AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, August 9, 2023 – 5:30 pm
El Camino Hospital | 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: 935 8192 8556# No participant code. Just press #.**

To watch the meeting, please visit: ECH Board Meeting Link

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

MISSION: To heal, relieve suffering, and advance wellness as your publicly accountable health partner.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER/ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 – 5:31 pm**
2	**AB 2449 – REMOTE PARTICIPATION**	Bob Rebitzer, Board Chair	Possible Motion	**5:31 – 5:32**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:32 – 5:33**
4	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons in the audience to make a brief statement, at most three (3) minutes, on issues or concerns not covered by the agenda.* b. Written Correspondence	Bob Rebitzer, Board Chair	Information	**5:33 – 5:36**
5	**QUALITY COMMITTEE** - FY23 Q4 STEEEP UPDATE - FOCUSED REVIEW: HEALTH EQUITY	Carol Somersille, MD Chair of Quality Committee; Dr. Holly Beeman, Chief Quality Officer	Discussion	**5:36 – 6:06**
6	**ADJOURN TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required *public comment*	**6:06 – 6:07**
7	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**6:07 – 6:08**
8	*Health and Safety Code Section 32106(b)* for a report and discussion involving healthcare facility trade secrets: **CEO REPORT** – Reflections on Current Healthcare Environment	Dan Woods, Chief Executive Officer	Discussion	**6:08 – 6:38**
9	Report involving *Gov't Code Section 54957(b)* for discussion and information on personnel performance matters – Senior Management: **EXECUTIVE SESSION**	Bob Rebitzer, Board Chair	Discussion	**6:38 – 6:48**
10	**CONSENT CALENDAR** *Any Board Member may remove an item for discussion before a motion is made.*	Bob Rebitzer, Board Chair	Motion Required	**6:48 – 6:53**

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at **(650) 988-8254** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	Approval *Gov't Code Section 54957.2:* a. Minutes of the Closed Session of the Hospital Board (06/14/2023) ***Reviewed and Recommended for Approval by the Quality, Patient Care, and Patient Experience Committee – 08/07/2023*** *Health & Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*:* b. Credentialing and Privileges Report			
11	**ADJOURN TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**6:53 – 6:54**
12	**RECONVENE OPEN SESSION/ REPORT OUT**	Bob Rebitzer, Board Chair	Information	**6:54 – 6:55**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
13	**CONSENT CALENDAR ITEMS:** *Any Board Member or member of the public may remove an item for discussion before a motion is made.* ***Approval*** a. Hospital Board Minutes (06/14/23) Open Session Minutes b. Amended FY24 Committee Assignments ***Reviewed and Recommended for Approval by the Quality, Patient Care, and Patient Experience Committee – 06/05/2023*** c. QAPI Plan ***Reviewed and Recommended for Approval by the Medical Executive Committee*** d. Policies, Plans, and Scope of Services ***Information*** e. FY2023 Period 12 Financials (Pre-Audit) f. FY24 Organization Goals	Bob Rebitzer, Board Chair	Motion Required *public comment*	**7:05 – 7:15**
14	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**7:15 – 7:20**
15	**BOARD COMMENTS**	Bob Rebitzer, Board Chair	Discussion	**7:20 – 7:30**
16	**ADJOURNMENT**	Bob Rebitzer, Board Chair	Motion Required *public comment*	**7:30 – 7:31**

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Holly Beeman, MD, MBA, and Chief Quality Officer, Carol Somersille, MD
Date: August 9, 2023
Subject: STEEEP Quality Dashboard Through Q4 FY2023

Purpose:

To update the El Camino Hospital Board of Directors on quality improvement activities and results as displayed in the Q4 FY23 STEEEP dashboard (unless otherwise noted).

Assessment:

A. Quality Measures

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

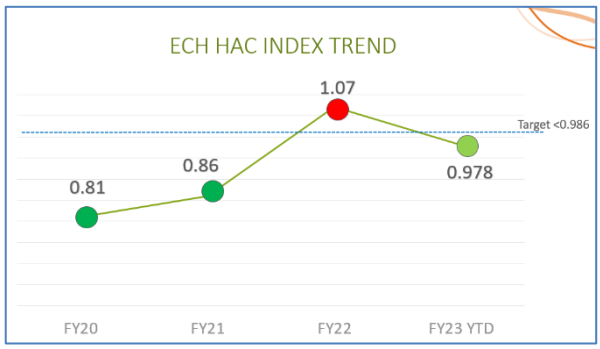
Final FY23 performance, 0.978 exceeded (favorable) the target of 0.986. At the unit and dashboard level the individual measures within the HAC Index are shown as number of events, the numerator only. This was intentional as showing this granular performance enables individual units and departments to set unit specific targets. Each of these measures is tracked for public reporting as a rate. The table below describes the denominator basis for each measure.

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

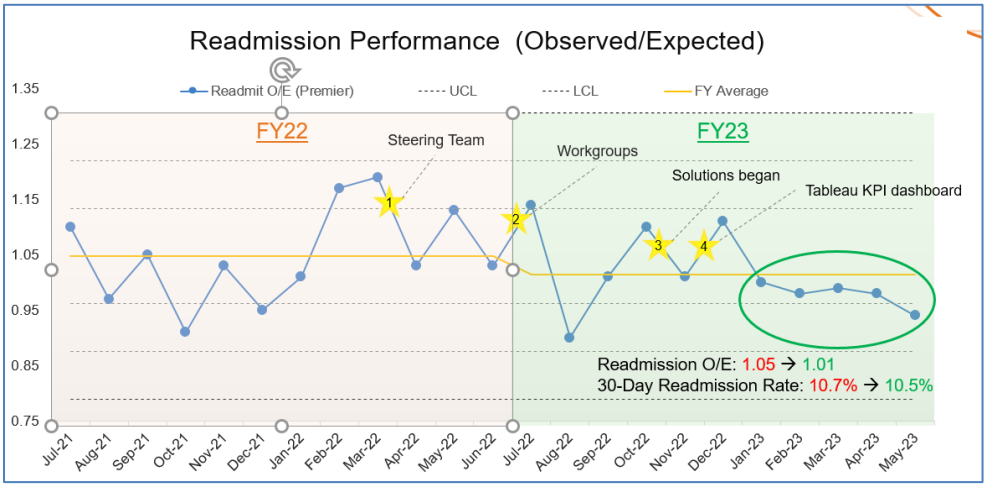
The target for FY23 was to reduce the HAC Index (Harm Events) by 7.5%. We exceeded the target. There was an 8.02% reduction in the HAC Index in FY23.

- C Difficile infection rate decreased by 6%
- Pneumonia rate decreased by 13%
- Fall rate decreased by 12%
- Surgical site infection rate increased by 44%
- Pressure injury rate decreased by 55%

HAC Index rending over the past 4 years is displayed in the graph below:



ii. **Readmission Index.** Efforts to reduce readmissions in the face of a disrupted post-acute landscape have been successful. May readmission index of 0.98 is the fifth consecutive month of outstanding performance with an index < 1.0.



iii. **Mortality index.** Performance year to date and in June 2023 was unfavorable to goal. The increase in mortality index is due to the increase in Sepsis Mortality.

iv. **Sepsis Mortality Index.** The improvement (reduction) in the Mortality Index in May 2023 of 0.82 was not sustained and the June index was 1.38. Our sepsis team is in the process of focused review of each case in June to identify opportunities for improvement.

v. **Elective Delivery and Cesarean Birth**: The obstetrical measures are core measures and due to the data validation process and chart abstraction needed, the results lag by 3 months. We have no new data to report since the last update in May 2023.

vi. **Emergency Department Throughput**. This measure assess the time patients evaluated, treated and then discharged home spend in the department. There has been progressive improvement (shortening of time) in this measure on both campuses for the past 4 months. We are at goal in June 2023.

vii. **Stroke Measures (STEEEP Dashboard)**. You may recall that throughout FY22 the performance on both measures, door to needle and door to groin, were not at target every quarter.

viii. **Imaging turn-around time**: This remains a patient safety concern and is being addressed by changing vendors for the radiologists we contract with to perform readings overnight. Our current night read partner is experiencing staffing shortages, inefficiencies which result in prolonged (>3 hours) read times over night. This is a direct driver of our longer throughput times in the Emergency Departments. Dr. Adams is leading this transition.

B. Patient Experience Measures:

i. **Inpatient HCAHPS Likelihood to Recommend:** Inpatient units overall did meet goal for June, but not for fiscal year to date. MV campus met goals for the past two months and are in the top decile (90th percentile). Unfortunately, our Los Gatos campus has had a myriad of issues with room temperature and comfort of surroundings and we will continue to focus attention on Los Gatos. We continue to emphasize being proactive (nurse leader rounding) and ensuring that bedside shift report is happening.

ii. **Maternal Child Health HCAHPS Likelihood to Recommend:** Mountain View MCH did not meet target for the month of June or for the fiscal year to date. The soft opening for of our new Mother Baby units is in progress and all have embraced these improvements. In addition, staff worked together, a key driver, also increased. The team continues to focus on proactive rounding and service recovery.

iii. **ED Likelihood to Recommend**: The overall ED target was not achieved for June or fiscal year. Both campuses are struggling with staff shortages (LOA, sick calls) and we continue to work on throughput. We are focusing on length of stay on the inpatient units to improve the efficiency of the admission to the floor process our patient's experience. We have a process improvement team working on optimizing the utilization of our discharge lounge. This should also free up more space on inpatient units to alleviate the backlogs of patient's boarding in the ED awaiting an inpatient bed.

iv. **ECHMN Likelihood to Recommend Care Provider**: ECHMN exceeded target for June, which makes five months in a row! The FY23 goal was not met, but substantial improvements were see in likelihood to recommend care provider and likelihood to recommend clinic. Responses from patients to questions about access and wait times improved throughout the year.

Attachments:

STEEEP Dashboard through Q4 of FY23

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**	0.803	1.295	0.964	1.440	**0.978**
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	7	14	9.25	**8.56**	7	13	9	6	**8.75**
	HAC Component: Surgical Site Infections (SSI)	5	4	7	2	4.5	**4.16**	6	11	4	6	**6.75**
	HAC Component: nvHAP	36	29	26	24	28.75	**26.59**	26	31	20	39	**29.00**
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	**35.38**	25	50	35	33	**35.75**
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	**1.85**	2	2	0	0	**1.00**
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)	75.0% (3/4)	50.0% (3/6)	**60.0% (15/25)**
	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)	50.0% (3/6)	N/A	**66.7% (8/12)**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	**84%**	78.43%	78.34%	78.28%	77.01%	**78.02%**
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	**1.00**	1.02	1.10	0.99	0.97	**1.03**
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	**0.85**	1.03	1.08	1.10	1.08	**1.08**
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	**0.98**	1.02	1.27	1.17	1.07	**1.13**
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	**23.5%**	28.8%	24.7%	24.0%	N/A	**25.9%**
Efficient	Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	**162 min**	176 min	168 min	169 min	165 min	**170 min**
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%	96.6%	96.6%	**97.0%**
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%	97.3%	97.5%	**97.5%**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	**81**	79.9	78.8	76.6	78.4	**78.5**
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	**75**	70.3	72.3	73.8	70.4	**71.7**
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	**81.5**	72.3	72.1	**83.7**	74.0	**75.0**
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	**83.4**	81.1	81.6	83.6	83.8	**82.7**

Updated: 7/19/23

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 Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS

BOARD MEETING MEMO

To: El Camino Hospital Board of Directors

From: Holly Beeman, MD, MBA – Chief Quality Officer,

Date: August 9, 2023

Subject: Health Equity at El Camino Health

Deliverable:
On a quarterly basis, the El Camino Health Board of Directors seeks to review a quality topic in detail in addition to their monthly review of current performance and process improvement activities related to quality measures displayed on the STEEEP dashboard. For the August 2023 board of directors meeting, Dr. Beeman will share information with directors on the activities of management related to Health Equity. The Quality team and the Board Quality Committee are aligned on the direction and scope of the work underway. This review serves to inform the Board of Directors on activities underway and planned for improving Health Equity at El Camino Health.

Background:
Health inequity denotes differences in health outcomes that are systematic, avoidable and unjust. Inequities in health are steeped in our centuries-long history of structural racism. The COVID-19 pandemic has illuminated and amplified the harsh reality of health inequities experienced by brown and black people. This, combined with the social justice awakening resulting from of the murder of George Floyd in March 2020, have heightened the nations, and our, focus on health disparities and their underlying causes. Health care organizations, like El Camino Health, alone do not have the power to improve all of the multiple determinants of health for all of society; we do have the power and ability to ensure high quality and safe care are provided equitably to every patient in our care. We are compelled to ensure we provide care, which is free of avoidable and undesirable variation. Having accurate information and data about our patients and communities is essential to identify and mitigate bias and inequities in the care we provide.

Goal of Health Equity Activities:
El Camino Health patients experience being seen and heard and receive whole-person care both while they are in our facilities, and, when they depart ECH for post hospitalization recovery. Whole-person care incorporates all elements of a persons lived experiences and unique characteristics. To achieve this, our workforce is trained and interested in knowing our patients as a 'whole person'. Our workforce has the tools, workflows and resources needed to consistently and accurately collect whole person information from our patients. Our system is able to aggregate meaningful data about our patient population to identify and prioritize allocation of resources to meet the unique needs of our patients.

Summary: The current state of Health Equity efforts and action plans are described in detail in the attached power point presentation "Health Equity" and Health Equity A3.

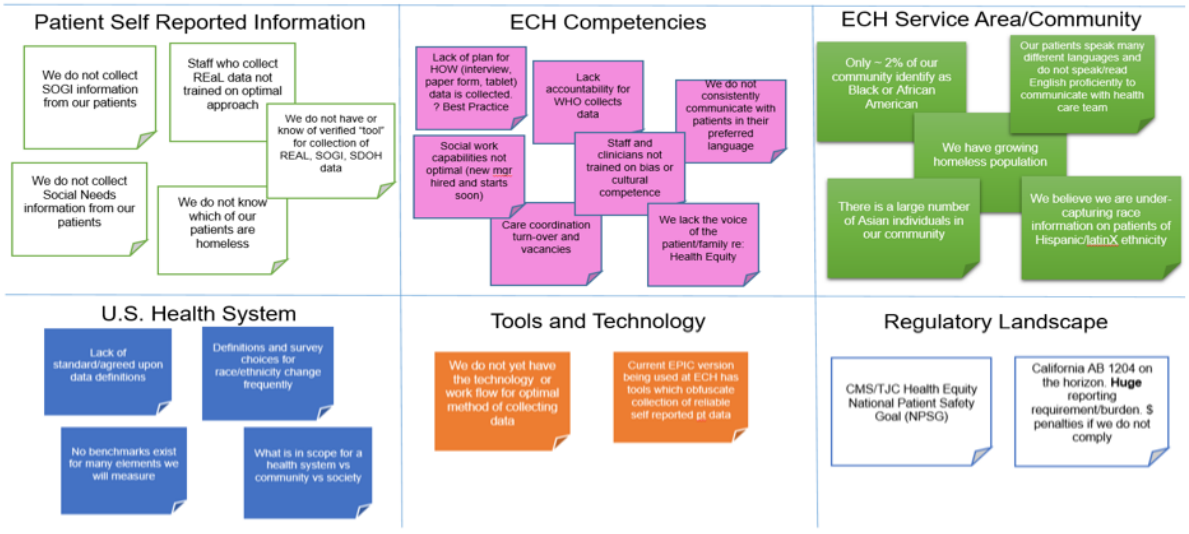
Attachments:
1. Health Equity A3
2. Health Equity Slide Presentation

Title: El Camino Health, Health Equity A3 Sponsor: Holly Beeman

Background: What problem are we talking about and why?

Health inequity denotes differences in health outcomes that are systematic, avoidable and unjust. Inequities in health are steeped in our centuries-long history of structural racism. The COVID-19 pandemic has illuminated and amplified the harsh reality of health inequities experienced by brown and black people. This, combined with the social justice awakening resulting from of the murder of George Floyd in March 2020, have heightened the nations, and our, focus on health disparities and their underlying causes. Health care organizations, like El Camino Health, alone do not have the power to improve all of the multiple determinants of health for all of society; we do have the power and ability to ensure high quality and safe care are provided equitably to every patient in our care. We are compelled to ensure we provide care, which is free of avoidable and undesirable variation. Having accurate information and data about our patients and communities is essential to identify and mitigate bias and inequities in the care we provide.

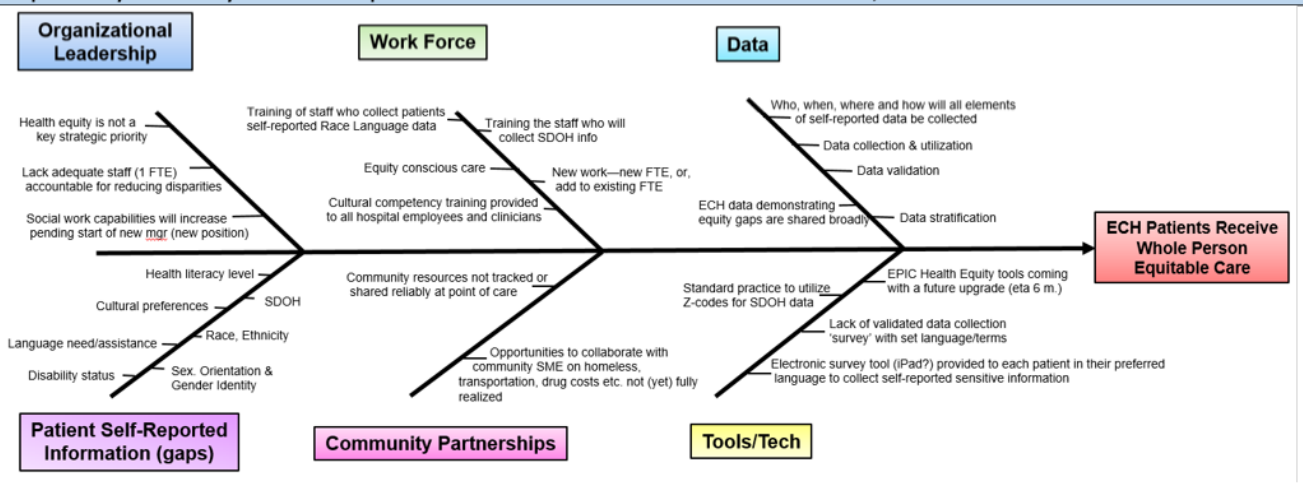
Current Conditions: Where do things stand now?



Target Condition / Goal(s): What specific outcome is required, and by when?

El Camino Health patients experience being seen and heard and receive whole person care both while they are in our facilities, and, when they depart ECH for post hospitalization recovery. Whole person care incorporates all elements of a persons lived experiences and unique characteristics. To achieve this, our workforce is trained and interested in knowing our patients as a 'whole person'. Our workforce has the tools, workflows and resources needed to consistently and accurately collect whole person information from our patients. Our system is able to aggregate meaningful data about our patient population to identify and prioritize allocation of resources to meet the unique needs of our patients.

Gap Analysis: Why does the problem or need exist? Based on data, What are the Root Causes?

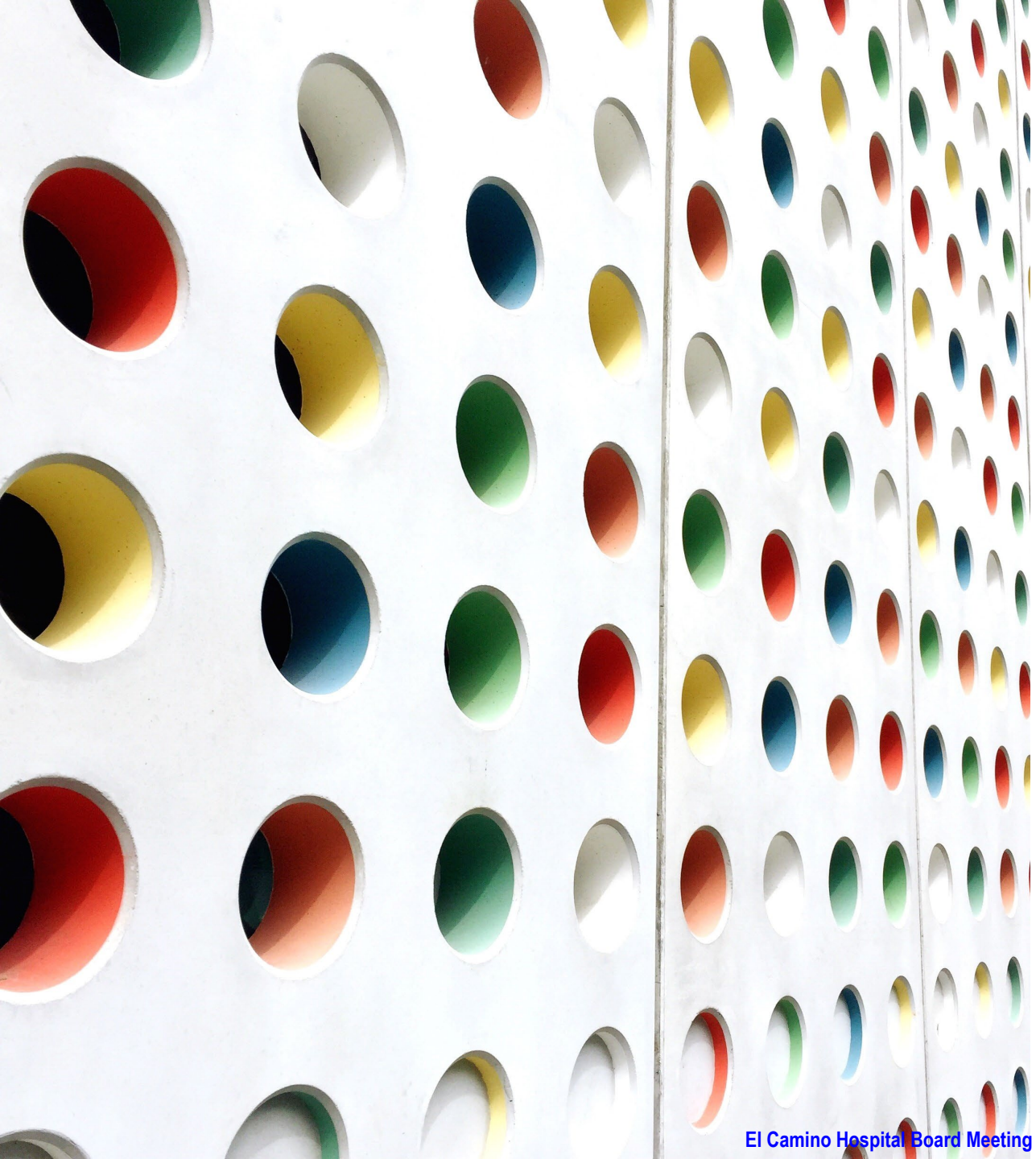


Experiments: What do you propose and why?		
Root Cause	**Potential Countermeasure**	**Expected Impact**
Lack of standard collection procedures for REaL-D, SDOH, SOGI information	Identify who will collect which data. Provide training to staff who will collect data.	Establish basis to assess if our care of patients is inequitable, and, provide information to care team to deliver "whole person" care
Lack of validated survey tool/language as basis for soliciting pt reported data	Ensure EPIC configuration aligns with best practice data collection tools	Entering, extracting and analyzing HE data will be enabled with this upgrade
We do not know which of our patients are homeless. We lack standard work for doing so	Utilize new homeless dashboard to identify and formulate countermeasures	Know which of our patients need add'l resources from ECH or community, and, provide them.
Is our treatment of sepsis patients equitable for patients of all races	Track sepsis bundle compliance by race monthly	Unearth our own internal biases which impact the care and outcomes of our patients with sepsis
We do not communicate with our patients in their preferred language.	Pilot ipad in every room on nursing unit with same protocol used for Fall Risk AI study.	Proof of concept that LTR improved, readmissions decreased in study group (? Other metrics to monitor for impact)

Action Plan: How will you implement? 4Ws, 1H

1. Quality Council reporting—encourage departments to analyze one outcome measure through health equity lens
2. Assess for bias in how we manage patients with sepsis through analysis of bundle compliance by race
3. Partner with Research and Patient Experience to perform pilot with deployment of language line iPAD in every patient's room whose preferred language is not English
4. Determine if we accurately identify which of our patients are homeless, and, audit if we are providing resources consistent with our policies

Study, Reflect, Plan Next Steps: How will you assure ongoing PDSA?

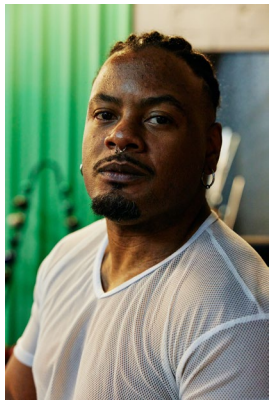


Health Equity

El Camino Hospital Board of Directors
August 9, 2023

Holly Beeman, MD, MBA
Chief Quality Officer




Health inequity denotes differences in health outcomes that are systematic, avoidable and unjust

Goal

El Camino Health patients experience being seen and heard and receive **whole-person care** both while they are in our facilities, and, when they depart ECH for post hospitalization recovery. **Whole-person care** incorporates all elements of a persons lived experiences and unique characteristics.

Health Equity at El Camino Health

WHY NOW

ECH INITIAL PRIORITIES

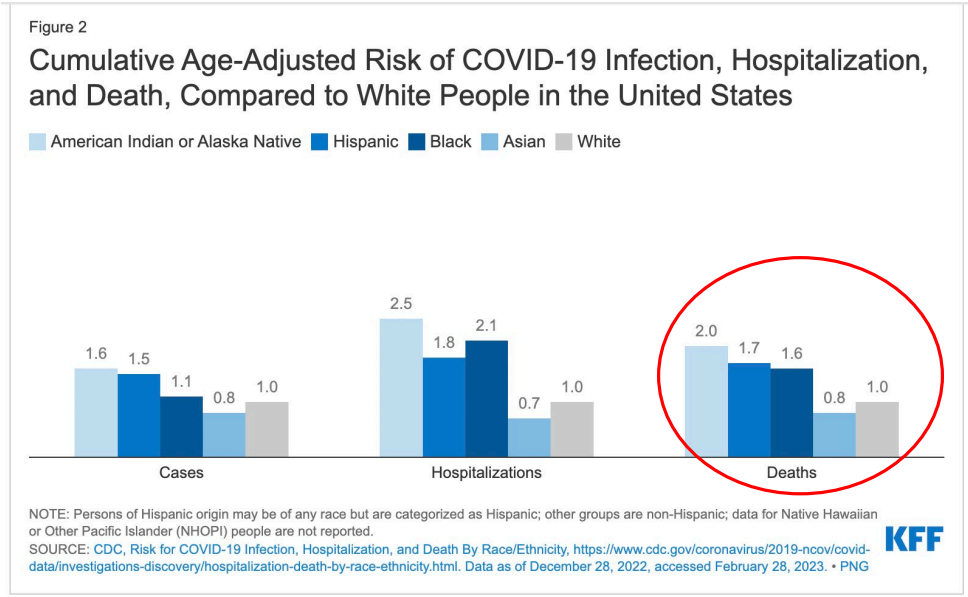
DATA & MEASUREMENT

Why Now?

WHY NOW

SOCIAL JUSTICE AWAKENING

COVID'S DISPARATE IMPACT



Death rates for Hispanic and Black people **1.7** and **1.6 times** higher

“There is No Quality Without Equity”

Kedar Mate

CEO, Institute for Healthcare Improvement

Regulatory Landscape

The Joint Commission (TJC)

- National Patient Safety Goal to Improve Health Equity
- Effective July 1, 2023

California Assembly Bill 1204 Equity Reporting

- Required annual equity report to include an analysis of health status and access to care disparities on the basis of specified categories, including age, sex, and race, and a health equity plan to reduce disparities.
- The bill would authorize the department to impose a fine not to exceed $5,000 against a hospital that fails to comply and requires the department to list those that failed to submit an equity report on its internet website.

ECH Health Equity Initial Priorities

1. Identify **who**, **when** & **how** our team will collect **REaL-D**, **SOGI**, **SDOH** data
2. Optimize technology and tools for data collection and analysis
3. Four initial interventions

1.	2.	3.	4.
Quality Council Reporting and Analysis w. **Race/Ethnicity**	Communicate w. patients in their preferred **language**	Is our management of **Sepsis** patients individualized?	Do we recognize & support **homeless** patients per our policies?

Health Equity Measurement

REaL-D

Race
Ethnicity
Language
Disability

SOGI

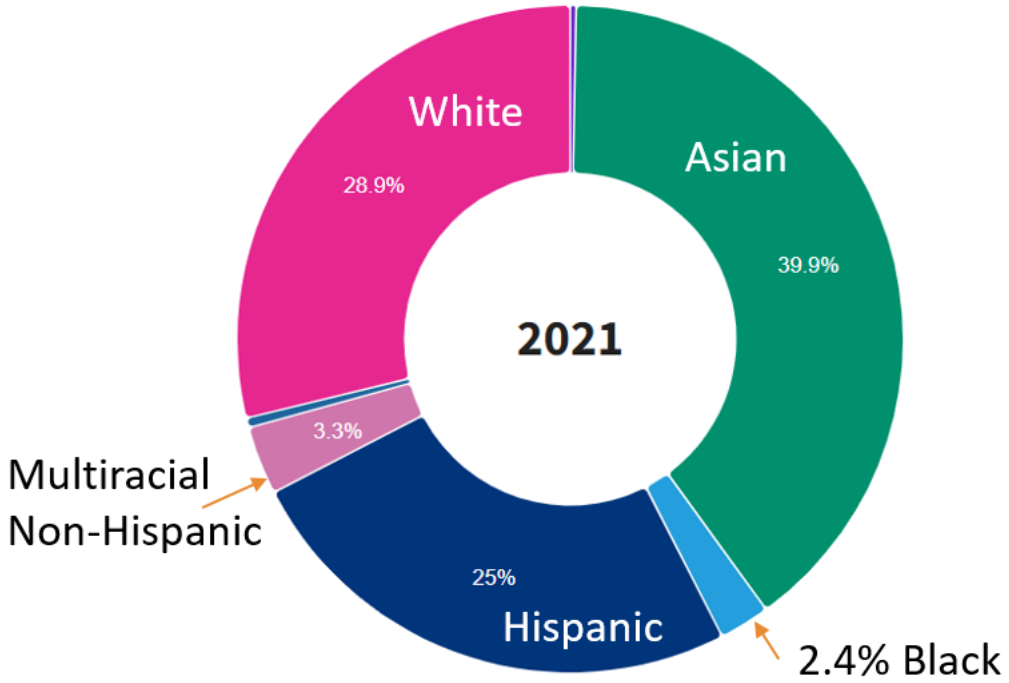
Sexual Orientation
Gender Identity

SDOH

Social Determinants
of
Health

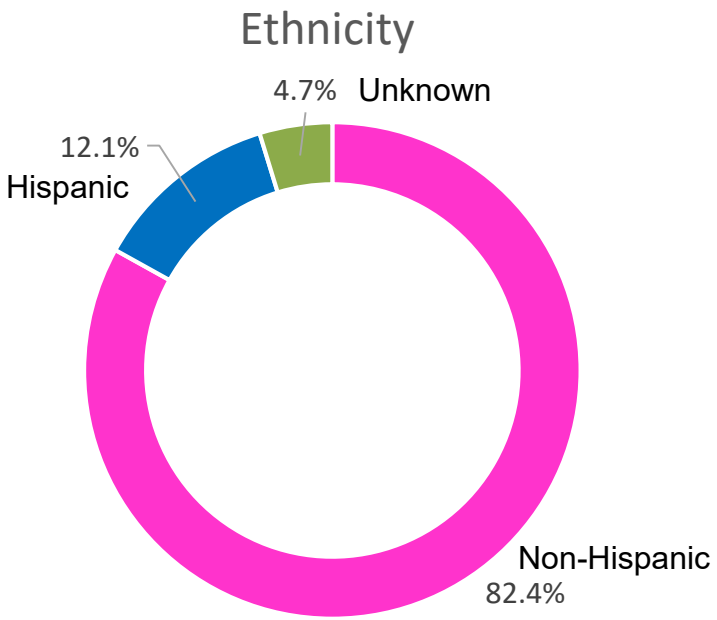
Santa Clara County Race and Ethnicity

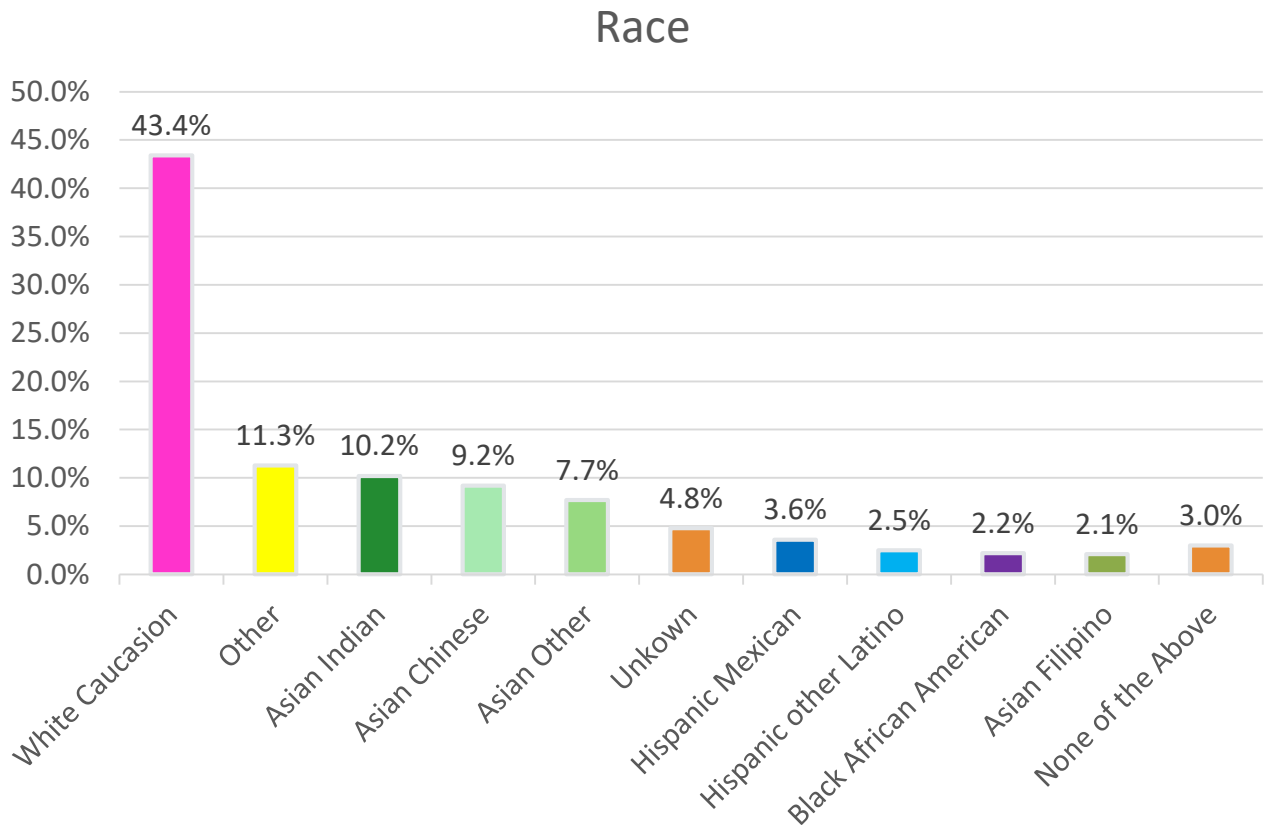
(July 2022 estimates US Census Bureau)



ECH Patient Self-Reported Race and Ethnicity

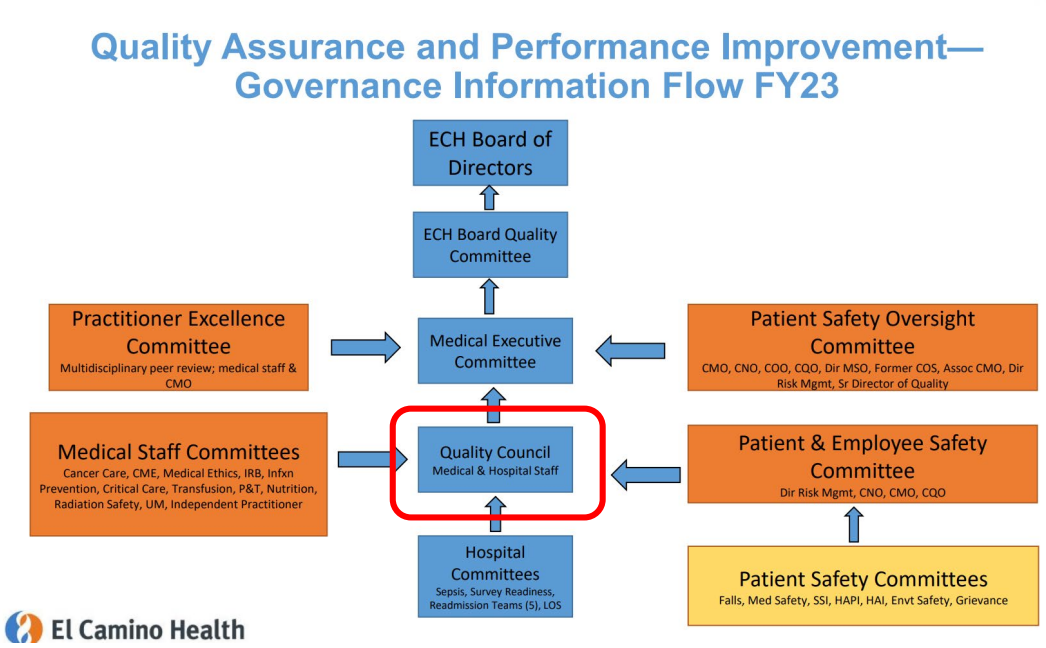
(Source: EPIC Slicer Dicer, All Inpatients Jan-July 2023)





1. Quality Council Reporting

Quality Council = the **heart** of all things quality and process improvement for El Camino Hospitals

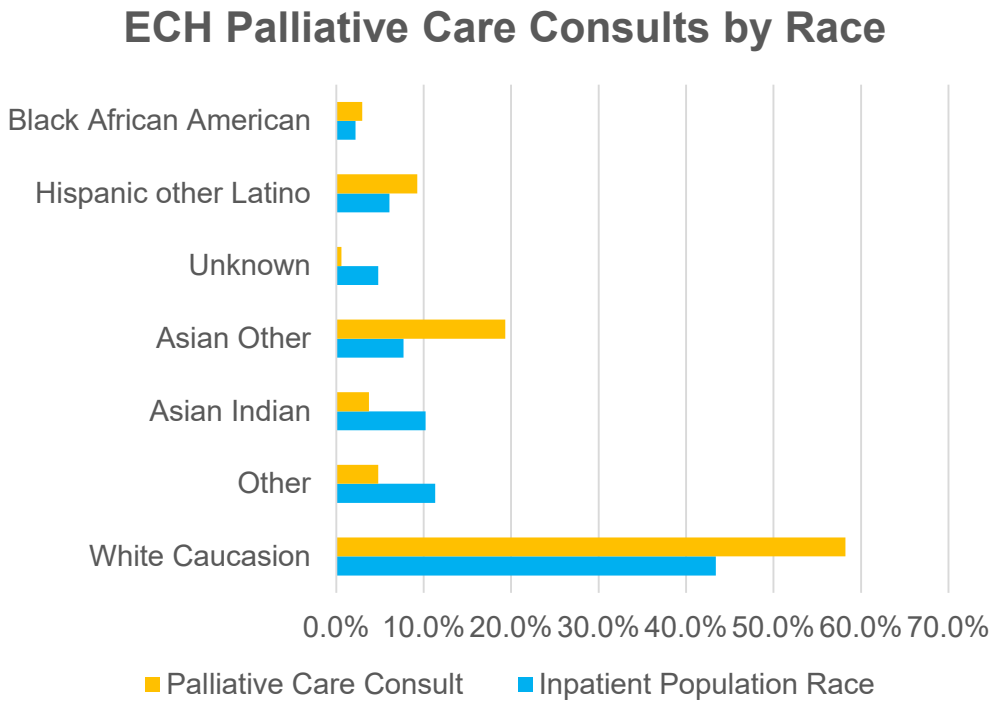


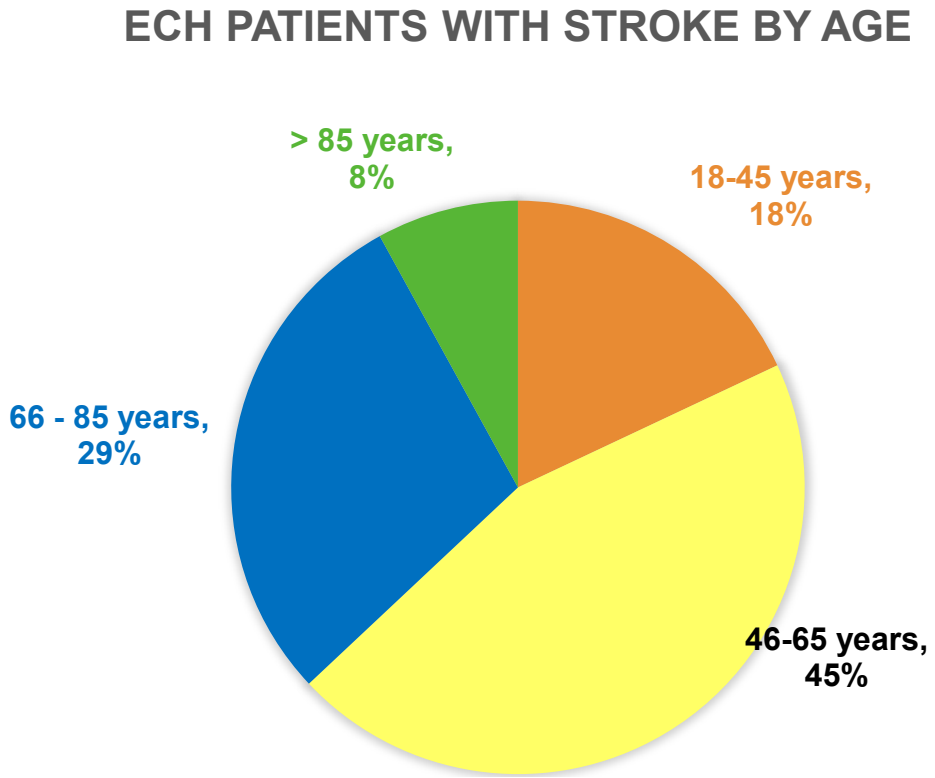
Annual (A) Reports

- 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

Quality Council

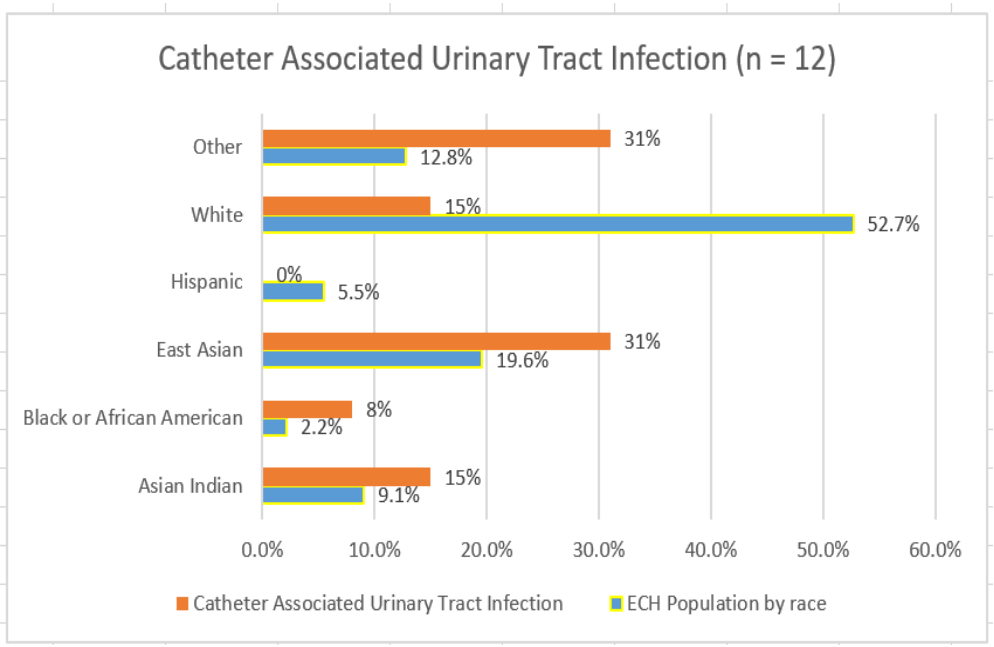
Outcome Stratification by Race, Ethnicity, Language, Age (examples)

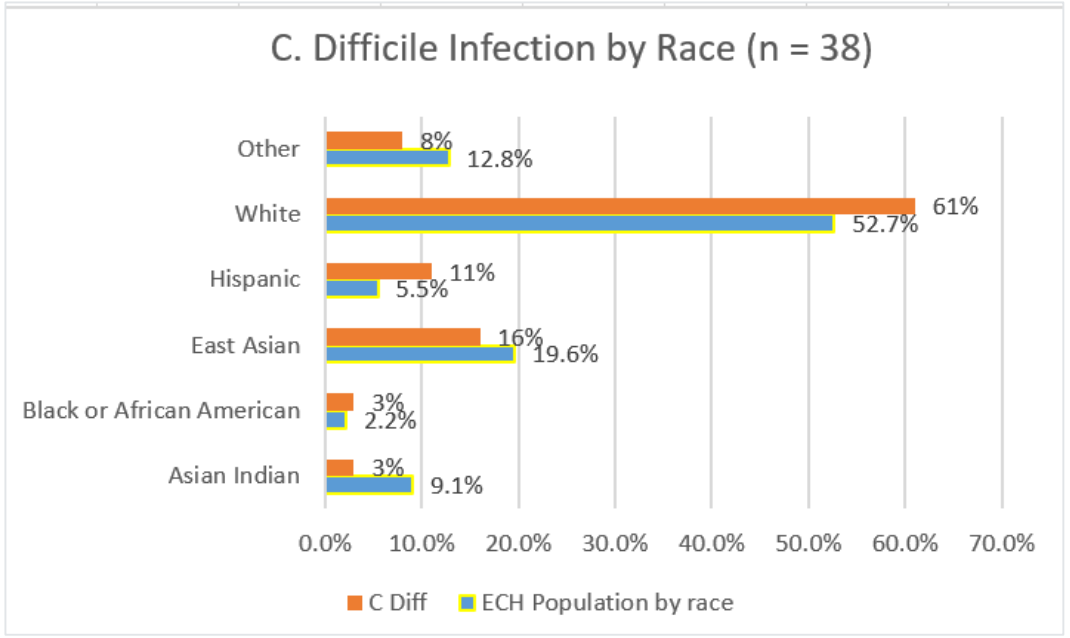




Examples from Quality Council

Hospital Acquired Infection by Race

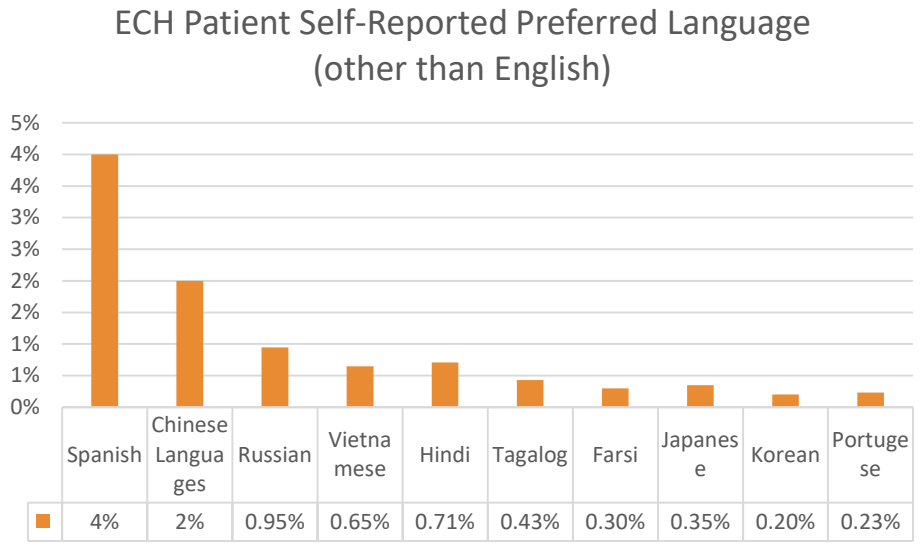




2. ECH Patient preferred language

Count of language services used April 2023

Count of Service Minutes Target Language	Total
Spanish	1863
Chinese Mandarin	712
Russian	312
Vietnamese	203
Korean	136
Japanese	94
Chinese Cantonese	88
American Sign Language (ASL)	79
Farsi	72
Portuguese	23
Turkish	19
Hindi	17
Arabic	10
Tigrinya	9
Filipino/Tagalog	8
Cambodian (Khmer)	8
Gujarati	7
Persian	6
Bulgarian	6
Punjabi	5
Tamil	4
French	4
Ukrainian	4
Taiwanese	2
Romanian	2
Somali	2
Azerbaijani/Azeri	2
Toisanese	1
Serbian	1
Ilocano	1
Portuguese (Brazilian)	1



Insight: Congruence between reported preferred language and language services used

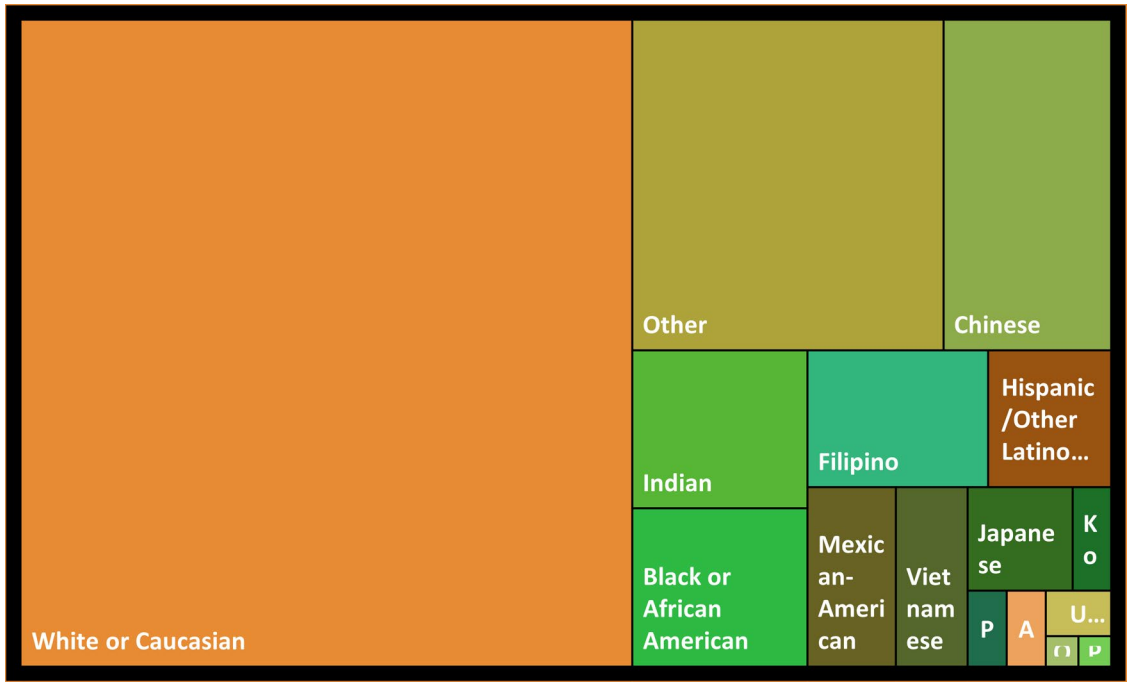
Plan:
Experiment (Pilot) with expanding training and # of Voyce Language iPads deployed to patients.

Currently: Each Nursing Unit has several Voyce iPads shared across all patients needing translation services.

Pilot: Have Voyce Language iPad in every patient's room throughout their stay for patients whose preferred language is not English

3. Sepsis patient care

FY2022 Sepsis Patients by Race

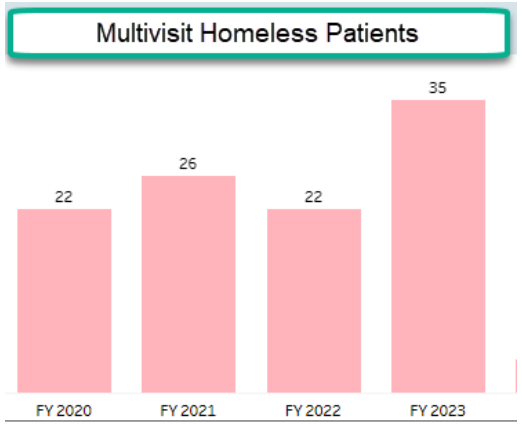


Is SDOH collected with Sepsis Event?			
Race	No	Yes	Grand Total
American Indian or Alaska Native	3		3
Asian	168	2	170
Black or African American	26	3	29
Hispanic or Latino	69	4	73
Other	29		29
Pacific Islander	4		4
Patient Refused	1		1
Unknown	2		2
White or Caucasian	400	2	402
Grand Total	**702**	**11**	**713**

SDOH Prevalence by Race		
Race	No	Yes
American Indian or Alaska Native	100.00%	0.00%
Asian	98.82%	1.18%
Black or African American	89.66%	10.34%
Hispanic or Latino	94.52%	5.48%
Other	100.00%	0.00%
Pacific Islander	100.00%	0.00%
Patient Refused	100.00%	0.00%
Unknown	100.00%	0.00%
White or Caucasian	99.50%	0.50%
Grand Total	**98.46%**	**1.54%**

Insight: Currently we collect Social Determinants of Health information on only 1% of Sepsis Patients

4. Homeless Patients



(Number of homeless patients with 4 or more hospital encounters per year)

4. Homeless Measurement Focus

Homelessness by Zip Code

	FY 2023	FY 2024
Jul	2.5%	2.3%
Aug	2.5%	
Sep	1.9%	
Oct	2.3%	
Nov	1.8%	
Dec	2.0%	
Jan	2.0%	
Feb	1.8%	
Mar	2.0%	
Apr	2.0%	
May	2.4%	
Jun	2.2%	

Identified at time of registration

≠

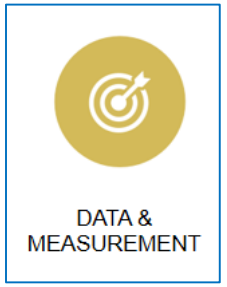
Homelessness by Clinical Documentation

	FY 2023	FY 2024
Jul	1.3%	1.1%
Aug	1.4%	
Sep	1.2%	
Oct	1.4%	
Nov	1.4%	
Dec	1.4%	
Jan	1.7%	
Feb	1.4%	
Mar	1.5%	
Apr	1.4%	
May	1.5%	
Jun	1.4%	

Documented by clinician in medical record

Insight: We do not yet have training and standard work for collection of housing security at time of registration

Data and Measurement Challenges



- Self-identification of this data is the gold standard
- Resistance from patients and clinicians to collect and use data
- Legal and privacy concerns around collection and use of race and ethnicity data
- No standardized category definitions
- Lack of standardized collection procedures

Data Challenge Example--RACE

"Race" is a **socially** and **politically** defined construct which categorizes humans largely based on observable physical features and ancestral origin. While racial groupings are not indicators of biological differences, race has remained among the strongest predictors of health care access, quality and outcomes for generations due to its direct correlation with impacts of all levels of racism.

(New York City Coalition to End Racism in Clinical Algorithms Inaugural Report September 2022)

No standard on race/ethnicity data

U.S. Census Bureau (2020)

Figure 1.
2020 Census Hispanic Origin Question

➜ **NOTE: Please answer BOTH Question 6 about Hispanic origin and Question 7 about race. For this census, Hispanic origins are not races.**

6. Is this person of Hispanic, Latino, or Spanish origin?

- ☐ **No**, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin – *Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.*

7. What is this person's race?
*Mark [X] one or more boxes **AND** print origins.*

- ☐ White – *Print, for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.*
- ☐ Black or African Am. – *Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.*
- ☐ American Indian or Alaska Native – *Print name of enrolled or principal tribe(s), for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.*
- ☐ Chinese
- ☐ Filipino
- ☐ Asian Indian
- ☐ Vietnamese
- ☐ Korean
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Chamorro
- ☐ Other Asian – *Print, for example, Pakistani, Cambodian, Hmong, etc.*
- ☐ Other Pacific Islander – *Print, for example, Tongan, Fijian, Marshallese, etc.*
- ☐ Some other race – *Print race or origin.*

Medicare Beneficiary R/E Data

U.S. Department of Health and Human Services
Office of Inspector General
Data Brief
June 2022, OEI-02-21-00100

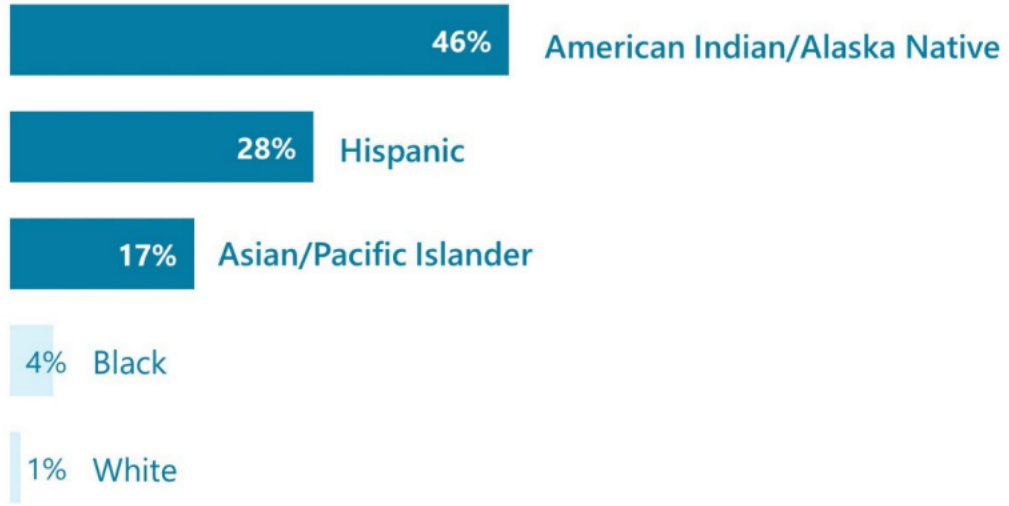
Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities

Data Source = Social Security Administration data + Research Triangle Algorithm

Prior to 1980 only three categories; White, Black or Other

After 1980, six categories conflating race and ethnicity. Response limited to **ONE** category

Exhibit 1: Percentage of Medicare Beneficiaries Identified in Medicare's Enrollment Data as a Race and Ethnicity With Which They Do Not Identify Themselves on the Nursing Home Assessment



Source: OIG analysis of CMS data, 2021.

ECH Race Data Collection

Similar to U.S. Census Bureau method

More granular options for race (22 options)

90% of data collected by Patient Access Services

Face-to-face intake during registration

Title
American Indian or Alaska Native
Asian/Chinese
Asian/Filipino
Asian/Indian
Asian/Japanese
Asian/Korean
Asian/Other
Asian/Vietnamese
Black or African American
Hispanic/Cuban
Hispanic/Mexican-American
Hispanic/Other Latino or Spanish Origin
Hispanic/Puerto Rican
Other
Pacific Islander/Guamanian or Chamorro
Pacific Islander/Native Hawaiian
Pacific Islander/Other Island
Pacific Islander/Samoan
Patient Refused
Unknown
White or Caucasian

Race is deeply personal

"Individuals views of their racial and ethnic identity are shaped by a variety of factors, including their perceptions of how others view them. Fitting into a specific box for racial and ethnic category is becoming even more challenging as the diversity of the U.S. population grows and more people identify as multiracial."

KFF Jan 31, 2023. Proposed Changes to Federal Standards for Collecting and Reporting Race/Ethnicity Data: What are They and Why do they Matter?

Discussion

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Dan Woods, Chief Executive Officer
Date: August 9, 2023
Agenda Item: Amended FY24 Committee and Liaison Assignments

Recommendation:

Board Chair Rebitzer and Governance Committee Chair Chen have recommended no changes to most assignments this year. The only change will be that Director Chen will no longer be serving on the Compliance and Audit Committee. We are asking the Board to approve the Amended FY24 Committee and Liaison Appointments.

Summary:

Each year, the Board Chair submits a proposed slate of Committee and Liaison assignments for approval. The Board Advisory Committee Charters state: "All Committee members, with the exception of new Community members, shall be appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th each year, renewable annually."

Pursuant to the Governance Committee's Charter, the Committee "shall review and make recommendations to the Board regarding the Board Chair's appointments of Advisory Committee Chairs and Advisory Committee members."

FY24 Amendment: The amended assignments include the following:

- **Lanhee Chen**: Will continue to serve as Chair of the Governance Committee but will step down from serving on the Compliance and Audit Committee

List of Attachments: Amended Slate for FY24 Committee and Liaison Assignments

El Camino Health

FY24 El Camino Hospital Board of Directors
Advisory Committee & Liaison Appointments

COMMITTEE APPOINTMENTS						
COMMITTEE	COMPLIANCE & AUDIT	EXEC COMPENSATION	FINANCE	GOVERNANCE	INVESTMENT	QUALITY
CHAIR	Jack Po, MD	Bob Miller	Don Watters	Lanhee J. Chen	Brooks Nelson	Carol Somersille, MD
BOARD MEMBERS	Julia E. Miller	George O. Ting, MD	Peter C. Fung, MD	Don Watters	Peter C. Fung, MD	Jack Po, MD
	TBD	Carol Somersille, MD		Julia E. Miller	John Zoglin	John Zoglin
		TBD				
COMMUNITY MEMBERS	Lica Hartman	Teri Eyre	Wayne Doiguchi	Christina Lai	Nicola Boone	Pancho Chang
	Sharon Anolik Shakked	Estrella Parker	Bill Hooper	Ken Alvares	John Conover	Krutica Sharma
	Christine Sublett		Cynthia Stewart	Mike Kasperzak	Robin Driscoll	Melora Simon
					Ken Frier	
MEDICAL STAFF OFFICERS & MEDICAL NETWORK BOARD MEMBERS						Prithvi Legha, MD
						Philip Ho, MD
						Steve Xanthopoulos, MD *Alternate*
						Shahram Gholami, MD *Alternate*

LIAISON APPOINTMENTS		LEGEND: *Hospital Board Members *District Board Members *Community & Staff Members	
COMMUNITY BENEFIT ADVISORY COUNCIL (CBAC) (Liaison)	Carol Somersille, MD	ECH FOUNDATION BOARD OF DIRECTORS (Liaison)	Julia E. Miller

Previously Approved by Hospital Board of Directors: 06/14/2023

El Camino Health

EL CAMINO HEALTH
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Holly Beeman, MD, MBA, and Chief Quality Officer
Date: August 9, 2023
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QAPI) for 2023

Situation: The Board Quality, Patient Care and Patient Experience Committee ("Quality 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. This plan has been reviewed and approved by the Quality Council, the Patient and Employee Safety Committee, the Medical Executive Committee and the Quality Committee.

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." 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.

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.

Recommendation: Approve FY23 Quality Assessment and Performance Improvement Plan (QAPI) as approved by the Quality, Patient Care and Experience Committee on June 5, 2023.

List of attachments:

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

El Camino Health

BOARD OF DIRECTORS
Policies for Review
August 9, 2023

Department	Policy Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
Employee Wellness	1. COVID-19 Vaccine Plan	Revised	Plan	1. Updated Sections: Reference, Procedure, Responsibilities,	• HR Leaders | CHRO • Infection Prevention • Med Dept Exec • ePolicy • MEC

El Camino Health

Summary of Financial Operations

Pre-Audit Fiscal Year 2023 Financials

7/1/2022 to 06/30/2023

Please Note: Pre-Audit FY2023 Financials are pending review & approval by the Finance Committee

Operational / Financial Results: YTD FY2023 (as of 06/30/2023)

($ thousands)

		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	306	264	42	15.8%	276	30	10.9%	---	---	---
	Total Acute Discharges	22,045	21,063	982	4.7%	21,371	674	3.2%	---	---	---
	Adjusted Discharges	42,719	42,358	361	0.9%	41,886	833	2.0%	---	---	---
	Emergency Room Visits	77,844	66,191	11,653	17.6%	68,778	9,066	13.2%	---	---	---
	OP Procedural Cases	135,523	161,064	(25,541)	(15.9%)	153,129	(17,606)	(11.5%)	---	---	---
	Gross Charges ($)	5,757,133	5,356,197	400,936	7.5%	5,122,895	634,238	12.4%	---	---	---
Operations	Total FTEs	3,297	3,323	(26)	(0.8%)	3,101	196	6.3%	---	---	---
	Productive Hrs. / APD	27.9	30.3	(2.4)	(7.9%)	28.6	(0.8)	(2.7%)	---	---	---
	Cost Per CMI AD	17,593	18,036	(443)	(2.5%)	16,167	1,426	8.8%	---	---	---
	Net Days in A/R	57.3	54.0	3.3	6.2%	57.3	(0.0)	(0.0%)	47.7	49.7	
Financial Performance	Net Patient Revenue ($)	1,378,049	1,357,918	20,131	1.5%	1,309,152	68,898	5.3%	1,662,567	985,255	
	Total Operating Revenue ($)	1,439,351	1,407,654	31,697	2.3%	1,353,519	85,832	6.3%	1,822,912	1,315,225	
	Operating Margin ($)	**160,954**	**143,786**	**17,168**	11.9%	**195,086**	**(34,132)**	(17.5%)	**22,978**	**46,033**	
	Operating EBIDA ($)	**256,853**	**233,216**	**23,638**	10.1%	**286,044**	**(29,190)**	(10.2%)	**134,260**	**128,892**	
	Net Income ($)	284,696	178,692	106,004	59.3%	43,765	240,930	550.5%	97,493	88,120	
	Operating Margin (%)	**11.2%**	**10.2%**	**1.0%**	9.5%	**14.4%**	**(3.2%)**	(22.4%)	**1.9%**	**3.5%**	
	Operating EBIDA (%)	**17.8%**	**16.6%**	**1.3%**	7.7%	**21.1%**	**(3.3%)**	(15.6%)	**8.3%**	**9.8%**	
	DCOH (days)	263	325	(62)	(19.0%)	285	(21)	(7.5%)	306	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 9, 2021.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021
DCOH total includes cash, short-term and long-term investments.

El Camino Health

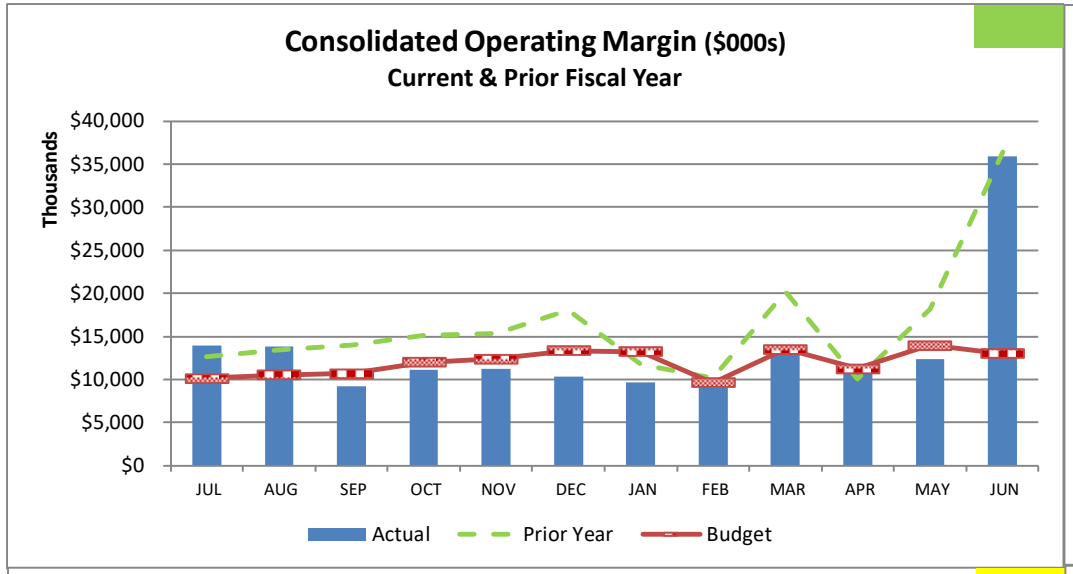
Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

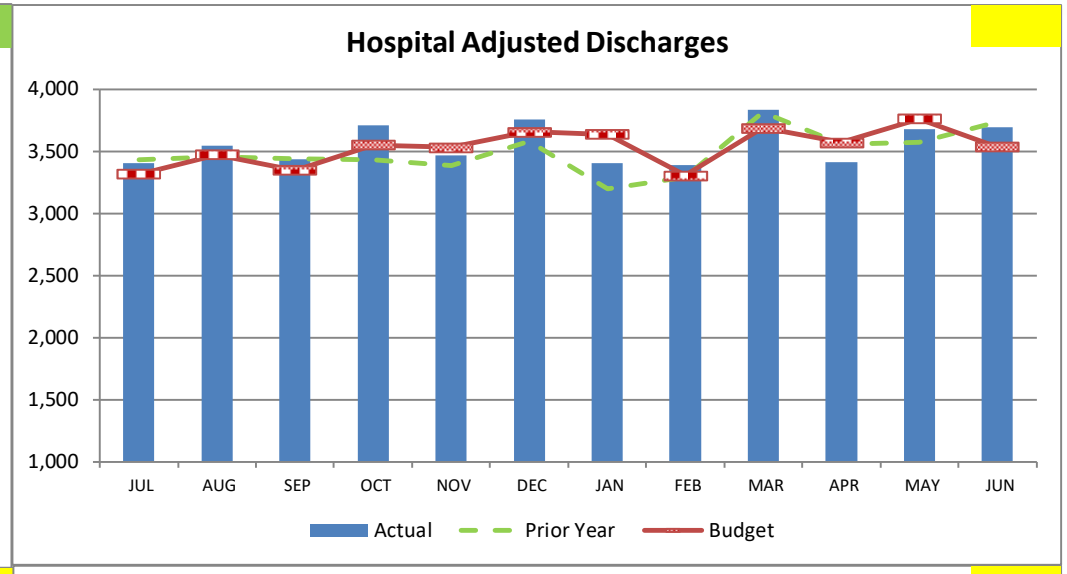
Key Statistics: Period 12 and YTD (as of 06/30/2023)

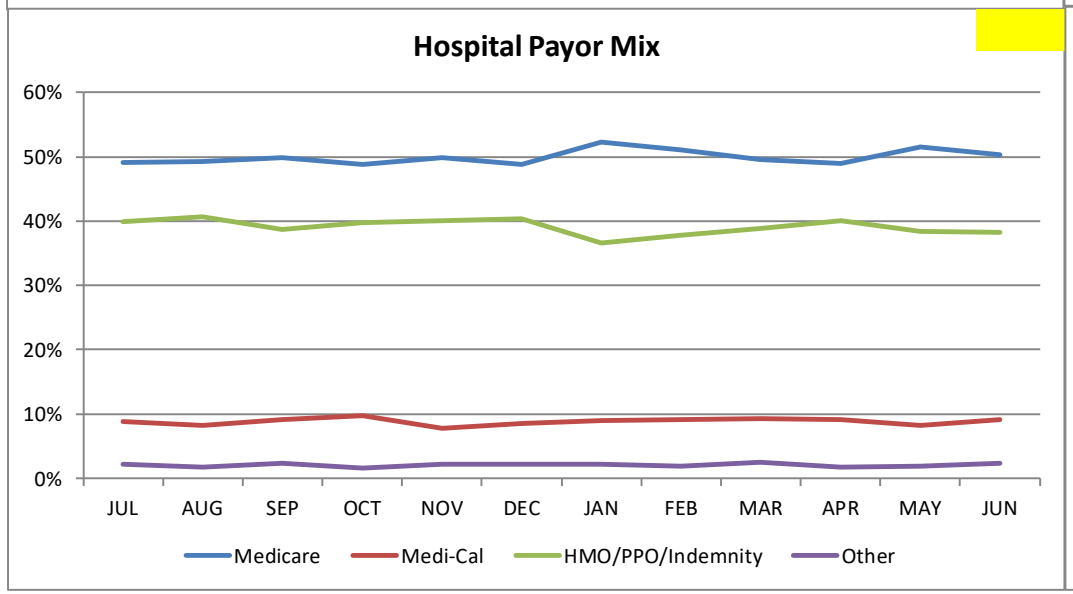
	Month to Date			Variance (%)		Year to Date			Variance (%)	
Key Metrics	**PY**	**CY**	**Budget**	**CY vs PY**	**CY vs Budget**	**PY**	**CY**	**Budget**	**CY vs PY**	**CY vs Budget**
ADC	283	304	268	7.6%	13.6%	276	306	264	10.9%	15.8%
Utilization MV	76%	80%	70%	5.9%	14.1%	73%	80%	69%	9.5%	15.5%
Utilization LG	33%	39%	35%	16.2%	11.4%	34%	40%	34%	17.4%	17.1%
Utilization Combined	62%	67%	59%	7.6%	13.6%	61%	67%	58%	10.9%	15.8%
Adjusted Discharges	3,735	3,691	3,535	(1.2%)	4.4%	41,886	42,719	42,358	2.0%	0.9%
Total Discharges (Exc NB)	1,842	1,884	1,755	2.3%	7.3%	21,371	22,045	21,063	3.2%	4.7%
Total Discharges	2,204	2,228	2,136	1.1%	4.3%	26,095	26,484	25,750	1.5%	2.9%
Inpatient Case Activity										
MS Discharges	1,289	1,328	1,190	3.0%	11.6%	14,442	15,372	14,228	6.4%	8.0%
Deliveries	385	385	408	0.0%	(5.5%)	5,092	4,832	4,984	(5.1%)	(3.0%)
BHS	132	117	116	(11.4%)	0.9%	1,377	1,381	1,394	0.3%	(0.9%)
Rehab	42	51	42	21.4%	22.1%	450	450	457	0.0%	(1.5%)
Outpatient Case Activity										
Total Outpatient Cases	17,554	16,175	17,397	(7.9%)	(7.0%)	205,854	196,382	211,644	(4.6%)	(7.2%)
ED	4,848	5,102	4,185	5.2%	21.9%	52,725	60,859	50,580	15.4%	20.3%
OP Surg	624	654	431	4.8%	51.8%	7,119	7,569	5,259	6.3%	43.9%
Endo	264	223	249	(15.5%)	(10.6%)	2,880	2,800	2,770	(2.8%)	1.1%
Interventional	223	208	181	(6.7%)	15.0%	2,354	2,319	2,311	(1.5%)	0.3%
All Other	11,595	9,988	12,351	(13.9%)	(19.1%)	140,776	122,835	150,724	(12.7%)	(18.5%)
Hospital Payor Mix										
Medicare	48.8%	50.3%	47.8%	3.1%	5.1%	48.2%	49.9%	47.8%	3.6%	4.4%
Medi-Cal	8.8%	9.1%	8.4%	3.6%	8.2%	8.1%	8.9%	8.4%	9.4%	4.8%
Commercial	39.5%	38.2%	41.9%	(3.3%)	(9.6%)	41.5%	39.1%	41.9%	(5.8%)	(7.1%)
Other	2.8%	2.3%	2.0%	(17.3%)	16.5%	2.2%	2.1%	2.0%	(4.2%)	6.6%

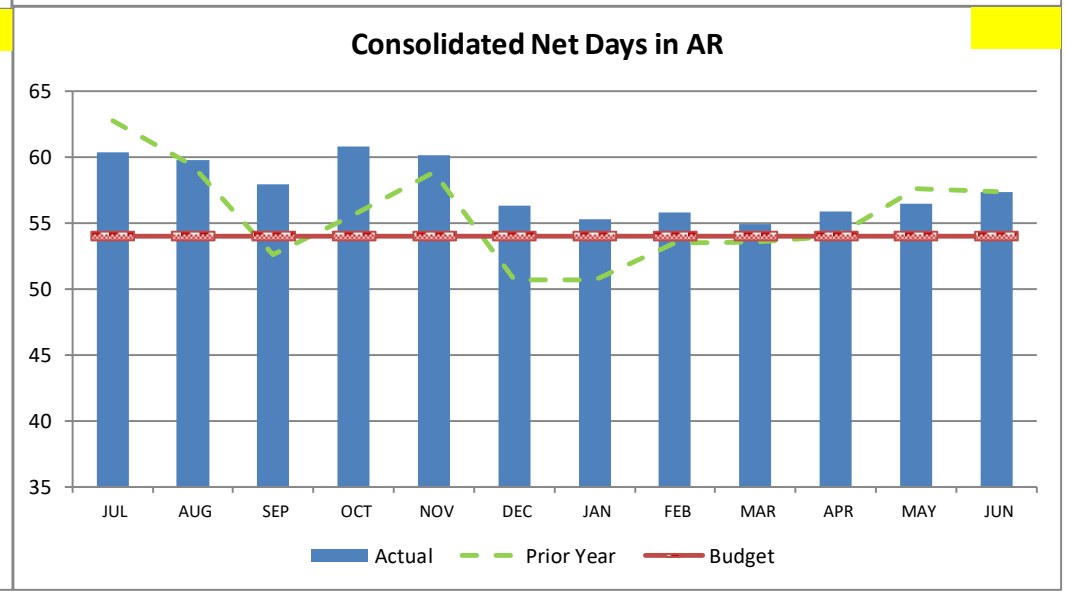
El Camino Health

YTD FY2023 Financial KPIs – Monthly Trends









El Camino Health

Period 12 and YTD Operating Income, Non-Operating Income and Net Income by Affiliate (as of 06/30/2023)

($000s)

	Period 12- Month			Period 12- FYTD		
	Actual	Budget	Variance	Actual	Budget	Variance
El Camino Hospital Operating Margin						
Mountain View	29,755	11,708	18,047	134,697	137,571	(2,875)
Los Gatos	9,303	4,323	4,980	62,339	47,416	14,923
Sub Total - El Camino Hospital, excl. Afflilates	**39,058**	**16,031**	**23,027**	**197,036**	**184,987**	**12,049**
Operating Margin %	**34.7%**	**14.2%**		**14.3%**	**13.8%**	
El Camino Hospital Non Operating Income						
Sub Total - Non Operating Income	**36,137**	**2,702**	**33,435**	**118,647**	**31,166**	**87,481**
El Camino Hospital Net Margin	**75,195**	**18,733**	**56,462**	**315,683**	**216,154**	**99,529**
ECH Net Margin %	**66.7%**	**16.6%**		**23.0%**	**16.1%**	
Concern	(206)	83	(289)	717	982	(266)
Foundation	1,079	(0)	1,079	2,290	(525)	2,815
El Camino Health Medical Network	(2,788)	(2,816)	28	(33,994)	(37,920)	3,926
Net Margin Hospital Affiliates	**(1,915)**	**(2,733)**	**818**	**(30,987)**	**(37,462)**	**6,475**
Total Net Margin Hospital & Affiliates	**73,280**	**16,000**	**57,279**	**284,696**	**178,692**	**106,004**

El Camino Health

Consolidated Balance Sheet (as of 06/30/2023)

($000s)

ASSETS		Audited
CURRENT ASSETS	**June 30, 2023**	**June 30, 2022**
Cash	230,539	196,067
Short Term Investments	129,402	125,816
Patient Accounts Receivable, net	218,528	209,668
Other Accounts and Notes Receivable	20,411	21,044
Intercompany Receivables	15,186	13,998
Inventories and Prepaids	45,037	36,476
Total Current Assets	**659,102**	**603,068**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	20,731	18,721
Plant & Equipment Fund	407,526	310,045
Women's Hospital Expansion	30,735	30,261
Operational Reserve Fund	207,898	182,907
Community Benefit Fund	17,743	18,299
Workers Compensation Reserve Fund	13,498	14,029
Postretirement Health/Life Reserve Fund	24,242	29,783
PTO Liability Fund	35,252	33,709
Malpractice Reserve Fund	1,885	1,906
Catastrophic Reserves Fund	28,042	24,668
Total Board Designated Assets	**787,551**	**664,329**
FUNDS HELD BY TRUSTEE	**-**	**0**
LONG TERM INVESTMENTS	**472,514**	**495,751**
CHARITABLE GIFT ANNUITY INVESTMENTS	**948**	**940**
INVESTMENTS IN AFFILIATES	**33,262**	**30,376**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	1,862,363	1,872,501
Less: Accumulated Depreciation	(791,528)	(778,427)
Construction in Progress	168,956	96,603
Property, Plant & Equipment - Net	**1,239,791**	**1,190,676**
DEFERRED OUTFLOWS	57,204	19,474
RESTRICTED ASSETS	36,339	31,200
OTHER ASSETS	153,023	216,842
TOTAL ASSETS	**3,439,734**	**3,252,657**

LIABILITIES AND FUND BALANCE		Audited
CURRENT LIABILITIES	**June 30, 2023**	**June 30, 2022**
Accounts Payable	50,629	51,286
Salaries and Related Liabilities	24,408	46,502
Accrued PTO	36,104	34,449
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	11,295	14,942
Intercompany Payables	12,362	13,489
Malpractice Reserves	1,863	2,096
Bonds Payable - Current	10,400	9,905
Bond Interest Payable	7,890	8,096
Other Liabilities	11,968	20,955
Total Current Liabilities	**169,217**	**204,021**
LONG TERM LIABILITIES		
Post Retirement Benefits	24,242	29,783
Worker's Comp Reserve	13,498	14,029
Other L/T Obligation (Asbestos)	29,543	37,944
Bond Payable	454,806	466,838
Total Long Term Liabilities	**522,088**	**548,593**
DEFERRED REVENUE-UNRESTRICTED	**1,103**	**12,312**
DEFERRED INFLOW OF RESOURCES	**74,491**	**104,367**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,419,180	2,136,565
Board Designated	209,043	210,197
Restricted	44,611	36,601
Total Fund Bal & Capital Accts	**2,672,834**	**2,383,363**
TOTAL LIABILITIES AND FUND BALANCE	**3,439,734**	**3,252,657**

El Camino Health

Fiscal Year 2024 Organizational Performance Goals

Pillar	Weight	OBJECTIVES/ OUTCOMES	Benchmark		Measurement Defined			Measurement Period
			Internal Benchmarks	External Benchmark	Minimum	Target	Stretch	
Threshold		Maintain positive EBIDA Margin	FY2020: 11.6%; FY2021: 15.8% FY2022 through March: 19.6% Budget FY2023: 16.7%	Moody's: Median for 'A1': 9.7% Median for 'Aa3': 8.9%	≥ 80% of budgeted Operating EBIDA Margin			FY2024
Quality and Safety	25%	HAC Index	FY2023 composite score	Benchmarked through CMS and Leapfrog metrics	2% improvement from FY2022 baseline	3% improvement from FY2022 baseline	4% improvement from FY2022 baseline	FY2024
Service	25% (Hospital)	Likelihood to Recommend (LTR) – Inpatient	FY2023 through March: 75.5 (81st % ile)	Press Ganey	**76.4 or 76%ile** Target minus distance between Target and Stretch	**78.1 or 80%ile** Target in line with top 50% of improvers	**80.8 or 86%ile** Target in line with top 30% of improvers	FY2024
	OR 25% (ECHMN)	Likelihood to Recommend (LTR) – ECHMN	FY2023 through March: 82.2 (28th % ile)	Press Ganey	**80.0 or 17%ile** Target minus distance between Target and Stretch	**81.3 or 32%ile** Target in line with top 50% of improvers	**82.6 or 39%ile** Target in line with top 30% of improvers	FY2024
People	25% (Managers)	Culture of Safety	FY2018: 4.04 FY2021: 3.96	2023 Nat. Avg. – 3.95	Methodology utilizes Press Ganey's statistical significance analysis for recommended targets			FY2024
					≥ 3.98 (baseline)	4.00 or 2024 National Average	4.02	
	OR 25% (Employees)		Participation in Culture of Safety Survey	Press Ganey average participation-75%	77%	80%	83%	FY2024
Finance	25%	Operating EBIDA Margin	FY2023 YTD Q3: $173 Million	Moody's: Median for 'A1': 9.7% Median for 'Aa3': 8.9%	*95% of Budget* *$221M*	*100% of Budget* *$233M*	*105% of Budget* *$245M*	FY2024

CEO Report
August 9, 2023
Dan Woods, Chief Executive Officer

Operations

Health System
El Camino Health was recently named to the 2023 “Great Hospitals in America” list by Becker's Hospital Review. Hospitals on the list are known for clinical excellence, patient safety, innovation, research and education, patient satisfaction and more. Additionally, "Great Hospitals in America" have been recognized for their leadership in the industry and their excellence in several specialties.

Women’s & Newborn Care
In June, El Camino Health was once again named a five ribbon hospital, receiving top honors on Newsweek's 2023 list of America's Best Maternity Hospitals. The distinction recognizes facilities that have provided exceptional care to mothers, newborns and their families, as verified by Statista Inc. ECH opened part of the first phase of the $150 million expansion of the Women’s & Newborn care hospital – this included a new entrance and lobby welcoming patients with soon to open new neonatal intensive care and mother-baby units to follow.

Heart & Vascular Institute
El Camino Health has received the American College of Cardiology's NCDR Chest Pain-MI Registry Platinum Performance Achievement Award for 2023. El Camino Health is one of only 262 hospitals nationwide to receive the honor.

The award recognizes El Camino Health's commitment and success in implementing a higher standard of care for heart attack patients and signifies that the health system has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations.

Human Resources

The Workplace Equity & Inclusion Steering Committee held its inaugural meeting. The committee is comprised of diverse department representatives who will act as operational change managers of future diversity initiatives and provide monthly feedback to diversity leadership on programming.

The assessment phase of our diversity work has been initiated. El Camino Health, in collaboration with The Equity Project, conducted an organization-wide survey to capture the DEI perspectives and priorities of staff. The survey closed on July 30th and we are awaiting results to begin action planning.

Marketing and Communications

We had local coverage for El Camino Health and the nurses’ union agreeing to a new contract, an interview with Dr. Nicole Tarui, medical director of the Maternal Outreach Mood Services (MOMS) program, for national minority mental health awareness month, CIO Deb Muro’s panelist remarks on El Camino Health’s innovation efforts at the Mountain View tech showcase including first hospital to launch FloPatch, and El Camino Health earning the 2023 Emergency Nurses Association Lantern Award.

For national coverage, El Camino Health was named on Becker's 2023 edition of its "Great hospitals in America" list and we were covered for launching the Taft Innovation Fund.
On social media, the top posts included: a story about how Julie Arbuckle, R.N. and clinical manager at El Camino Health's Cardiac and Pulmonary Wellness helped save the life of a San Jose resident at a party they were both attending, Pride Month 2023, and launch of the Taft Innovation Fund.

Corporate Health Services

Concern added 83 new public sector organizations. They expect specialty services for first responders, which includes; expanding the first responder specialty clinical panel, training for their peer support teams, and experts to coach the peer support teams. In addition we are developing a mental health screening program for first responders.

The South Asian Heart Center engaged **380** new and prior participants in screening, education, and coaching programs to prevent heart disease and diabetes and completed **710** consultations and coaching sessions. We hosted 8 lifestyle workshops and health information events attended by **300** participants and community members.

Foundation

In period 12, El Camino Health Foundation received $152,583 in new donations. This brings total funds raised by June 30, 2023 to $10,565,603, which is 110 percent of goal for fiscal year 2023.

On June 13, Norma's Literary Luncheon welcomed more than 200 guests to support the Orchard Pavilion renovation project, and to hear from Pulitzer Prize winning novelist, Jennifer Egan. This was the 11th consecutive year this event has been held, and the net event proceeds will generate more than $118,000 for the maternal care project.

On June 27th, the Foundation hosted an open house where guests and community leaders were invited to view the first phase of the Orchard Pavilion renovation project. The event included a VIP reception, attended by more than 100 guests and community leaders, with a program that featured leaders from El Camino Health and the El Camino Health District Board. Following the reception, more than 80 additional community members attended the second half of the event, which included guided tours through the newly renovated NICU and post-partum patient rooms on the second and third floors.

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, June 14, 2023

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

Board Members Present
Bob Rebitzer, Chair
Lanhee Chen, JD, PhD *(joined at 5:49 pm)*
Julie Kliger, MPA, BS
Julia E. Miller, Secretary/Treasurer
Jack Po, MD, Ph.D., Vice-Chair
Carol A. Somersille, MD
George O. Ting, MD
Don Watters**
John Zoglin

Board Members Absent
Peter Fung, MD

Others Present
Dan Woods, CEO
Mark Adams, MD, CMO
Holly Beeman, MD, CQO
Carlos Bohorquez, CFO
Omar Chughtai, CGO
Shahab Dadjou, President, ECHMN
Ken King, CAO
Andreu Reall, VP of Strategy**
Cheryl Reinking, CNO
Diane Wigglesworth,

***via teleconference*

Others Present (cont.)
Deb Muro, CIO**
Mary Rotunno, General Counsel**
Vineeta Hiranandani, VP of Marketing and Communications**
Tracy Fowler, Director, Governance Services
Stephanie Iljin, Manager, Administration
Brian Richards, Information Technology

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:39 p.m. by Chair Bob Rebitzer. Directors Chen and Fung were absent at time of roll call. Chair Rebitzer reviewed the logistics for the meeting. A quorum was present.	**The meeting was called to order at *5:39 p.m.***
2. AB2449 REMOTE PARTICIPATION	Chair Rebitzer asked the Board for declarations of AB2449 request for approval. None were noted.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board for declarations of conflict of interest with any items on the agenda. None were reported.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board, and no comments were made.	
5. RECOGNITION OF ECH BOARD MEMBER JULIE KLIGER	Chair Rebitzer recognized that it was the last meeting for Director Julie Kliger. He acknowledged her transformative leadership, her valuable strategic direction and oversight, and her advocacy for nurses and patients. Her commitment to the values and mission of our hospital has positively influenced the quality of care we provide, shaping our institution in lasting ways. Director Kliger was acknowledged with a standing ovation and a floral arrangement.	
6. QUALITY COMMITTEE REPORT	Dr. Beeman shared a report on Quality Committee activities, including improvements in C.diff prevention, continued focus on non-ventilator pneumonia and sepsis mortality rates. Discussion with the board included, but was not limited to, leadership engagement and positive reinforcement in changing culture and focusing on HAC index.	

7. ADJOURN TO CLOSED SESSION	Motion to adjourn to closed session at 5:49 p.m. pursuant to *Health and Safety Code Section 32106(b)* for reports and discussion involving healthcare facility trade secrets for discussion of Enterprise Risk Management, Los Gatos Campus Development, FY24 Operating and Capital Budget, FY24 Strategic Goal, and potential acquisitions; and*Gov't Code Section 54957.2* for approval of the minutes of the Closed Session of the Hospital Board (5/10/2023); and deliberations concerning reports on Medical Staff quality assurance matters (Medical Staff Credentialing & Privileges Report). **Motion:** to adjourn to closed session at **5:49 p.m.** **Movant**: Somersille **Second**: Watters **Ayes**: Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung **Recused**: None	***Adjourned to closed session at 5:49 p.m.***
8. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	The open session was reconvened at **7:13 p.m.** by Chair Rebitzer. Agenda Items 8-14 were addressed in closed session. During the closed session, the El Camino Hospital Board of Directors approved the minutes of the Closed Session of the Hospital Board (5/10/2023), and the Credentials and Privileges Report, as reviewed and recommended for approval by the Quality, Patient Care and Experience Committee by a unanimous vote of all Directors present (Directors Chen, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, and Zoglin).	
9. AGENDA ITEM 20: FY24 OPERATING AND CAPITAL BUDGET	Mr. Borhorquez gave an overview of the key points of the FY24 Operating and Capital Budget. Chair Rebitzer asked if any member of the Board or the public wished to discuss further. **Motion:** to approve the FY24 Operating and Capital Budget **Movant:** Po **Second:** Ting **Ayes:** Chen, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***FY24 Operating and Capital Budget was approved.***
10. AGENDA ITEM 21: FY24 ORGANIZATIONAL PERFORMANCE GOALS	Chair Rebitzer asked for a motion to approve the FY24 Organizational Performance Goals. **Motion:** to approve the FY24 Organizational Performance Goals	***FY24 Organizational Performance Goals were approved.***

	Movant: Chen **Second:** Watters **Ayes:** Chen, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	
11. AGENDA ITEM 22: CEO REPORT	Dan Woods presented the CEO report, presented by Dan, covered a range of topics. Mr. Borhorquez was recognized as one of the top CFOs in healthcare by Becker's Healthcare. The Employee Voice and Physician Survey was launched and completed with 83% participation by employees and 44% participation by physicians. The results of the survey were being analyzed and would be provided at a later date. Mr. Woods also acknowledged the Nurses Week and Hospital Week celebrations. An update was provided on the negotiations with the California Nurses Association, describing the ongoing discussions as amicable. El Camino Hospital sponsored and participated in a behavioral health conference, and there was praise for the leadership role of nursing at El Camino displayed during the event. The report concluded with an update on the Aspire program, which is focused on preventing teenage suicide.	
12. AGENDA ITEM 23: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to raise an item from the consent calendar for discussion. Director Zoglin asked to discuss e and h. Discussion on these items included physician recruitment and static goals for the committees. No items were removed and a motion was made to approve the full consent calendar. **Motion:** to approve the consent calendar to include: a. Minutes of the Open Session of the Hospital Board (5/10/2023) b. Enterprise Medical Director Rehabilitation Services c. Anesthesia Services Agreement d. Radiation Oncology Recruitment Agreement e. Medical Staff Development Plan f. FY24 Implementation Strategy Report and Community Benefit Plan g. FY24 Master Calendar h. FY24 Committee Goals i. FY24 Committee Pacing Plans j. FY24 Committee and Liaisons Appointments k. Committee Charter Updates l. Global Equity Managers m. Policies, Plans, and Scope of Services **Movant:** Miller **Second:** Po **Ayes:** Chen, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None	***The consent calendar was approved***

	Absent: Fung **Recused:** None	
13. AGENDA ITEM 25: BOARD COMMENTS	Final board comments included compliments on the agenda management, the efficiency of reading the materials in advance and the progress on the strategic plan.	
14. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:37 p.m. **Movant**: Miller **Second**: Po **Ayes:** Chen, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***The meeting adjourned at 7:37 p.m.***

Attest as to the approval of the preceding minutes by the Board of Directors of El Camino Hospital:

_____

Tracy Fowler, Director of Governance Services

Status Active PolicyStat ID 13375295

Origination	05/2018
Last Approved	06/2023
Effective	06/2023
Last Revised	06/2023
Next Review	06/2024
Owner	Heidi Yamat: Manager Accreditation and Regulatory 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 and oversight for implementing the Quality Improvement Plan to the Quality, Patient Care and Patient Experience Committee, hospital administration, medical staff, and its respective governance committees. Refer to Attachment A on Governance Information Flow.

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

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

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

Governing Board.

Medical Executive Committee (MEC)

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

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

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
Quality Committee	Franz Encisa: Director Quality and Public Reporting [PS]	06/2023
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	05/2023
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

Status **Pending** PolicyStat ID **12707047**

Origination	09/2021	Owner	Michael Rea: Mgr Emp Wellness & Health Svcs
Last Approved	N/A	Area	Employee Wellness & Health
Effective	Upon Approval	Document Types	Plan
Last Revised	06/2023		
Next Review	1 year after approval		

COVID-19 Vaccine Plan

COVERAGE:

This plan applies to El Camino Hospital employees, physicians, contractors, volunteers, observers and students. If there is a conflict between the Hospital plan and the applicable MOU, the applicable MOU will prevail.

PURPOSE:

El Camino Hospital has an obligation to provide a safe environment of care and is genuinely concerned about the safety of all, patients, visitors, employees, physicians, contractors, volunteers, observers and students. COVID-19 (SARS-CoV-2) is a contagious respiratory illness caused by the SARS-CoV-2 virus. COVID-19 can cause mild to severe illness, and at times can lead to death. It is thought that COVID-19 mortality rate is substantially higher (possible 10 times more) than that of most strains of flu. As of the date of the approval of this policy, the FDA, under the emergency use act (EUA), has approved three COVID-19 vaccines. All vaccines have been found to be both safe and effective in reducing the risk of COVID-19, and health-care related transmission.

REFERENCES:

Health Order Requiring Use of Face Masks in Patient Care Areas of Healthcare Delivery Facilities During Designated Winter Respiratory Virus Period; Rescission of Prior Health Orders, Santa Clara County Department of Public Health, Effective April 4, 2023. (sccgov.org))

Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination
https://www.federalregister.gov/documents/2021/11/05/2021-23831/medicare-and-medicaid-

programs-omnibus-covid-19-health-care-staff-vaccination

Center for Disease Control (CDC) Vaccines for COVID-19 5/23/2021 https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html

PROCEDURE:

A. This plan is intended to maximize vaccination against COVID-19 among all ECH healthcare workers and to comply with the State of California and Santa Clara County Public Health Department COVID-19 guidance regarding COVID-19 vaccination, testing and mandated masking of healthcare workers.

B. COVID-19 vaccination is a condition of hire and retention for all employees. All employees, physicians, contractors, volunteers, observers and students must be fully vaccinated (except in unusual and specific circumstances as described in Procedure D) as communicated by EWHS.

C. An individual is considered up to date with vaccines after receipt of one dose of the Pfizer or Moderna bivalent vaccine, regardless if or what prior vaccine doses were received; or who has had 2 doses of Novavax; or a booster dose of Novavax following a single Johnson & Johnson vaccine dose or a series of 2 monovalent Moderna or Pfizer-BioNTech doses.

D. Exemption requests will be considered under the following circumstances:

1. Medical/religious contraindications to vaccination including:
    a. Persons with written documentation by a healthcare provider of a medical contraindication to the COVID-19 vaccine (See addendum COVID-19 Exemption Request Form), including whether all or a specific vaccine are contraindicated.
    b. Written documentation of a qualifying religious exception (See addendum COVID-19 Vaccine Exemption Request Form).

E. The COVID-19 Vaccine Plan includes the following features:

1. When additional vaccination recommendations are published by Santa Clara County Public Health (SCCPH), El Camino Hospital will inform staff about the following:
    a. Requirement(s) for vaccination
    b. Dates when COVID-19 vaccine(s) are available
    c. Vaccine(s) will be provided at no out of pocket expense to the employee
    d. Procedure for receiving the vaccination
    e. Procedure for submitting written documentation of vaccine obtained outside ECH, EWHS
    f. Procedure for declining
    g. Consequences for non-compliance with this plan
2. If vaccine shortages occur or if SCCPH, CDPH, and/or the CDC recommendations are altered, all or part of this plan may be modified, suspended, or revoked.
3. Staff will be educated on the following (this education may occur either at the time of the vaccination activity, or at the time of hire or as part of ongoing training and

education, or any combination thereof):

a. Benefits of COVID-19 vaccine

b. Potential health consequences of COVID-19 illness for themselves and patients

c. Epidemiology and modes of transmission, diagnosis, and non-vaccine infection control strategies (such as the use of appropriate precautions & respiratory hygiene).

4. Visual cues for ID badges may be used to permit monitoring compliance with the above requirements.
5. All staff are responsible for compliance with this Plan.
6. Staff supervisors, managers and directors (as applicable to worker) are responsible for the enforcement of this Plan.

RESPONSIBILITIES

A. **COVID-19 Vaccine All ECH Staff:**

1. Receive the COVID-19 vaccine(s) provided by ECH and coordinated by EWHS
2. Or complete and submit a COVID-19 Exemption Request Form to EWHS stating the reason for the exemption request as described in the section above (see attached COVID-19 Exemption Review Process)
3. Or provide current written proof of receipt of required COVID-19 vaccine(s) if not given by EWHS or designee including the date and type of vaccination received
4. Comply with Santa Clara Health Department mandate to wear a mask regardless of vaccination during the designated Winter Respiratory Virus Period and/or at any other time as mandated by SCCHD or CDPH
5. Not report to work if experiencing any COVID-19 symptoms and call the EWHS Flu/ COVID Hotline (650-988-7808)

B. **COVID-19 Testing**

1. All staff are encouraged to test for COVID-19 whenever they experience symptoms of COVID-19 and/or when they know they have been or may have been exposed.
2. Unvaccinated Staff may be required to test for COVID-19 more frequently based on Santa Clara County Health Department mandates.

C. **Universal Masking**

1. Regardless of COVID-19 vaccination status, all healthcare workers in every healthcare setting shall adhere to standard precautions during the care of patients in order to prevent disease transmission.
2. Masking is required in patient care areas during the Winter Respiratory Virus Period as designated annually by the Santa Clara County Department of Public Health and/ or at any time deemed necessary by Santa Clara County Department of Public Health and/or the California Department of Public Health.

D. **Compliance**

1. Non-compliance with any part of this plan may lead to disciplinary action including suspension and up to termination. Non-compliance with health requirements may result in disciplinary action that will affect employee's incentive payout (bonus).

E. **Reporting**

1. Employee Wellness & Health Services (EWHS)
    a. Review and approve documentation of acceptable medical contraindications
    b. Forward religious exemptions requests to Human Resources for review and approval
    c. Coordinate COVID-19 vaccination distribution and tracking to departments for department-based COVID-19 vaccination of employees
    d. Maintain electronic records for staff that have received or declined COVID-19 vaccination
    e. Notify Managers and Supervisors regarding COVID-19 vaccination status of employees in their respective departments
    f. Report required COVID-19 vaccination data to government agencies as required
    g. Provide information to Human Resources regarding those employees who are not in compliance with this policy
    h. Review employee COVID-19 vaccination rates

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Attachments

COVID-19 Vaccine Exemption Request Form

COVID-19 Vaccines Exemption Review Process.docx.pdf

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending

Medicine Department Executive Committee	Michael Rea: Mgr Emp Wellness & Health Svcs	06/2023
HR Leaders and CHRO	Michael Rea: Mgr Emp Wellness & Health Svcs	06/2023
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	06/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	05/2023
Infection Prevention Committee	Delfina Payer: Quality Data Analyst [PS]	05/2023
HR Leaders and CHRO	Tamara Stafford: Dir Talent Development & EWHS	04/2023