes, and action items.

Comments

Meetings right now are very well organized, but might not be organized around the right topics per se (i.e. patient experience focus).

Getting more alignment - but still fuzzy on exec team/committee action items/KPIs when KPIs not being met

Question 3 of 3

Q3 Quality, Patient Care, and Patient Experience Committee members are provided with the necessary information and resources to prepare for meetings.

Comments

I actually think the staff spends an absurd amount of time preparing for the meeting, way too much IMO to the point where they spend a week out of every month just on the reports. We need to figure out on both sides how to do this better (i.e. less meetings?).

Improving on provide context/status ahead of time on G

The time lag is frustrating with data often so delayed.

Section 7: Resources and Support

2 Questions

Question 1 of 2

Q1 The Quality, Patient Care, and Patient Experience Committee is provided with the necessary resources and support to fulfill its mission and responsibilities effectively.

Comments

Previous statements on senior exec team not fully supportive of Committee role as oversite when targets not being met.

Strongly agree with resources and support, disagree about whether we are asked the right questions and at the right level.

Question 2 of 2

Q2 Quality, Patient Care, and Patient Experience Committee members are provided with adequate training, education, and development opportunities.

Comments

Not applicable as we are just implementing the opportunity for attending conferences next year

I think most of us get experience outside of the committee, I'm not sure the committee itself does that much training anymore? We did more pre-covid.

Could do more math/controls training possibly for some committee caregivers and some more training on hospital improvement for non-caregivers

Could be better

This fell off a bit in the pandemic - would be good to see a few other hospital's processes to help us find the governance sweet spot.

Onboarding training excellent and comprehensive. Requests to share relevant quality improvement journal articles and other development opportunities not yet fulfilled.

Section 8: Comments and Suggestions

2 Questions

Question 1 of 2

Q1 Do you have any actionable suggestions for Quality, Patient Care, and Patient Experience Committee improvements?

Open Answer

1. More discussion on our progress regarding Health Equity
2. Designation of a C-Suite administrator who will champion patient experience

I think we need a coach or a facilitator to get the presumption of ill-will to really settle down between staff and member of the executive team.

We need to focus more on patient experience.

We need to think much more about the entire continuum of the health system instead of still focusing so much on the hospitals.

CEO, committee and exec team sit down and set clear processes/approaches/responsibilities for Committee vis a vis Quality Goals.

As we move to a meeting cadence that is less frequent, consider still pushing out reports on a monthly cadence to keep us familiar with the data and measures, and know that you'll need to spend more time priming us as we are further from the day-to-day.

Consider using checklists and comparison graphs to reduce oversight tasks. Consider 'journal club' or other means of disseminating new journal articles to interested committee members. Consider targeting patients and statisticians for committee membership.

Question 2 of 2 |

Q2 How would you like to provide subject matter expertise at the governance level to advance the excellence of quality care through El Camino Health?

Open Answer

As we enter this new year, I would like us to attend one of the two conferences suggested by Holly Beeman. After our continuing education jaunt, I suggest that the group that attends each conference report to the rest of the committee. If we get together and discuss what we learned among ourselves in addition to providing our subject matter knowledge, then we will be better able to work on translating the knowledge to actionable improvements.

Believe we need more aggressive cross committee communications. Many committees have very little time in front of full board -- and when they do they focus on their vertical issues -- where as many committees might have overlap/trade-offs with quality committee

1. Engage us in strategy - particularly when planning for launch/expansion/contraction of service lines. Important decisions that have a major impact on quality are made without our engagement (i.e., radiology cover; expansion of services)
2. Engage us on process oversight to keep us out of the weeds - (e.g., when do you make policy exceptions, why and how you are considering changing your approach to an RCA)

3. Provide us with enough information so that we can do surveillance - spot issues and concerns that are bubbling up; don't hide behind a carefully curated set of measures that are chosen to look good

By adding outside experience and contributing community perspectives.

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: June 5, 2023
Subject: Voice of the Patient Feedback

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

Summary:

1. Situation: This feedback is from a patient who had their baby at ECH MV.

2. Authority: To provide insight into the MCH patient experience and items that make a difference to our families and their experience while delivering a child at ECH.

3. Background: The MCH building has been in place since 1993 and while furniture replacements and upgrades have been made over the years, the current remodel and furniture upgrade is substantial bringing the building to contemporary care delivery environment standards with private NICU rooms and substantially larger postpartum rooms. The furniture will also be upgraded to a more comfortable and flexible configuration (see photos on page with patient comment)

4. Assessment: The MCH patients, staff, and leaders reviewed many options for patient furniture and settled on a comfortable (sheets available) couch converted to bed for partners or other family members providing comfort and flexibility. They gathered feedback from many different key stakeholders to assure the right fit for the environment. Cleaning capability is also a major consideration when selecting furniture for the hospital environment.

5. Other Reviews: None

6. Outcomes: When Phase I of the remodeled building opens (2nd and 3rd floor) the NICU on the 2nd floor will have new furniture and private rooms to accommodate the families and the MBU unit will also have new furniture for families to spend the night as well as a comfortable place to work and rest. Cleaning capability is also been evaluated by our infection prevention experts.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What was the process for the selection of the new furniture, were families included?

2. When will the new areas in MCH be open for patients/families?

Patient Comment from Press Ganey

The chair beds were nice but my husband was still uncomfortable. I don't think they have any sheets for a layer of softness. Other than that, he said the last hospital he went to for his sons delivery, didn't let down at all so it was an upgrade lol.

El Camino Health

EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, and Chief Quality Officer
Date: June 5, 2023
Subject: The Joint Commission National Patient Safety Goal (NPSG.16.01.01), Health Care Equity

Summary:

1. Background: The Joint Commission (TJC) established National Patient Safety Goals (NPSGs) in 2002 to help accredited organizations address specific areas of concern in regard to patient safety. The first set of NPSGs was effective January 1, 2003. The Joint Commission determines the highest priority patient safety issues, including NPSGs, from input from practitioners, provider organizations, purchasers, consumer groups and other stakeholders. For 2023, there are 12 unique patient safety goals in eight domains. The Joint Commission introduced a new goal (National Patient Safety Goal 16.01.01) to improve health care equity. Complying with this national patient safety goal is in effect as of July 1, 2023.

2. Assessment: The six elements of performance for NPSG.16.01.01 are;

    1. The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients.
    2. The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.
    3. The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.
    4. The hospital develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population.
    5. The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity.
    6. At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity.

3. Recommendation: Please review and reflect on the attached El Camino Health NPSG Health Care Equity Goal Action Plan during our Committee Meeting. Dr. Beeman will additionally share a power point presentation on Health Equity initiatives at ECH to stimulate discussion and idea generation during the meeting.

List of attachments:

1. TJC 2023 National Patient Safety Goals
2. El Camino Health NPSG Health Care Equity Goal Action Plan

The Joint Commission

2023 Hospital National Patient Safety Goals

(Easy-To-Read)

Identify patients correctly

NPSG.01.01.01

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01

Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01

Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01

Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01

Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.

Identify patient safety risks

NPSG.15.01.01

Reduce the risk for suicide.

Improve health care equity

NPSG.16.01.01

Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.

Prevent mistakes in surgery

UP.01.01.01

Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01

Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01

Pause before the surgery to make sure that a mistake is not being made.

ECH NPSG 16 Health Care Equity Action Plan 05.25.2023

	General Acute Care & Behavioral Health Care Hospital Requirement	Action Plan	Progress
EP1	The hospital designates an individual(s) to lead activities to improve health care equity for the hospital's patients	• Health Equity Department created in March 2023. • Health Equity Manager position created and hired. • A dedicated Health Equity data analyst was also hired in April 2023.	Completed
EP2	The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.	• Ongoing observations in ED around Homelessness status; • Engaging Community Partnerships Departments to help understand available community recourses and potentially developing a digital platform for our patients; • Engaging Care Coordination and Social workers in the Health Equity efforts;	In progress
EP3	The hospital identifies health care disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics (age, gender, preferred language, race and ethnicity) of the hospital's patients.	• Engage the main data stakeholder in addressing data accuracy and training opportunities (the department of analytics and business applications, clinical quality data management team, service line data stewards, EPIC developers; • Revamp the collection of RELDSOGI data and reduce missing data by at least 50%.	In progress
EP4	The hospital develops a written action plan that describes how it will improve health care equity by addressing at least one of the health care disparities identified in its patient population	• Build additional health equity infrastructure; • Develop a patient centric questionnaire for SDOH and sociodemographic data; • Adjust MyChart "Details about me" to provide safe and sensitive options around SDoH for patients to self-report.	In progress
EP5	The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health care equity	• Analyzing the Homeless Equity dashboard, we established opportunities that exist in optimizing our homeless identification and data collection process. Additionally, the newly Epic-developed tools around homelessness and SDoH documentation are not used at this time by our staff members. • We secured a dedicated resource in Clinical Informatics team to assist with implementation of those tools moving forward. • We also established a strong collaboration with Epic Health Equity dedicated team that helps us to advance our strategic plan around health disparities.	In progress
EP6	At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health care equity	• Continue engaging with local, state and federal agencies about health disparities. • Identify scientific literature and continue searching for evidence-based data to support our theories and projects • Engage and collaborate with the I-DEB Committee and Affinity Groups around RELDSOGI accurate information and education for frontline staff the importance of unbiased collection of these important health and social factors.	In progress

El Camino Health

EL CAMINO HEALTH
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Holly Beeman, MD, MBA, and Chief Quality Officer
Date: June 5, 2023
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QAPI) for 2023

Recommendation: Approve FY23 Quality Assessment and Performance Improvement Plan (QAPI)

Summary:

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

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

3. Assessment: The FY23 El Camino Hospital QAPI plan describes our ability to develop, implement, and maintain an effective, ongoing, hospital-wide, and data-driven quality assessment and performance improvement program, which also includes tracking and monitoring of adverse events and medical errors. A notable enhancement to our FY23 QAPI plan is a focused section (section II) on our Patient Safety Plan and Safety First Mission Zero efforts to eliminate preventable harm.

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

5. Outcome: The Committee will approve the FY23 ECH QAPI Plan

List of attachments:

1. FY23 Quality Assessment and Performance Improvement Plan with referenced QAPI addendums.

Status **Pending** PolicyStat ID **13375295**

Origination	05/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	05/2023
Next Review	1 year after approval

Owner	Franz Encisa: Director Quality and Public Reporting
Area	Quality
Document Types	Plan

Quality Improvement & Patient Safety Plan (QIPS)

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip and Knee, 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 1100 active, telemedicine, provisional and consultant, 328 affiliate physicians, and 116 independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

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

El CAMINO HEALTH VISION

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

El CAMINO HOSPITAL VALUES

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

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

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

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

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

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

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

DEFINITIONS:

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

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

SERVICES/PROGRAMS

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

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

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

Section I Quality Improvement Plan

PURPOSE

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

OBJECTIVES

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 based on the complexity of the ECH's services/ programs.
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.
12. Respond to external hospital environment or community needs in regards of providing equitable care and positive quality outcomes.

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears 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 Plan to the medical staff and hospital administration. Refer to Attachment A on Governance Information Flow.

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

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

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

Medical Executive Committee (MEC)

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

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

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, implement improvements for these activities, and ensure sustainability of improvements made
8. Reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities

Medical Staff, Employees, and Contracted Services

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

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is co-chaired by the past chief of staff, their designee, and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY 2023 is reduction of the Hospital Acquired Conditions (HAC) 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 23 Quality Council report schedule.

Quality Services Department

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

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

The Quality Services Department is also responsible for:

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 C and D.
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 E 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 Risk Management and Patient Safety department on efforts to manage and reduce risk through Root Cause, Apparent Cause and Common Cause Analyses as responses to adverse events and near misses and events reported to regulatory agencies
7. Collaborates on performance of failure mode and effectiveness analysis (FMEA) at least every 18 months with Risk Management and Patient Safety
8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
10. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
11. Providing data as requested to external organizations, see data provided in Attachment F
12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix E for current list
13. 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
14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health (CDPH) to improve the quality of care and safety of care provided to our patients.
15. Facilitates identification of health care disparities in the patient population by stratifying quality and safety data

Hospital Services

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

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

IMPROVING ORGANIZATIONAL PERFORMANCE

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

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

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.
9. Response to changes not only in the internal, but also in the external environment or the community it serves

Performance Processes

1. **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.

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.
   g. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs
      Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:
      a. Establish a performance baseline;
      b. Describe process performance or stability;
      c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
      d. Identify areas for more focused data collection to achieve and sustain improvement.

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.
a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

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. Other types of safety events identified in the Safety Event Management and Cause Analysis procedure;

Improvement Model and Methodology

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

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

The model has two parts:

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:

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

T – Time-Bound

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

- 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.

Process Improvement and the El Camino Health Operating System

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. 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 Process 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 foundation.

The Process 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 Process Improvement Advisors with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization.

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

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

ECHOS: El Camino Health Operating System

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

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

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 Plan focuses on specific quality measures in three areas: quality & safety, service and finance. See below for the Fiscal Year 2023 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the Hospital Acquired Conditions Index, ECH formed five teams to address opportunities with patient falls, Hospital-acquired Pressure Injuries (HAPI), Hospital-acquired Pneumonia (nvHAP), C. Difficile infections, and Surgical Site Infections at the beginning of the fiscal year and who meet bi-weekly: Patient Falls Committee, Skin Integrity Committee (SIC), Hospital-acquired Pneumonia (HAP) team, and Infection Control and Prevention subcommittees for C.Diff and SSI. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

Fiscal Year 2023 Performance Incentive Goal Dashboard

Pillar	Goal	Measurement Defined			
		FY 22	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.066	1.013	0.986	0.959
Service	Likelihood to Recommend (LTR) – Inpatient	80.8	80.8	81.0	81.3
	LTR – El Camino Health Medical Network	74.5	83.2	83.4	84.1
People	Culture of Safety	N/A	3.99	4.02	4.04
Finance	Operating EBIDA Margin	286.0M	$114.17M	$119.88M	$125.59M

HAC Index

FY22 Baseline					
Metric	Num.	Den.	Rate	Weight	Weighted Rate
Falls	153	patient days*	xxx	0.20	0.265
Hospital Acquired Pressure Injury	8		xxx	0.25	0.022
nvHospital Acquired Pneumonia	115		xxx	0.20	0.365
C. Difficile Infection	37		xxx	0.10	0.355
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06
HAC Index				Sum »	1.066

Commitment to Patient Experience

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

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

interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.

SECTION II: Patient Safety Plan

PURPOSE

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

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

The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing

quality and patient safety initiatives.

GUIDING PRINCIPLES

1. We believe that patient safety is at the core of a quality healthcare system.
2. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.
3. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.
4. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.
5. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.
6. We will foster a culture that respects diversity and inclusivity as a shared responsibility promoting access and equity for our workforce and patients.

OBJECTIVES

1. Deliver high quality safe care for every patient.
2. Engage our workforce and patients in safe practices at work at all levels of the organization using SAFETY skills (universal skills).
3. Promote a culture of safety.
4. Build processes that improve our capacity to identify and address patient safety issues.
5. Classify patient safety events and perform cause analysis to better undertand cauess of errors and areas of improvement using the root cause or apparent cause analysis tools as delineated in the Safety Management and Cause Analysis procedure.
6. Educate workforce, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm.
7. Encourage organizational learning about medical/health care errors.
8. Incorporate recognition of patient safety as an integral job responsibility.
9. Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame.
10. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions.
11. Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.
12. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

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

Governing Board

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

Quality Committee of the Board

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

Enterprise Hospital Committees

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

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

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

Patient Safety Department

El Camino Hospital has a Patient Safety Department consisting of a Director of Risk Management and

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

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

1. Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
2. Coordination of an annual Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.
3. Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
4. Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
5. Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach and Leader Mentor program as well as development of a Patient Safety Academy.
6. In partnership with Risk Management and Quality, performance of Failure and Effects Mode Analysis (FMEA).
7. In partnership with Risk Management, implementation of performance improvement related to patient safety based on trends or needed risk mitigation.
8. Regulatory follow up needed related to patient safety
9. Promote transparency of errors and mistakes through sharing lessons learned

PATIENT SAFETY PLAN

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

1. Incident reporting is a cornerstone of Safety First/Mission Zero and our Culture of Safety. Training is provided to all workforce members upon hire and with refreshers on reporting concerns using ISAFE, the hospital's electronic incident reporting system with the expectation that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/ improvements. The ISAFE system also allows for reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to ensure timely response and follow-up, track and trend feedback themes and inform quality improvement opportunities.
2. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment J) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.
3. As this organization supports the concept that errors occur due to a breakdown in systems and processes and a fair and just culture, workforce members involved in an event with an adverse

outcome will be supported by:

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

4. PESC Dashboard and Patient Safety Targets, Refer to Attachment G. The PESC establishes a dashboard annually to monitor patient and employee safety events with desired quality targets based on any available benchmarks and organizational goals.
5. Patient Safety Priorities are based on the following:
    a. Serious Safety Events as identified by the Safety Event Classification team whose process is described in the Safety Event Management and Cause Analysis procedure
    b. Other patient safety events that are not classified as an SSE but raise concerns due to aggregate trend or potential for harm
    c. Information from internal assessments related to patient safety such as tracers
    d. Information from external organizations related to patient safety such as the Joint Commission Sentinel Event Alerts, ISMP
    e. Accreditation and regulatory requirements related to patient safety
    f. Fallouts from PESC dashboard.

Patient Safety Initiatives

• Safety First Mission Zero SAFETY skill program • Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis • Hand Hygiene Audits • Monthly Leader and Executive Rounding using 4C SAFETY skill scripts • New hire and manager Orientation to include SAFETY skill education • HeRO Recognition and Award Program	
Quality Indicators of Patient Safety:	
• Nurse Sensitive Indicators (Medication Safety, Falls) • Healthcare Associated Infections • Surgical site infections • Surgical Safety Checklist	• Pressure Injuries • Transfusion reactions/ blood/blood product administration • Use of Restraints

	• Employee Safety • Serious Safety Event Rate • Culture of Safety Survey results
Safety Programs:	
• Central Safety Committee • Emergency Preparedness Committee • Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Antimicrobial Stewardship Program • Radiation Safety Committee
Data from Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

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

Confidentiality

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

Data, reports, and minutes of the Quality Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality, Risk Management and Patient Safety Departments and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be

accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Chief Quality Officer, Sr. Director, Quality Services Department, Director of Risk Management or Patient Safety or the Compliance Officer.

Annual Evaluation

The Chief Quality Officer or the Sr. Director of Quality Services, and the Director of Risk Management and Patient Safety shall coordinate the annual evaluation of the Quality and Patient Safety program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address both 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.

Attachments

Att A Governance Information Flow.pdf

Att B FY23 Combined Quality Council Reporting Calendar rev 1.25.22.pdf

Att C Org Goals and Quality FY23.pdf

Att D Board Quality and Safety Dashboard FY23.pdf

Att E Abbrev Registries List.pdf

Att F External Regulatory Compliance Indicators 2022.pdf

Att G Patient Employee Safety Committee Dashboard

Att H Safety First/Mission Zero Leader Skill Toolkit

Att I Safety First/Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

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

Attachments

Att A Governance Information Flow

Att B FY23 Combined Quality Council Reporting Calendar

Att C Enterprise Quality FY23

Att D STEEEP FY23Q2 for Board

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicator 2023

Att G Patient Employee Safety Dashboard FY23 Q2

Att H Leader Skills Toolkit

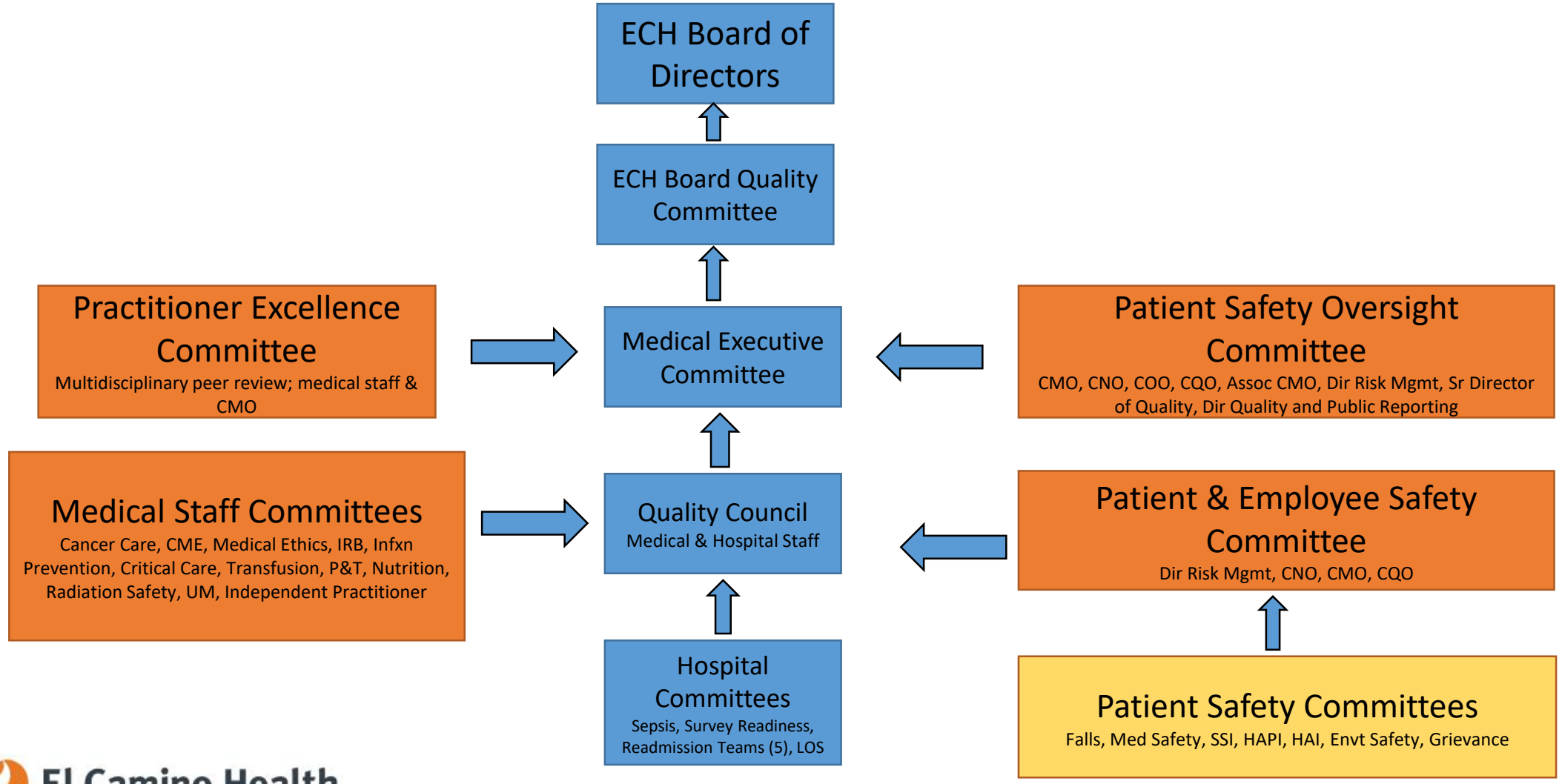
Att I Universal Skills Toolkit

Att J HPI Classification Tools for SEC

Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	05/2023
Quality Council	Franz Encisa: Director Quality and Public Reporting [PS]	04/2023
Patient and Employee Safety Committee	Delfina Payer: Quality Data Analyst	03/2023
	Franz Encisa: Director Quality and Public Reporting	03/2023

Quality Assurance and Performance Improvement—Governance Information Flow FY23



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FY 23 Quality Council

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

1st Wednesday – 7:00 am to 9:00 am

2022	**July 6, 2022**	**August 3, 2022**	**September 7, 2022**
		• Antibiotic Stewardship • Health Information Management • Orthopedics Service Line • Patient Experience (HCAHPS)	• Nutritional Services • Pharmacy • Heart/Vascular Institute • Care Coordination
	October 5, 2022	**November 2, 2022**	**December 7, 2022**
	• MV Emergency Dept. • LG Emergency Dept. • ED Physician Service Contract Evaluation • Information Services	• 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
2023	**January 4, 2023**	**February 1, 2023**	**March 1, 2023**
	• 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 5, 2023	**May 3, 2023**	**June 7, 2023**
	• Imaging Services / Radiology • Contract Services • Value Based Purchasing • Sterile Processing	• Core Measures • CPR • Laboratory & Pathology • Utilization Management	• Palliative Care • MV Peri-Operative Services • LG Peri-Operative Services • Stroke Program

Revised: January 26, 2023

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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 ▪ Utilization Management ▪ Value Based Purchasing	▪ Regulatory Update

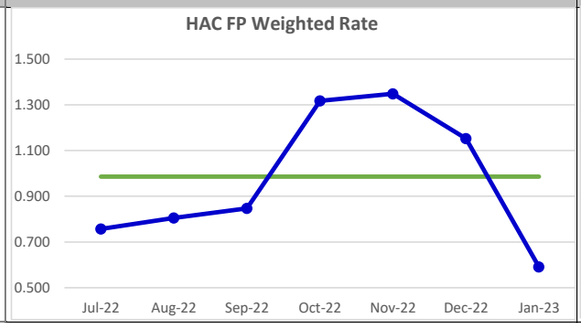
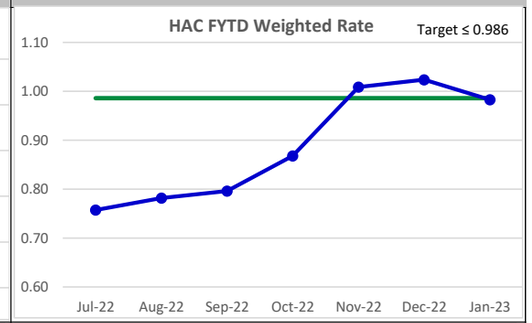
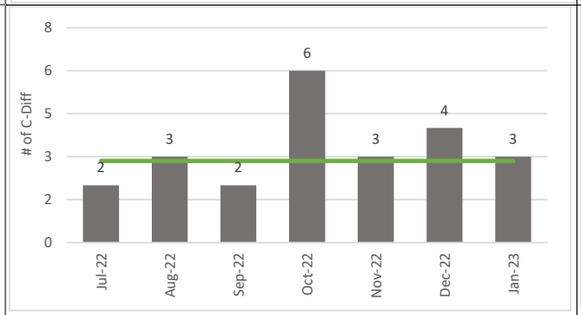
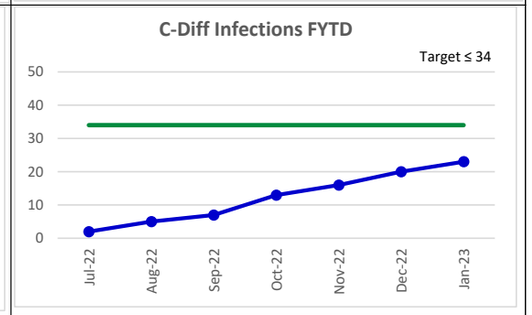
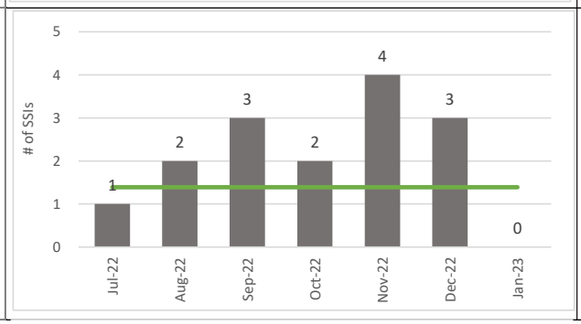
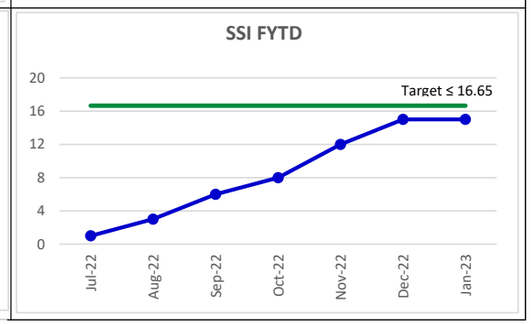
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:

March, 2023

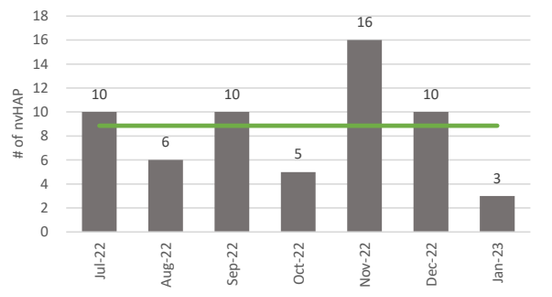
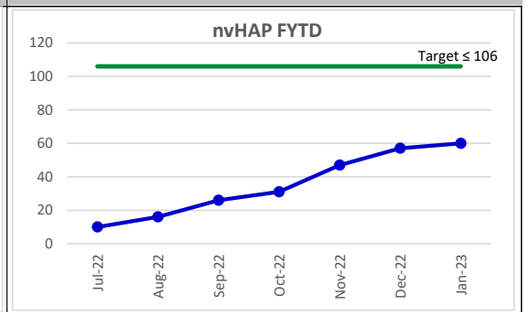
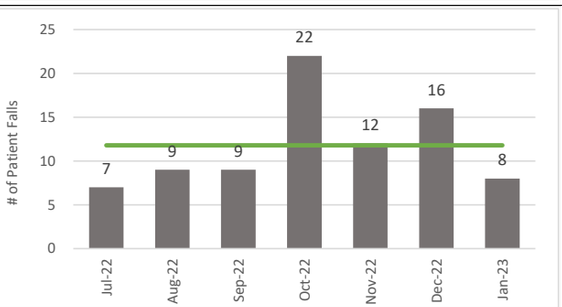
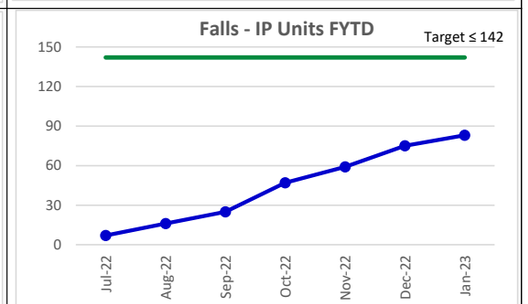
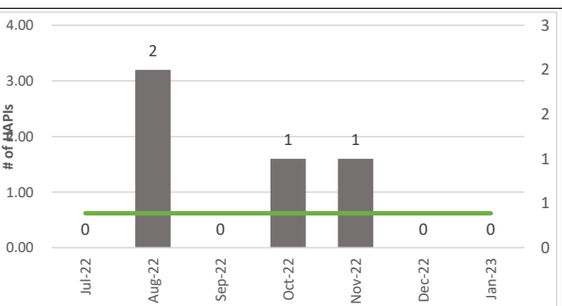
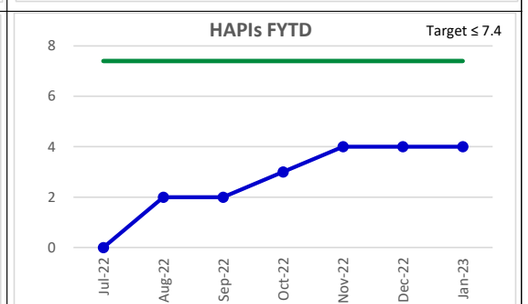
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index** *Latest data month: Jan, 23*	0.591	0.983	1.066	0.986 (7.5% ↓)		
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Jan, 23*	3	3.29 / month	3.08 / month	2.85 / month		
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Jan, 23*	0	2.14 / month	1.50 / month	1.39 / month		

El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:
March, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Jan, 23*	3	8.57 / month	9.58 / month	8.86 / month		
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Jan, 23*	8	11.86 / month	12.75 / month	11.79 / month		
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Jan, 23*	0	0.57 / month	0.67 / month	0.62 / month		

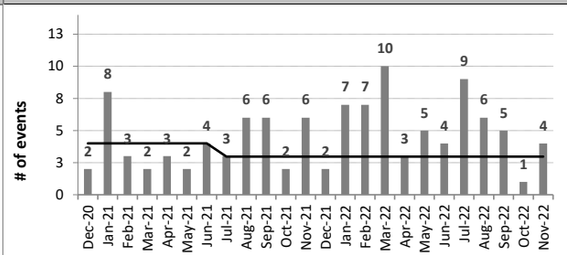
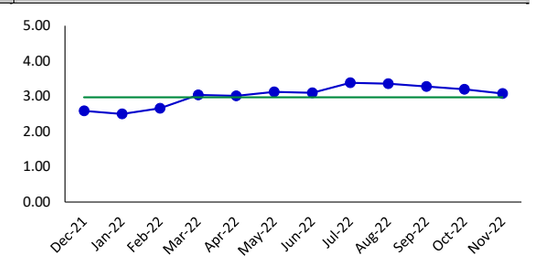
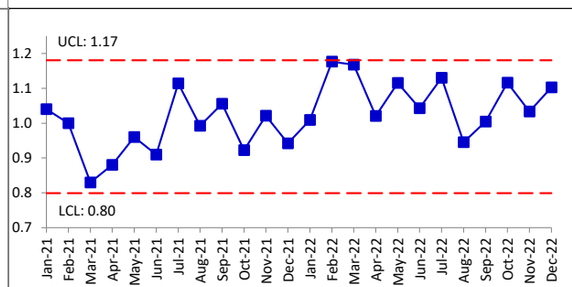
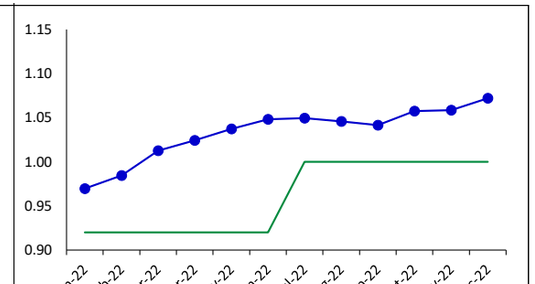
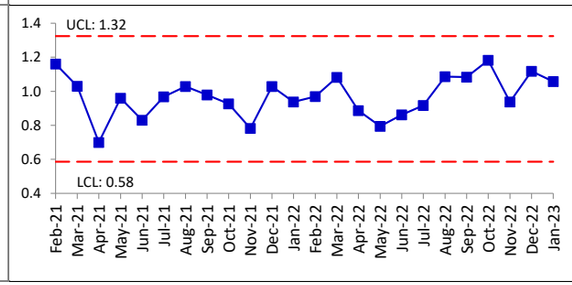
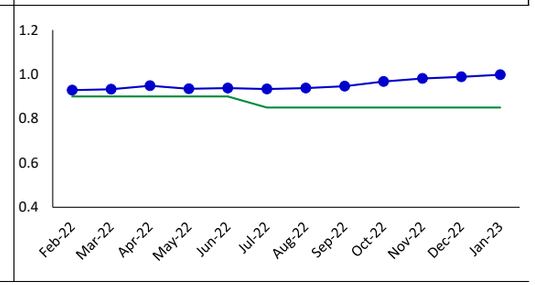
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:

March, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Serious Safety Event Rate (SSER)** **Latest data month: Nov, 22*	4	3.08 (63/204828)	3.10 (Jul, 21 - Jun, 22)	n/a		
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Dec, 22*	1.10 (9.97%/9.04%)	1.06 (9.24%/8.76%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*	1.06 (2.67%/2.53%)	1.06 (2.10%/1.98%)	0.94	0.85		

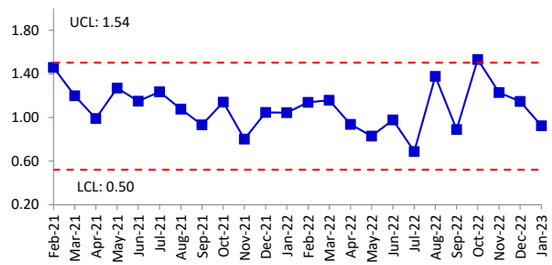
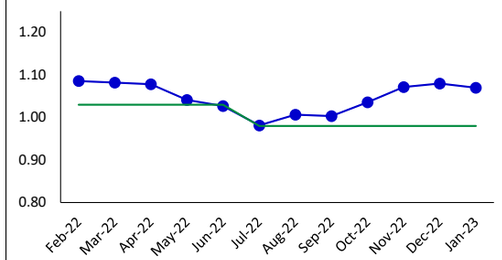
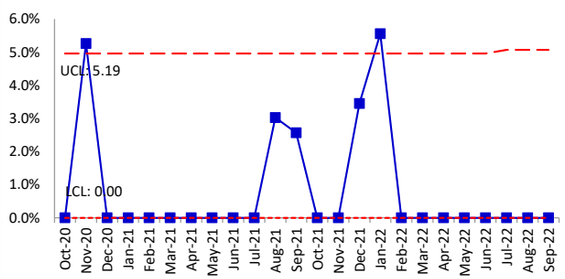
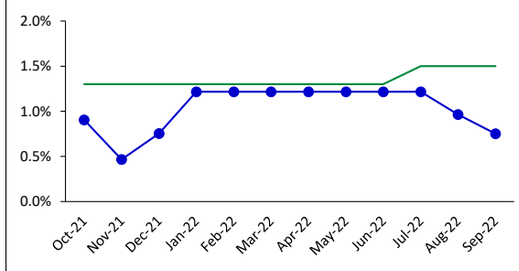
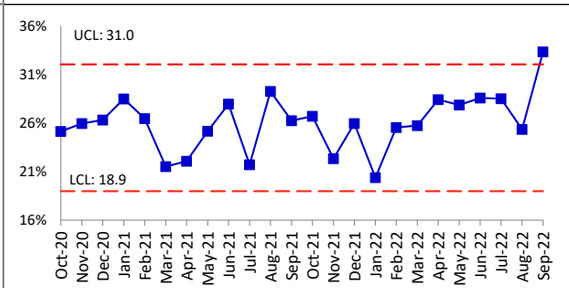
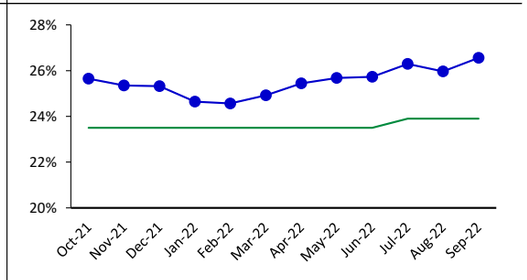
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:

March, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*	0.92 (13.29%/14.37%)	1.11 (13.11%/11.82%)	1.03	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Sept, 22*	MV: 0.0% (0/24) LG: 0.0% (0/9) ENT: 0.0% (0/33)	MV: 0.0% (0/77) LG: 0.0% (0/27) ENT: 0.0% (0/104)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	1.5% (FY23 Target)		
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Sept, 22*	MV: 37.0% (50/135) LG: 20.5% (8/39) ENT: 33.3% (58/174)	MV: 30.5% (146/479) LG: 21.4% (24/112) ENT: 28.8% (170/591)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	23.9% (FY23 Target)		

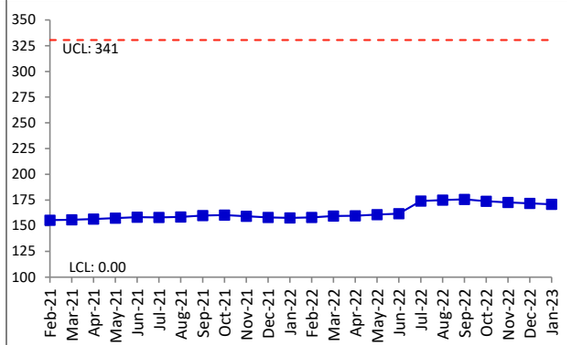
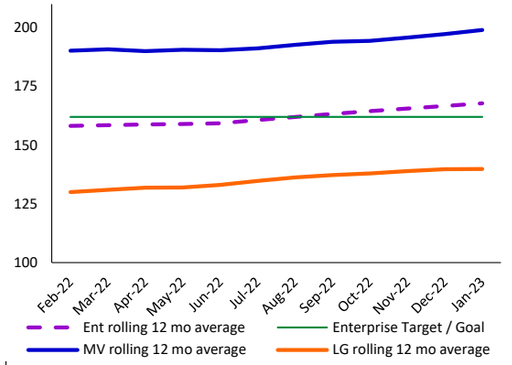
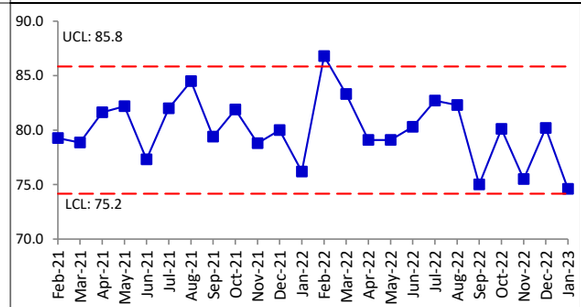
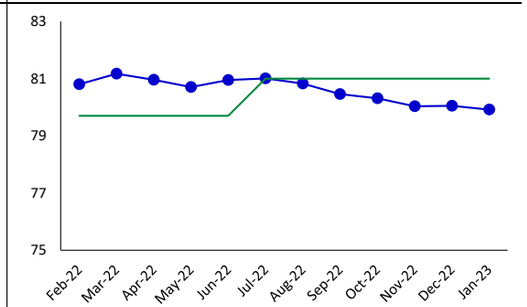
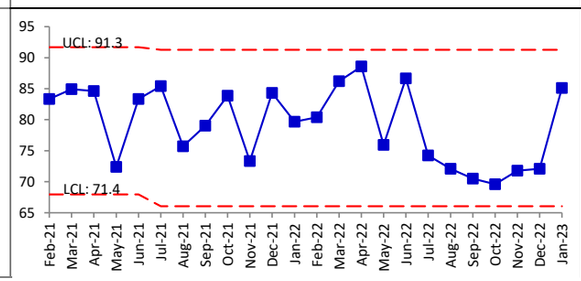
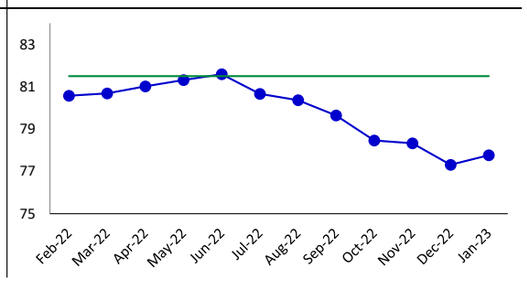
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:

March, 2023

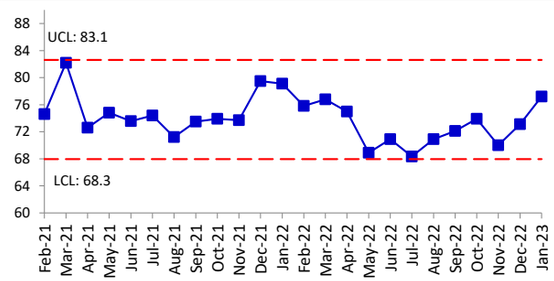
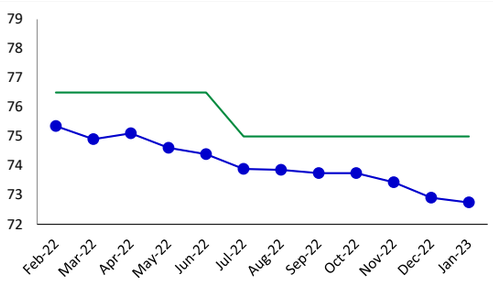
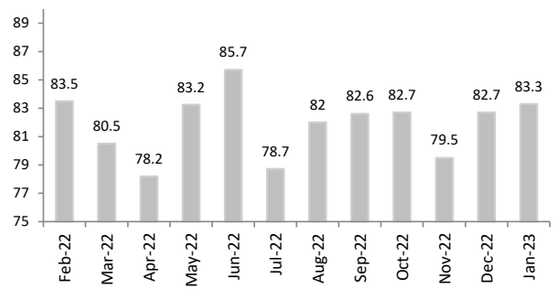
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
13	**OP18b: Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Jan, '23*	MV: 191 mins LG: 140 mins ENT: 166 mins	MV: 200 mins LG: 142 mins ENT: 171 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins		
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*	74.6	78.7	80.8	81.0		
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*	85.1	73.5	81.3	81.5		

El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:
March, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Jan, 23*	77.2	72.1	74.5	75.0		
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Jan, 23*	83.3	81.7	83.2	83.4		NA

Notes:

1) SSER through Nov, 22
2) Readmissions through Dec, '22
3) PC-01 & PC-02 FY23Q1 (July - Sept 2022) results available
4) ECHMN: reflect new vendor (PG) survey results
5) Updated 2/21/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Jan, 23*	As of Jan, '23 the FYTD HAC Index (0.983) is around target of 0.986.	H. Beeman, MD	New for FY23, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (5) key inpatient safety events. The elements of the composite are weighted as noted: Falls 20%, hospital-acquired Pressure Injuries (HAPIs) 25%, non-ventilator hospital-acquired pneumonia (nvHAP) 20%, Clostridium difficile infections (C-Diff) 10%, and surgical site infections (SSIs) 25%.	See below
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Jan, 23*	Jan, '23 FYTD monthly average of **3.29 is 15.4% over the FY23 target of 2.85/month.**	C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Jan, 23*	Jan,'23 FYTD monthly average of 2.14 exceeds **the FY23 target of 1.39/month.**	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Jan, 23*	Jan, '23 FYTD monthly average = 8.57 **which is 3.3% under the FY23 target of 8.86/month.**	C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Jan, 23*	Jan, '23 FYTD monthly average of **11.86 is slightly over (0.6%) the FY23 target of 11.79/month.**	Nursing	1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'. 2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports. 3) Numerator exclusions: L&D, intentional falls. 4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU 5) Formula: (# falls/patient days) * 1,000 6) Latency: rare; corrections may change previously reported results.	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Jan, 23*	2nd consecutive month of 0 cases, the FYTD monthly average of **0.57/month is slightly under the FY23 target of 0.62/month.**	A. Aquino	1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries 2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & proned Covid-19 patients 3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	Numerator: EPIC Report and staff validation Denominator: EPSi patient days

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Serious Safety Event Rate (SSER)** **Latest data month: Nov, 22*	FY23 YTD Serious Safety Events (Top 60%): Medication Errors - 15%; SSI - 15%; Falls - 10%; HAI - 10%; Skin Integrity Concern - 10% 9-16-22: (Per Risk Mgmt) FY23 target deferred for now; the SSER is expected to ↑ @ this phase of the HRO journey. PG recommends a new baseline be established in 6-8 months, w/ ↓ over 2yrs after the new baseline.	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HPI Systems
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** * Latest data month: Dec, 22	**FYTD performance > than the FY23 target.**	H. Beeman, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*	(61) deaths Dec, '22, (53) deaths Jan, '23 **FYTD performance of 1.06 is > target of 0.85.**	H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*	Dec, '22: (28) deaths attributed to Sepsis representing 46% of Dec, '22 expirations (*n* =61). Jan, '23: (19) deaths attributed to Sepsis representing 34% of Jan, '23 expirations (n=53). **FYTD performance of 1.11 is > target of 0.98.**	J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Premier Quality Advisor
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *****Latest data quarter: Sept, 22*	Final data for July, August & Sept 2022 released. **FYTD beating both baseline (FY22) & FY23 target** **Trending down**	H. Beeman, MD	1) Numerator: Patients with elective deliveries 2) Denominator: Delivered newborns with gestation weeks >/= 37 to 39 weeks For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): The FY23 target for PC-01 1.5% (top 25th %ile for MDC). MCH needs to retain some ability to do medically indicated, yet not meeting criteria, early deliveries.	IBM CareDiscovery Quality Measures
12	**PC-02: Cesarean Birth** (reported quarterly) *****Latest data quarter: Sept, 22*	Final data for July, August, & Sept 2022 released. **FYTD 28.8% above baseline (FY22) & FY23 target of 23.9%** **Trending up**	H. Beeman, MD	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): FY23 target for PC-02 NTSV is 23.9%. Given our population (Asian average in CA was 25.2% from 07/2021-06/2022 for same nursery level CA MDC, + have significantly older population than CA), we think this is pretty aggressive.	IBM CareDiscovery Quality Measures

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
13	**OP18b: Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Jan, '23*		J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. **Time stamp is used for this calculation:** ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*	IP: Inpatient units overall did not meet goal for December, however there was a substantial improvement. Los Gatos was not at target the previous month, but due to an increased effort on nurse leader rounding, bedside shift report and purposeful rounding (known as the Power of 3), Los Gatos did achieve target this month. Los Gatos is also at target for FYTD (fiscal year to date). In our Mountain Campus, 3B increased substantially due to an increased focus on nurse leader rounding, nurse communication (key drivers) and WeCare behaviors. We will continue to enforce these best practices. **FYTD performance of 78.7 lags behind the FY23 target of 81.0.**	C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*	We continue to struggle with visitor and family issues and construction in MCH in our Mountain View campus. Our Los Gatos campus is on target for the last couple of months. The recent change in our visitor policy has helped, however our construction issues prevail. The team is focused on proactive rounding and we are moving patients often to accommodate a quieter room. As the census increases, there was more patient movement which resulted in dissatisfied patients and families. **FTYD performance remains ↓ target of 81.5, though reflects seeing a 4rth consecutive month of improvement**	C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Jan, 23*	We did not meet our target for the month of December, but did improve in both LTR (likelihood to recommend) and our key driver of staff worked together. We continue to have record high census and acuity and we continue to focus on patient flow, improving throughput and wait times. For those patients waiting greater than four (4) hours, are scores decline substantially. We are working on a plan to discharge lower acuity patients faster and working on continuing our teamwork. The new ED Navigator is now on board and is helping with communication about wait times and other customer service issues that arise. **FYTD performance slightly ↑ improved to 72.1 from prior month & remains below target of 75.0.**	C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Jan, 23*	We did not meet our target for the month of December, but had increases in our overall score, our primary care numbers and our urgent care scores. We are focusing on training for staff and providers and have multiple plans in place to address our increased volume, staffing issues, and operational issues impacting our clinics. **FYTD performance of 81.7 < target of 83.4, though reflects a slight improvment over last month.**	C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Notes:

1) SSER through Nov, 22
2) Readmissions through Dec, '22
3) PC-01 & PC-02 FY23Q1 (July - Sept 2022) r
4) ECHMN: reflect new vendor (PG) survey
5) Updated 2/21/23

Month to Quality Committee of the Board: February, 2023

El Camino Health

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				
		FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FYTD
Safe Care	HAC Index	1.05	1.3	1.6	0.86	1.066	**0.986**	0.80	1.25			**1.01**
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	7	14	9.25	**8.56**	7	13			**10.0**
	HAC Component: Surgical Site Infections (SSI)	5	4	7	2	4.5	**4.16**	6	7			**6.5**
	HAC Component: nvHAP	36	29	26	24	28.75	**26.59**	26	31			**28.5**
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	**35.38**	25	50			**37.5**
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	**1.85**	2	2			**2.0**
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	25% (1/4)	10% (1/10)	75.0% (6/8)	0% (0/6)	28.6% (8/28)	**50%**	50% (4/8)	71.4% (5/7)			**60% (9/15)**
	Stroke: Door-to-Groin <= 90 minutes	50% (1/2)	28.6% (2/7)	50% (1/2)	25% (1/4)	33.3% (5/15)	**50%**	100% (2/2)	75.0% (3/4)			**83% (5/6)**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	**84%**	78.43%	78.34%			**78.38%**
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	**1.00**	1.02	1.04			**1.03**
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	**0.85**	1.03	1.07			**1.05**
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	**0.98**	1.02	1.26			**1.14**
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	**23.5%**	---	---	---	---	---
Efficient	OP18b: Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	**162 min**	176 min	169 min			**170 min**
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%			**97.3%**
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%			**97.6%**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	**81**	79.9	78.8			**79.4**
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	**75**	70.3	72.3			**71.3**
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	**81.5**	72.3	71.1			**71.8**
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	**83.4**	81.1	81.6			**81.4**

Updated: 1/18/23

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

Legend:

- **Green: At or exceeding target**
- **Yellow: Missed target by 5% or less**
- **Red: Missed target by > 5%**
- **White: No target**

Cell: N7
Comment: Mary_Mc:
This displays the FYTD quarterly average.

Cell: B16
Comment: Readmission Index FY23Q2: displaying 2 months only; too early to run December '22 Readmission Index. MMc

Cell: B19
Comment: PC-02 Calendar:
FY22Q4 will be submitted to CMS 11/1; then reported on next STEEEP Feb, '23. FY23Q1 will be available for reporting after 2/1/23 upon submission to CMS. MMc

Cell: B20
Comment: Arith Obs LOS/Geo Exp LOS: Sep, '22 previously reported data was based upon all inpatients instead on only Medicare Inpatients. Corrected past data; notified Sr. Leadership. MMc

Cell: B23
Comment: % Ethnicity: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

Cell: B24
Comment: % Race: New for FY23; no target. Definition: Numerator: % that are populated with a valid value - excluding: Blanks, Refused to Answer or Unknown. Population: Inpatients (Patient Type = Inpatient) + ED + Outpatients Patient Type = Observation or Surgical Day Care). MMc

El Camino Hospital Data Registries – March 2023 Attachment E

#	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

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

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 2023 REPORTING PERIOD ATTACHMENT F

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	

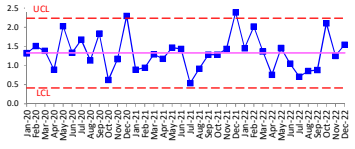
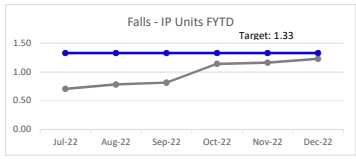
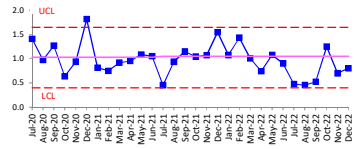
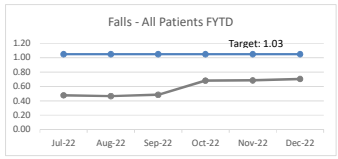
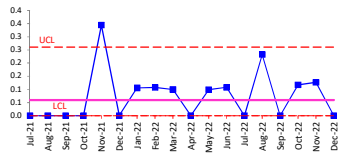
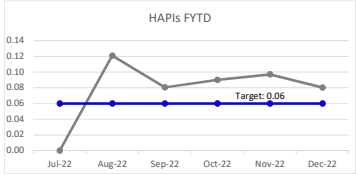
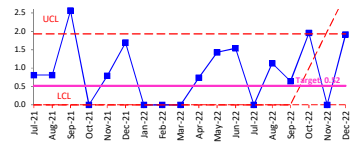
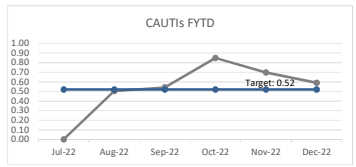
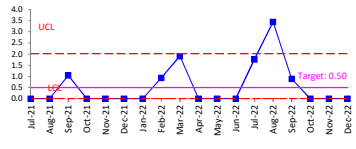
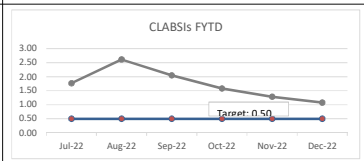
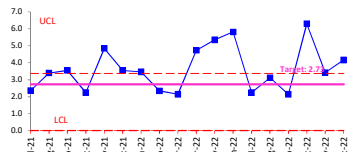
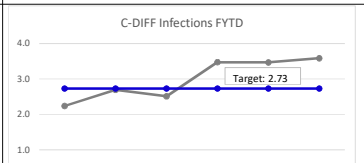
EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2022 REPORTING PERIOD ATTACHMENT G

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

Patient and Employee Safety Dashboard

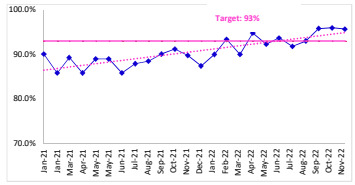
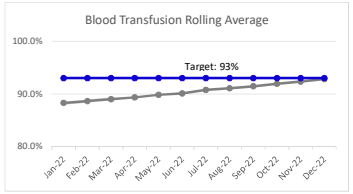
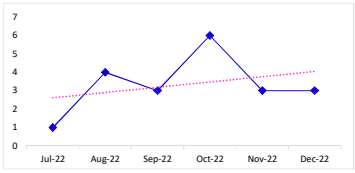
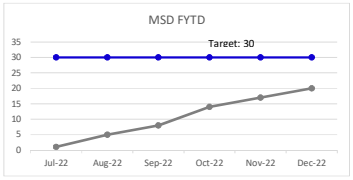
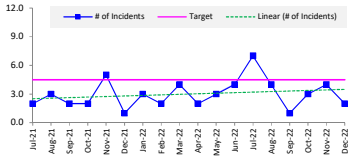
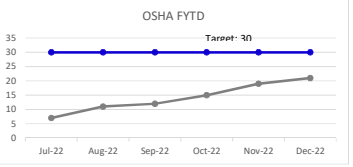
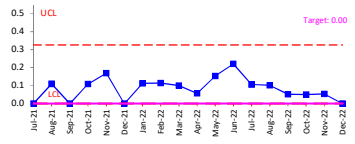
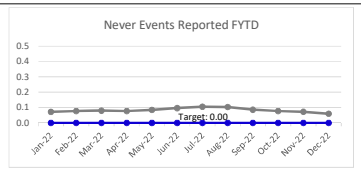
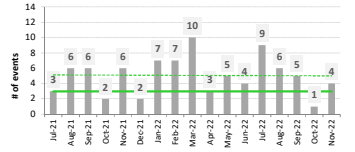
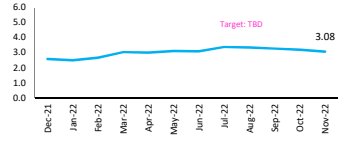
Reporting Period: **FY23 End of Q2** (unless otherwise specified)

		Performance		Baseline	Target	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
	SAFETY EVENTS	FY23, Q2	FYTD 23	FY22 Actual	FY23 Target/ Goal	*Displaying at least the last 24 months of available data*			
1	**IP Units area Patient Falls Reported to NDNQI** *per 1000 Patient Days (NDNQI reported)* *excludes ED, L&D, and intentional falls (ED rate calculated separately)* *Latest data month: Oct - Dec 2022*	0.33 50/152765	1.23 75/61024	1.33 153/115261	1.33 11.79 / mo (7.5% ↓)			October: 25 Inpatient Area falls, of those 3 were ED falls (MV) which are calculated separately Total October NDNQI = 22, Total November NDNQI is 12 and Total December NDNQI is 16 as well. There were 50 falls in FY23 Q2.	Andria Mills
2	**All Patient Falls - Internal (ECH licensed facilities)** *All patient falls per 1000 Adjusted Patient Days (EPSI Report)* *Latest dat month: Oct - Dec 2022*	0.92 (54/58560)	0.71 (82/116302)	1.03 (226/218410)	<=0.95 (209 falls) (7.5% ↓)			October is 25, November is 13, and December is 16 as well.	Andria Mills
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: Oct - Dec 2022*	0.08 (2/25026)	0.08 4/49868	0.07 8/111512	0.06 / mo (7.5% ↓)			Oct: 1, Nov:1, and Dec.: 0. Total FY23 Q2: 2 FYTD rate of 0.08.	Ann Aquino
4	**HAI- Catheter Associated Urinary Tract Infection (CAUTI)** *per 1000 Urinary Catheter days* *Reporting period: Oct - Dec 2022*	1.91 (3/4637)	0.59 (6/10168)	0.84 (13/15516)	Target: 0.52 MV = 7 LG = 1 SIR <= 0.75 (SIR is not an infection rate, for reference only)			FYTD 23 performance exceeds the target rate of 0.52 4 for Oct 2022 and '0' CAUTI for Nov and Dec 2022	Catherine Nalesnik
5	**HAI- Central Line Associated Blood Stream Infection (CLABSI)** *per 1000 Central Line Days* *Reporting period: Oct - Dec 2022*	0.00 (0/2645)	1.07 (7/6520)	0.33 (4/12242)	Target: 0.50 MV = 5 LG = 1 SIR <= 0.50 (SIR is not an infection rate, for reference only)			FYTD 23 performance exceeds the target rate of 0.50	Catherine Nalesnik
6	**HAI- Clostridium Difficile Infection (C.diff)** *per 10,000 Patient Days* *Reporting period: Oct - Dec 2022*	4.66 (13/27895)	3.58 (20/55800)	3.08 / mo	Target rate: 2.73 (2.85 c.Diff /month) (7.5%↓) SIR <= 0.70 (SIR is not an infection rate, for reference only)			HAC Index component on Quality Dashboard FYTD 23 performance exceeds the target rate of 2.73	Catherine Nalesnik

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY23 End of Q2** (unless otherwise specified)

		Performance		Baseline	Target	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
	SAFETY EVENTS	FY23, Q2	FYTD 23	FY22 Actual	FY23 Target/ Goal	*Displaying at least the last 24 months of available data*			
7	**Blood Transfusion Completed within 4hrs of Issue Time %** *Reporting period: Oct - Dec 2022*	95.8% (Avg FY23 Q2)	94.3% (Avg FYTD)	91.2%	↑93%			There is a change the FY goal from 98% to 93%. It is suggested that 2% improvement would be good since it is already above 90%. For FY23 Q2 was all above 95%.	Jeong Chae
8	**# of MSD (musculoskeletal disease) OSHA Recordable employee injuries NOT related to patient handling** *Reporting period: Oct - Dec 2022*	12	20	35	30 (↓ 35 from FY22)			The second QTR F/Y 23 we had 12 MSD (musculoskeletal disease) OSHA Recordable employee injuries NOT related to patient handling. October – 6 injuries November – 3 injuries December – 3 injuries	Mari Numanlia-Wone
9	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* *Reporting period: Oct - Dec 2022*	9	21	33 (2.8/ mo)	30 (10% ↓ from FY22 performance) (2.54/ mo)			There were 9 CAL-OSHA recordable workplace violence incidents in the 2nd qtr FY 23. Oct 2022: 3, Nov 2022: 4, and Dec 2022: 2.	Matthew Scannell
10	**Never Events Reported to CDPH Rate** (includes expired patients) *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2022*	0.03 2/58560	0.06 7/116302	0.10 (21 events)	0.0			Never Event data for FY23, Q2 Oct 2022: HAPI 2 2 (Stage 3, MV-3B, left ear, oxygen tubing medical device-related) (Stage 3, MV-4B, right ear, oxygen tubing medical device-related) Nov 2022: HAPI 1 (Unstageable, right nares MV-3B, NGT medical device-related) Dec 2022: None	Franz Encisa
11	**Serious Safety Event Rate (SSER)** # of events/ FYTD = rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* *Reporting period: *as of Nov 2022*	4 *as of Nov 22	3.08 63/204553	3.10 (Aug 2021 - Jul 2022)	TBD			As of Nov 22, there are 4 events classified as SSE. Oct 22: 1 As of Nov, 2022: 1 Fall 1 Medication Event 1 Delay in Treatment 1 Wrong Body Part SSER rolling 12 month average as of November 22 is 3.08.	Sheetal Shah

Safety First / Mission Zero:
Our High Reliability Leader Toolkit

At El Camino Health, we are committed to eliminating preventable harm to patients, visitors, employees and medical staff. To achieve our goal of providing consistently safe and error-free care, we will lead the way to extending Safety First/Mission Zero behaviors and tools to every action, both strategic and tactical, from the front line to the executive level.

Leader Skills	Leader Methods
Living the Safety Message	• Start every meeting with a safety message • Put safety first in decision making • Protect those who speak up for safety
Leading Safe and Reliable Operations	• Tiered daily safety huddles • Top 10 safety list • Real-time simulation and testing
Building Engagement and Accountability	• 4 Cs to influence • 5:1 feedback • Fair and just culture
Finding Problems and Fixing Causes Together	• Learning boards • Apparent cause analysis • Sharing lessons learned

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Universal Skills Toolkit

I commit to Safety First/Mission Zero behaviors and tools for our patients, families, visitors and colleagues.

safety firstmission zero

S **Speak Up for Safety**	• Share safety concerns with your team. • Immediately notify chain of command about patient and/or workforce harm events. • Speak up using **ARCC:** **A**sk a question. **R**equest an alternative. Voice a **C**oncern: "I have a safety concern." If necessary, escalate through **C**hain of command. • Report safety concerns in appropriate **electronic reporting system**.
A **Accurate Communication**	• Communicate concerns using **SBAR**: **S**ituation – Give a brief statement of the problem. **B**ackground – Share a concise overview of the facts. **A**ssessment – Summarize relevant observations. **R**ecommendation – Provide your suggestion for addressing the situation. • Communicate using **Three-Way Repeat and Read Back**. • Use **letter and number clarification**.
F **Focus on the Task**	• Pay attention to detail, minimize distractions. • Do self checks using **STAR**: **S**top – Pause for a moment to focus your attention on the task at hand. **T**hink – Consider the action you are about to take. **A**ct – Concentrate and carry out the task. **R**eview – Check to make sure that the task was done correctly.
E **Embrace a Questioning Attitude**	• Use **Clarifying Questions** to understand next steps. • Use **QVV** technique when you interpret information. **Q**ualify – Ask yourself if this is a good source of information. **V**alidate – Ask yourself if the information makes sense. **V**erify – If the answers to the above questions are no, check with an expert or known reference before proceeding.
T **Take Thoughtful Action**	• Have procedures in hand for high risk/complex/infrequent tasks so you can easily check what to do and ensure it is done right (**Continuous Use** • Know how to locate your reference materials such as policies, procedures and guidelines, and use when unsure of how to proceed (**Reference Use**). • Use **SORT** technique for problem solving when there is no policy or procedure for guidance. **S**tatement – What is the problem or goal? **O**ptions – What are the possible solutions? Consider consulting with experts or literature. **R**ule Out – Eliminate the improbable or impractical to select the best option. **T**ake Action and Test – Implement the selected option, check if desired result was achieved.
Y **You and Me Together**	• Use **Cross Check** and provide on the spot second opinions. • Use the **Five Tones** in all interactions. Smile and greet others (say hello). Introduce yourself using your preferred name and explain your role. Listen with empathy and an intent to understand. Communicate the positive intent of your actions. Provide opportunities for others to ask questions.

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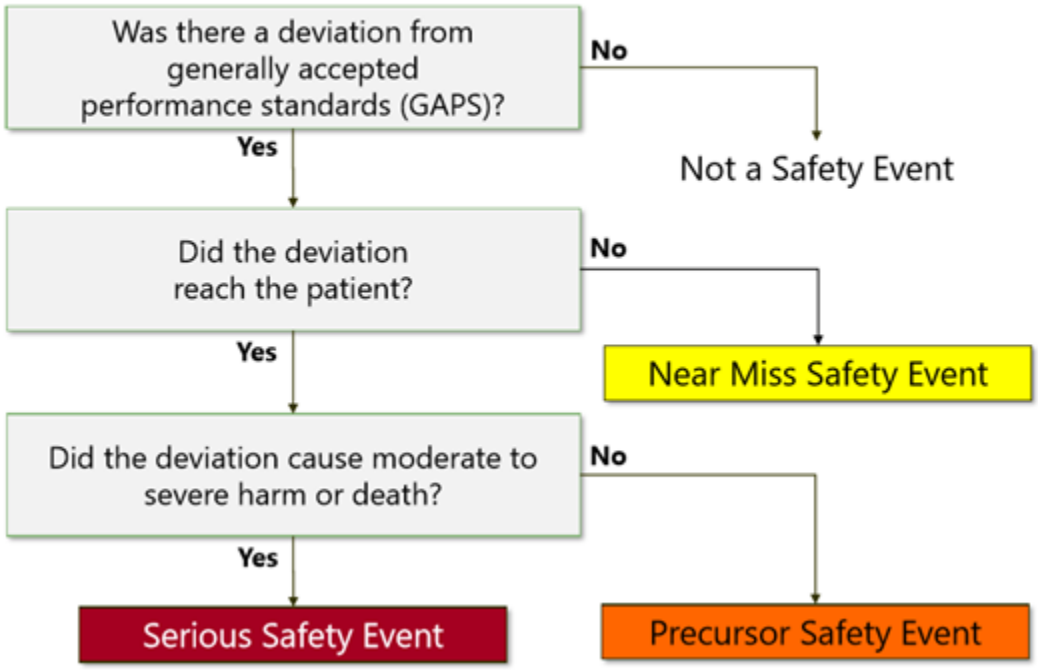
Safety Event Decision Algorithm



A deviation from generally accepted performance standards (GAPS) that...

SEC SAFETY EVENT CLASSIFICATION
HPI PRESS GANEY

Serious Safety Event
- Reaches the patient
- Results in moderate to severe harm or death

Precursor Safety Event
- Reaches the patient
- Results in minimal harm or no detectable harm

Near Miss Safety Event
- Does not reach the patient
- Error is caught by a detection barrier or by chance

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