El Camino Health

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

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

*John Zoglin will be participating via teleconference from 1005 Los Altos Ave., Los Altos, CA 94022*

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: 991 9988 7834 # No participant code. Just press #.**

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

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

**NOTE**: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

A copy of the agenda for the Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **1.** | **CALL TO ORDER/ROLL CALL** | Carol Somersille, MD<br>Quality Committee Chair | | **5:30 pm** |
| **2.** | **CONSIDER APPROVAL FOR AB 2449 REQUESTS** | Carol Somersille, MD<br>Quality Committee Chair | Possible Motion | **5:30 pm** |
| **3.** | **POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Carol Somersille, MD<br>Quality Committee Chair | Information | **5:30 pm** |
| **4.** | **PUBLIC COMMUNICATION**<br>a. Oral Comments<br>*This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.*<br>b. Written Public Comments<br>*Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.* | Carol Somersille, MD<br>Quality Committee Chair | Information | **5:30 pm** |
| **5.** | **CONSENT CALENDAR ITEMS**<br>a. Approve Minutes of the Open Session of the Quality Committee Meeting (02/03/2025)<br>b. FY25 Pacing Plan<br>c. FY25 Committee Goals<br>d. Value-Based Purchasing Report<br>e. Receive QC Recruitment Position Specification | Carol Somersille, MD<br>Quality Committee Chair | **Motion Required** | **5:30 – 5:40** |
| **6.** | **VERBAL CHAIR'S REPORT** | Carol Somersille, MD<br>Quality Committee Chair | Information | **5:40 – 5:45** |
| **7.** | **PATIENT STORY** | Cheryl Reinking, DNP, RN NEA-BC,<br>Chief Nursing Officer | Information | **5:50 – 5:55** |

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **8.** | **PATIENT EXPERIENCE REPORT** | Christine Cunningham, Chief Experience and Performance Improvement Officer | Information | **5:55 – 6:10** |
| **9.** | **FY25 ENTERPRISE QUALITY DASHBOARD** | Shreyas Mallur, MD, Chief Quality Officer | Discussion | **6:10– 6:20** |
| **10.** | **REVIEW FY 2026 COMMITTEE PLANNING ITEMS**<br>a. Committee Dates<br>b. Committee Goals<br>c. Pacing Plan<br>d. QC Charter | Shreyas Mallur, MD, Chief Quality Officer | Discussion | **6:20 – 6:40** |
| **11.** | **RECESS TO CLOSED SESSION** | Carol Somersille, MD Quality Committee Chair | **Motion Required** | **6:40 – 6:41** |
| **12.** | **REVIEW PROGRESS OF ENTERPRISE STRATEGIC VISION 2027 AND FY2026 ENTERPRISE QUALITY GOAL**<br>*Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets* | Dan Woods, CEO<br><br>Shreyas Mallur, MD, Chief Quality Officer<br><br>Andreu Reall, VP, Strategy | Discussion | **6:41 – 6:56** |
| **13.** | **QUALITY COUNCIL MINUTES**<br>a. Quality Council Minutes (02/05/2025)<br>*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee* | Carol Somersille, MD Quality Committee Chair | Information | **6:56– 7:01** |
| **14.** | **APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (02/03/2025)**<br>*Report involving Gov't Code Section 54957.2 for closed session minutes.* | Carol Somersille, MD Quality Committee Chair | **Motion Required** | **7:01 – 7:06** |
| **15.** | **RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT**<br>*Health and Safety Code Section 32155 and Gov't Code Section 54957 – Deliberations concerning reports on Medical Staff quality assurance committee and report regarding personnel performance of the Medical Staff* | Mark Adams, MD, Chief Medical Officer | **Motion Required** | **7:06 – 7:16** |
| **16.** | **VERBAL SERIOUS SAFETY EVENT REPORT**<br>*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee* | Shreyas Mallur, MD, Chief Quality Officer | Discussion | **7:16 – 7:21** |
| **17.** | **EXECUTIVE SESSION**<br>*Gov't Code Section 54957(b) for discussion and report on personnel performance matters Senior Management* | Carol Somersille, MD Quality Committee Chair | Discussion | **7:21 – 7:31** |
| **18.** | **RECONVENE TO OPEN SESSION** | Carol Somersille, MD Quality Committee Chair | **Motion Required** | **7:31 – 7:32** |

| | AGENDA ITEM | PRESENTED BY | ACTION | ESTIMATED TIMES |
|---|---|---|---|---|
| **19.** | **CLOSED SESSION REPORT OUT**<br>To report any required disclosures regarding permissible actions taken during Closed Session. | Carol Somersille, MD Quality Committee Chair | Information | **7:32 – 7:33** |
| **20.** | **COMMITTEE ANNOUNCEMENTS** | Carol Somersille, MD Quality Committee Chair | Information | **7:33 – 7:39** |
| **21.** | **ADJOURNMENT** | Carol Somersille, MD Quality Committee Chair | **Motion Required** | **7:39 – 7:40** |

**Next Meetings:** May 5, 2025, June 2, 2025

**Minutes of the Open Session of the**
**Quality, Patient Care, and Patient Experience Committee**
**of the El Camino Health Board of Directors**
**Monday, February 3, 2025**
**El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040**

**Members Present**
**Carol Somersille, MD,** Chair
**Melora Simon,** Vice Chair *(joined at 5:42 p.m.)*
**Pancho Chang ****
**Shahram Gholami, MD**
**Jack Po, MD**
**Krutica Sharma, MD**
**Steven Xanthopoulos, MD**
**John Zoglin**

**Members Absent**

**via teleconference

**Staff Present**
**Dan Woods,** CEO
**Mark Adams, MD,** CMO
**Theresa Fuentes**, CLO
**Shreyas Mallur, MD,** CQO
**Cheryl Reinking**, DPN, RN CNO
**Christine Cunningham,** Chief Experience and Performance Improvement Officer
**Lyn Garrett,** Senior Director, Quality
**Christine Cunningham,** Chief Experience and Performance Improvement Officer
**Peter Goll,** CAO, ECHMN
**Jaideep Iyengar, MD,** ECHMN
**Kirstan Smith, BSN,** Director of Clinical Quality, ECHMN
**Anne J. Yang,** Executive Director, Governance Services
**Gabriel Fernandez,** Coordinator, Governance Services

| Agenda Item | Comments/Discussion | Approvals/ Action |
|---|---|---|
| **1. CALL TO ORDER/ ROLL CALL** | The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:37 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Melora Simon was absent at the roll call. | Call to order at **5:37 p.m.** |
| **2. CONSIDER APPROVAL FOR AB 2449 REQUESTS** | No members of the Quality Committee requested Emergency AB-2449 approval. Mr. Chang participated remotely under regular Brown Act teleconferencing requirements. | |
| **3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES** | Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported. | |
| **4. PUBLIC COMMUNICATION** | There were no comments from the members of the public. | |

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| **5. CONSENT CALENDAR** | Chair Somersille asked if any Committee member would like to pull an item from the consent calendar.<br><br>**Motion**: To approve consent calendar (a) Minutes of the Open Session of the Quality Committee Meeting (12/02/2024)<br><br>**Received**: (b) FY25 Pacing Plan<br><br>**Movant**: Po<br>**Second**: Simon<br>**Ayes**: Somersille, Chang, Gholami, Simon, Po, Sharma, Xanthopoulos, Zoglin<br>**Noes**: None<br>**Abstain**: None<br>**Absent:** None<br>**Recused**: None | ***Consent Calendar Approved*** |
| **6. AD HOC COMMITTEE UPDATE** | Dr. Sharma provided a verbal report of the progress made by the recruitment ad hoc committee. The recruitment goal is to find three community members with a particular emphasis on community members with expertise in health equity, customer and patient experience, and outpatient quality. Dr. Sharma shared the projected timelines for reviewing candidates and other recruiting efforts. Chair Somersille reiterated that there was a change in the criteria for candidates to assist in sourcing candidates from High Reliability Organizations. | |
| **7. QUALITY COMMITTEE CHARTER** | Dr. Sharma requested a clerical revision to the Charter. No further discussion on the Quality Committee Charter ensued.<br><br>**Motion**: To approve the Quality Committee Charter with the requested clerical revision.<br><br>**Movant**: Sharma<br>**Second**: Gholami<br>**Ayes**: Somersille, Chang, Gholami, Simon, Po, Sharma, Xanthopoulos, Zoglin<br>**Noes**: None<br>**Abstain**: None<br>**Absent:** None<br>**Recused**: None | |
| **8. PATIENT STORY** | Ms. Reinking shared a Patient Story stemming from a Press Ganey comment from a patient. Ms. Reinking shared that a patient expressed concern with the noise levels during the evening hours. Ms. Reinking outlined the steps taken to identify the noise source and identified it as a floor buffer machine being utilized. Ms. Reinking highlighted the collaboration between nursing staff and | |

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| | the Environmental Services team to identify an alternative time that would best not disturb patients' sleep cycles and ensure staff observe 'quiet hours' in the evening. | |
| **9. Q2 FY25 STEEEP DASHBOARD REVIEW FY25 ENTERPRISE QUALITY DASHBOARD** | Dr. Mallur provided the Q2 FY25 STEEEP Dashboard Review / FY25 Enterprise Quality Dashboard on quality, safety, and experience measure performance through December 2024. Dr. Mallur highlighted the following metrics within the dashboards:<br>• **C. Difficile Infection**: There have been 16 (2 cases per month) Hospital Acquired C.Diff infections in Q2 FY2025.<br>• **Catheter Associated Urinary Tract Infection (CAUTI):** There have been six (6) CAUTI in Q2 FY2025 to have less than ten for the fiscal year.<br>• **Central Line Associated Blood Stream Infection (CLABSI):** The rate of CLABSI for the end of Q2 FY2025 year to date (0.16) is favorable to target (0.42 cases per month).<br>• **Surgical Site Infection**: The number of cases/months of surgical site infections for Q2 FY2025 (4.33) is unfavorable to target (2.5).<br>• **30 Day Readmission Observed Rate:** Performance through Q2 FY2025 (9.5%) is favorable to target<br>• **Risk Adjusted Mortality Index:** Performance for Q2 FY25 (0.97) is favorable to target (1.00).<br>• **Sepsis Mortality Index:** Performance for Q2 FY2025 (1.07) is unfavorable to target (1.00).<br>• **Median Time from ED Arrival to ED Departure (Enterprise):** The current FY25 Q2 performance (151 minutes) is favorable to the target of < 160 minutes (lower is better).<br><br>The Committee inquired regarding turnaround times for radiology imaging, which Dr. Mallur shared can be most attributed to a shortage of radiologists but emphasized that the metric is important because imaging turnaround times affect other departments, such as emergency room turnaround times. | |
| **10. EL CAMINO HEALTH MEDICAL NETWORK REPORT** | Dr. Iyengar, Mr. Goll, and Ms. Smith presented the quarterly El Camino Health Medical Network Report.<br><br>Ms. Smith presented the year-over-year trends for the ECHMN Quality metrics. Ms. Smith highlighted the following trends observed from CY2021 through 12/31/2024:<br>• 35% improvement in Breast Cancer Screening | |

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| | • 36% improvement in Colorectal Cancer Screening<br>• 32% improvement in Diabetes: HBA1c <9%<br>• 19% improvement in Controlling BP<br><br>Ms. Smith shared that of the 10 core measures, the Medical Network successfully met all 10 core quality measures and both radar quality measures. Ms. Smith also noted that although 4 of the core measures were suppressed in the CMS 2024 decile benchmarking, ECHMN performed exceptionally well in the remaining six measures, with one measure in the 8th decile, three measures in the 9th decile, and two measures in the 10th decile. | |
| **11. RECOMMEND QUALITY IMPROVEMENT & PATIENT SAFETY PLAN (QIPS) FOR APPROVAL** | Dr. Mallur presented the Quality Improvement and Safety Plan for recommendation of Hospital Board approval. The Committee inquired regarding coordination of Common Cause analysis to identify trends in patient safety events.<br><br>**Motion**: To recommend Hospital Board approval of the Quality Improvement & Patient Safety Plan (QIPS).<br><br>**Movant**: Po<br>**Second**: Sharma<br>**Ayes**: Somersille, Chang, Gholami, Simon, Po, Sharma, Xanthopoulos, Zoglin<br>**Noes**: None<br>**Abstain**: None<br>**Absent:** None<br>**Recused**: None | |
| **12. RECESS TO CLOSED SESSION** | **Motion**: To recess to closed session at 6:55 p.m.<br><br>**Movant**: Po<br>**Second**: Chang<br>**Ayes**: Somersille, Chang, Gholami, Simon, Po, Sharma, Xanthopoulos, Zoglin<br>**Noes**: None<br>**Abstain**: None<br>**Absent:** None<br>**Recused**: None | ***Recessed to Closed Session at 6:55 p.m.*** |
| **13. AGENDA ITEM 19: CLOSED SESSION REPORT OUT** | During the closed session, the Quality Committee unanimously approved the recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors and the Closed Session Minutes of the December 2, 2024 meeting. | ***Reconvened Open Session at 7:24 p.m.*** |

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| **14. AGENDA ITEM 20: COMMITTEE ANNOUNCEMENTS** | The Committee did not have any announcements. | |
| **15. AGENDA ITEM 21: ADJOURNMENT** | **Motion**: To adjourn at 7:25 p.m.<br>**Movant**: Sharma<br>**Second**: Simon<br>**Ayes**: Somersille, Chang, Gholami, Simon, Po, Sharma, Xanthopoulos, Zoglin<br>**Noes**: None<br>**Abstain**: None<br>**Absent:** None<br>**Recused**: None | ***Meeting adjourned at 7:25 p.m.*** |

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

_____
Gabriel Fernandez, Coordinator, Governance Services

Prepared by: Gabriel Fernandez, Coordinator, Governance Services
Reviewed by: Carol Somersille, MD, Quality Committee Chair; Theresa Fuentes, Chief Legal Officer

APPROVED BY QC
05/06/2024

# Quality, Patient Care, and Patient Experience Committee
# FY25 Pacing Plan

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| **STANDING AGENDA ITEMS** | | | | | | | | | | | | |
| Consent Calendar[1] | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| Verbal Committee Member Expertise Sharing or Chair's Report | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| Patient Experience Story | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| Serious Safety Event (as needed) | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| Recommend Credentialing and Privileges Report | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| Quality Council Minutes | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ | | ✓ | ✓ |
| **SPECIAL AGENDA ITEMS – OTHER REPORTS** | | | | | | | | | | | | |
| Quality & Safety Review of reportable events | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| Quarterly Board Level Enterprise/ STEEEP Dashboard Review | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| El Camino Health Medical Network Report | | ✓ | | | ✓ | | | ✓ | | | ✓ | |
| Committee Self-Assessment Results Review | | | | | | | | | | | | ✓ |
| Annual Patient Safety Report | | | ✓ | | | | | | | | | |
| Annual Culture of Safety Survey Report | | | ✓ | | | | | | | | | |
| Patient Experience Report | | | ✓ | | | | | | ✓ | | | |
| Health Equity Report | | | | | | ✓ | | | | | | ✓ |
| Recommend Safety Report for the Environment of Care | | | | | ✓ | | | | | | | |
| PSI Report | | | | | | ✓ | | | | | | |
| Value-Based Purchasing Report | | | | | | | | | ✓ | | | |
| Recommend Quality Improvement & Patient Safety Plan (QIPS) | | | | | | | | ✓ | | | | |
| Refresh Quality/Experience Dashboard measures for FY26 | | | | | | | | | | | | ✓ |
| Artificial Intelligence Report | | | | | | ✓ | | | | | | |
| **COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR** | | | | | | | | | | | | |
| Propose Committee Goals | | | | | | | | | ✓ | | | |
| Recommend Committee Goals | | | | | | | | | | | ✓ | |
| Propose FY Committee Meeting dates | | | | | | | | | ✓ | | | |
| Recommend FY Committee Meeting dates | | | | | | | | | | | ✓ | |
| Propose Organization Goals | | | | | | | | | ✓ | | | |
| Recommend Organization Goals | | | | | | | | | | | ✓ | |
| Propose Pacing Plan | | | | | | | | | ✓ | | | |
| Recommend Pacing Plan | | | | | | | | | | | ✓ | |
| Review & Revise Charter | | | | | | | | | ✓ | | | |
| Recommend Charter | | | | | | | | | | | ✓ | |

1: Includes Approval of Minutes (Open & Closed), Progress Against FY Committee Goals (Quarterly), Current FY Pacing Plan (Quarterly), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

# FY25 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

## PURPOSE

The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health ("ECH"). The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

## STAFF: Chief Quality Officer (Executive Sponsor)

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

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan. | Q4FY24 review and update which measures to include on the FY25 Quality Dashboards. | Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered. |
| **2.** Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets. | Q4FY24 review FY25 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars. | Performance measures on the Quality Dashboards.<br>▪ Monthly Quality Dashboard<br>▪ Quarterly Board Level Quality Dashboard |
| **3.** Identify and reduce health care disparities for ECH patients. | Biannual report to Quality Committee FY25. | Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report". |
| **4.** Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee. | Fiscal Year 2025 | • Attend a minimum of 6 meetings in person.<br>• Actively participate in discussions at each meeting.<br>• Review of annual committee self-assessment results |
| **5.** Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics. | Fiscal Year 2025 | Attend a conference and/or session with a subject matter expert.<br>• Verbal/Written report of key learnings to the Quality Committee. |

**Chair:** Carol Somersille, MD
**Executive Sponsor**: Shreyas Mallur, MD, Chief Quality Officer

El Camino Health

**EL CAMINO HOSPITAL**
**COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee of the Board
**From:** Shreyas Mallur, MD, Chief Quality Officer
**Date:** March 3, 2025
**Subject:** Hospital Value-Based Purchasing (VBP) Impact for Federal Fiscal Year (FFY) 2025.

**Recommendation:** Review the report, noting measure results in all four domains: safety, Patient Experience, Clinical Care, and Efficiency. ECH will receive back 1.79% of the 2 percent IPPS withholding, totaling a $225,553 loss in DRG payments over FFY 2025.

**Summary:** Provide the Committee with a preview of the estimated impact of VBP measures on ECH DRG payments effective October 1, 2024 (FFY 2025).

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

**2.** Background: Value Based Purchasing is CMS' effort to link Medicare's payment system to healthcare quality in the inpatient setting. Section 1886(o) of the Social Security Act sets forth the statutory requirements for the VBP program. The program withholds 2% of Medicare payments and uses the retained payments to fund the value-based incentive payments to hospitals based on their performance in the program.

**3.** Assessment:

- **A.** The estimated net impact of VBP for FFY 2025 is a loss of **$225,553** for ECH. This compares to a loss of **$430,151** for FFY2024 and a gain of **$78,156** for FFY2023.
- **B.** ECH performed better than the threshold this year on most metrics in the Clinical and Safety domains.
- **C.** Our two lowest-performing domains were Medicare Spending per Beneficiary (MSPB) and Patient Experience.

**List of Attachments:**

Hospital Valued-Based Purchasing: El Camino Hospital FFY 2025 (effective 10/1/2024)

| Clinical Outcomes - Domain Score - Unweighted[1]: 30.00 / Weighted[2] 7.5 | | | | | |
|---|---|---|---|---|---|
| Baseline Period (AMI/HF/COPD/CABG/PN): 07/01/2015 - 06/30/2018 | | Performance Period: 07/01/2020 - 06/30/2023 | | | |
| Baseline Period (THA/TKA): 04/01/2015 - 03/31/2018 | | Performance Period: 04/01/2020 - 03/31/2023 | | | |
| Measure | Threshold | Benchmark | ECH Performance | Indicator Direction | Points Scored |
| Acute Myocardial Infarction (AMI) 30 Day Survival Rate | 0.873 | 0.890 | 0.877 | *Higher Better* | 3 |
| Chronic Obstructive Pulmonary Disease (COPD) 30 Day Survival Rate | 0.915 | 0.932 | 0.887 | *Higher Better* | 0 |
| Coronary Artery Bypass Grafting (CABG) 30 Day Survival Rate | 0.970 | 0.980 | 0.975 | *Higher Better* | 7 |
| Heart Failure (HF) 30 Day Survival Rate | 0.884 | 0.910 | 0.900 | *Higher Better* | 6 |
| Pneumonia (PN) 30 Day Survival Rate[3] | 0.841 | 0.874 | 0.842 | *Higher Better* | 2 |
| Total Hip Arthroplasty/Total Knee Arthroplasty Complication | 0.025 | 0.018 | 0.380 | *Lower Better* | 0 |

| Person/Community Engagement - Domain Score - Unweighted[1]: 18 / Weighted[2] 4.5 | | | | | |
|---|---|---|---|---|---|
| Baseline Period: 01/01/2019 - 12/31/2019 | | Performance Period: 01/01/2023 - 12/31/2023 | | | |
| Measure | Threshold | Benchmark | ECH Performance | Indicator Direction | Points Scored |
| Communication with Nurses | 79.42% | 87.71% | 77.24% | *Higher Better* | 0 |
| Communication with Doctors | 79.83% | 87.97% | 79.47% | *Higher Better* | 0 |
| Responsiveness of Hospital Staff | 65.52% | 81.22% | 59.31% | *Higher Better* | 0 |
| Communication about Medicines | 63.11% | 74.05% | 58.34% | *Higher Better* | 0 |
| Cleanliness and Quietness of Hospital Environment | 65.63% | 79.64% | 60.00% | *Higher Better* | 0 |
| Discharge Information | 87.23% | 92.21% | 87.29% | *Higher Better* | 1 |
| Care Transition | 51.84% | 63.57% | 52.16% | *Higher Better* | 1 |
| Overall Rating of Hospital | 71.66% | 85.39% | 73.61% | *Higher Better* | 2 |

| Safety - Domain Score - Unweighted[1]: 32 / Weighted[2] 8 | | | | | |
|---|---|---|---|---|---|
| Baseline Period: 01/01/2019 - 12/31/2019 | | Performance Period: 01/01/2023 - 12/31/2023 | | | |
| Measure | Threshold | Benchmark | ECH Performance | Indicator Direction | Points Scored |
| Catheter-Associated Urinary Tract Infection | 0.65 | 0 | 0.957 | *Lower Better* | 0 |
| Central Line-Associated Blood Stream Infection | 0.589 | 0 | 0.159 | *Lower Better* | 7 |
| Clostridium difficile Infection | 0.52 | 0.014 | 0.471 | *Lower Better* | 1 |
| Methicillin-Resistant Staphylococcus aureus Bacteremia | 0.726 | 0 | 0.464 | *Lower Better* | 6 |
| Surgical Site Infection (SSI)* | N/A | N/A | (N/A) | *Lower Better* | N/A |

| Efficiency - Domain Score - Unweighted[1]: 0 / Weighted[2] 0 | | | | | |
|---|---|---|---|---|---|
| Baseline Period: 01/01/2021 - 12/31/2021 | | Performance Period: 01/01/2023 - 12/31/2023 | | | |
| Measure | Threshold | Benchmark | ECH Performance | Indicator Direction | Points Scored |
| Medicare Spending per Beneficiary - MSPB | 0.98689 | 0.839949 | 0.998483/0 | *Lower Better* | 0 |

| Projected Financial Impact | |
|---|---|
| IPPS Oper Revenue[4] | $106,896,400 |
| 2% IPPS Witholding | $2,137,928 |
| VBP Performance Adj. | 1.79 |
| Adj. Impact (1.5976 - 2.0) | -0.4024 |
| Expected Revenue/Loss[5] | ($225,553.87) |

Footnotes:

* Based on a composite of SSI-Colon Surgery & SSI Abdominal Hysterectomy

[1] - Unweighted Score is weighted within the domain Total Possible Points (100)

[2] - Weighted Score is based on Unweighted Score * 0.25; 100 pts / 4 Domains

[3] - New Measure

[4] - Based on CHA DataSuite

[5] - 2% Witholding x (VBP Performance Adj - Withholding Percentage)

# Position Specification
## El Camino Health Board
## Quality, Patient Care, and Patient Experience Committee Member

**POSITION**

**Quality, Patient Care, and Patient Experience Committee Membership Requirements:**

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

**Quality, Patient Care, and Patient Experience Committee Charter and Responsibilities**:

See attached Charter.

**Professional Experience/Competencies**:

Candidates will have experience in at least one of the three noted areas:

- Customer Experience: Irrespective of industry background, the committee candidate shall have knowledge of customer or patient experience. The candidate shall have experience driving improvement and service recovery, including experience utilizing the net promotor score or other loyalty-based measurements as a key performance indicator.
- Healthy Equity: Health equity exists when every individual has a fair opportunity to attain full health potential and is not disadvantaged from achieving this potential. The Quality Committee candidate shall have health system experience in defining, evaluating, and mitigating the social determinants that stand in the way of health and well-being.
- High-Reliability Organization: Irrespective of industry background, the committee candidate should have experience in maintaining a high-reliability organization with a culture of safety

**Additional Professional Experience/Competencies:**

- Healthcare Quality background preferred
- Governance (Board and/ or Board Committee) experience is preferred but not required
- The successful candidate will be independent as defined in the Committee Charter

El Camino Healthcare System values diversity and seeks candidates who represent the broad and diverse nature of its patients and employees.

# Position Specification
## El Camino Health Board
## Quality, Patient Care, and Patient Experience Committee Member

**Personal Characteristics:**

The ideal candidate will have the following critical characteristics and behaviors:

- An impeccable reputation for honesty and integrity
- Collaborative nature
- Solid communication and interpersonal skills, with the ability to be effective with other Board members and executive management
- High energy and sense of urgency
- Innovative, creative, and imaginative
- Mission-driven
- Comfortable with change

**MEETINGS**

**The Quality, Patient Care, and Patient Experience Committee generally meets in person nine times annually and jointly with the Board of Directors for educational sessions one or two times annually. Occasionally, an additional meeting is held as required for non-scheduled matters.**

**ABOUT EL CAMINO HEALTH**

El Camino Health provides personalized healthcare experience at two not-for-profit acute care hospitals in Los Gatos and Mountain View, as well as primary care, multi-specialty care, and urgent care locations across Santa Clara County. For nearly sixty years, the organization has grown to meet the needs of individuals and communities it serves. Bringing together the best in new technology and advanced medicine, the network of nationally recognized physicians and care teams delivers high-quality, compassionate care. Key service lines include behavioral health, cancer, heart and vascular, mother-baby, neurology, orthopedics, spine, urology, and women's health. The hospitals have earned numerous awards for clinical excellence, including being named as a top 100 hospital in the nation by Fortune/IBM Watson Health and Newsweek, Best Maternity Care Hospital for Los Gatos hospital by Newsweek, and earning a 4 or 5 Star Overall Hospital Quality Rating from Centers for Medicare & Medicaid Services (CMS). El Camino Health has earned four consecutive American Nurses Credentialing Center Magnet Recognitions for nursing excellence and quality patient care.

**El Camino Health Fiscal Year 2024 Facts:**

- Number of beds: 466
- Employees: 4,381
- Number of physicians: 1,552
- Inpatient volume: 22,356
- Outpatient volume: 269,460
- Number of deliveries: 4,642
- Community Benefit Grants: $3.3M

El Camino Health

**EL CAMINO HOSPITAL BOARD OF DIRECTORS**
**COMMITTEE MEETING MEMO**

**To:** Quality Committee of the Board of Directors, El Camino Health
**From:** Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
**Date:** March 3, 2025
**Subject:** Patient Experience Feedback from Press Ganey Survey Comments

**Purpose:** To provide the Committee with written patient feedback that is received from the Press Ganey written comments.

**Summary:**

1. Situation: These comments are from a patient who received a Press Ganey survey following discharge from an inpatient stay at Mountain View Telemetry/Stroke Unit (3C).

2. Authority: To provide insight into one patient's experience and the importance of managing expectations related to discharge.

3. Background: This patient provided helpful feedback regarding unclear communication related to discharge time.

4. Assessment: This patient was unclear about the discharge time and was not sure when to have their transportation arrive or if they should order subsequent meals. Providing the exact time for discharge is difficult due to information that may be required before a discharge is completed. For example, if pending test results must be completed and interpreted before the patient can be released, it may make giving an exact time difficult. Therefore, communicating the approximate times specific tests take and the reason for the tests and wait times are very important to meet the patient's expectations and continue to provide ongoing comfort measures and care while awaiting the final discharge orders. We are working with our nurses using a unique tool called "practicing excellence" to allow the nurses to practice communication techniques when exact times aren't known, which is the case when delivering healthcare while still meeting the patient's expectations.

5. Outcomes: We will continue to monitor our comments and our Press Ganey scores in relation to these communication areas we are improving as a result of our training plans.

6. List of Attachments: See patient comments.

## Comment from Press Ganey

“I am very happy with the staff. The only ambiguity I felt was the time of release. I didn't know if I should order the subsequent meals (which require more than 1/2 a day, and when I need to contact my ride. It did work out though.”

El Camino Health

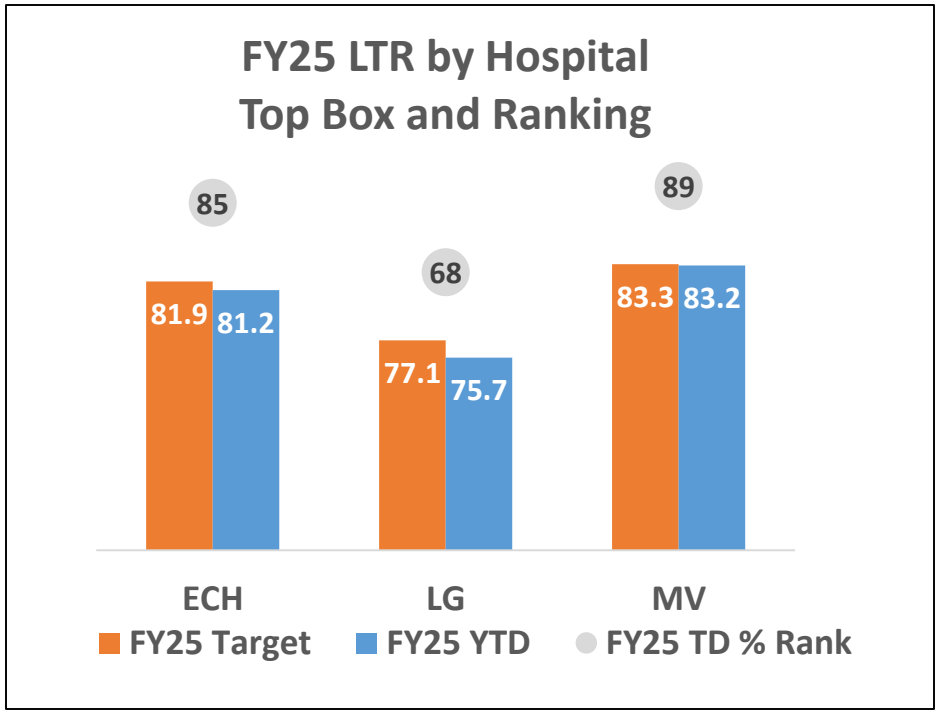
# Quality Committee
# Patient Experience Update
# March 3, 2025

*Christine L. Cunningham, CPXP, MBA*

**“Setting the standard for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way”**

# FY25 Half Year Review

# ECH Inpatient




ECH Target: 80% ile
ECH Rank: 85% ile
**Above by 5% ile**

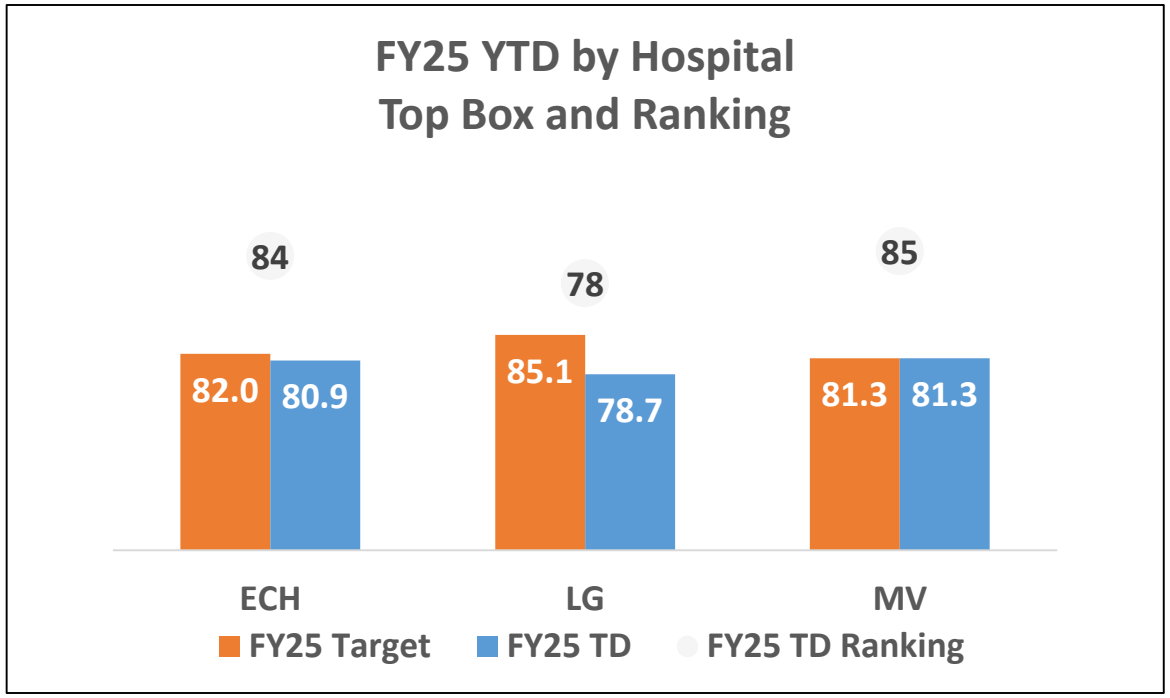
## Performance & Action Items

- Enterprise: exceeding percentile target by 5%ile points
- Mountain View continues to perform in the top decile
- Los Gatos performing under target

**Los Gatos Action Plan**:

- As Nurse Communication is a key driver (highly correlated with LTR), continue with Nursing Excellence Communication program (August – April). 98% staff participation
- Round and coach with RN Leaders to provide ‘words that work’ and ‘at the elbow’ support
- Round and coach with nursing staff to provide support / coaching on bedside shift report and purposeful rounding (track data and report to staff)
- Enforce best practices, engage with staff and share ideas during daily huddle
- Refresh training on behavioral standards, service recovery training, and nursing standard work

# ECH Mother Baby




ECH Target: 82.0 (top box)
ECH Top Box: 80.9
**Below 1.1**

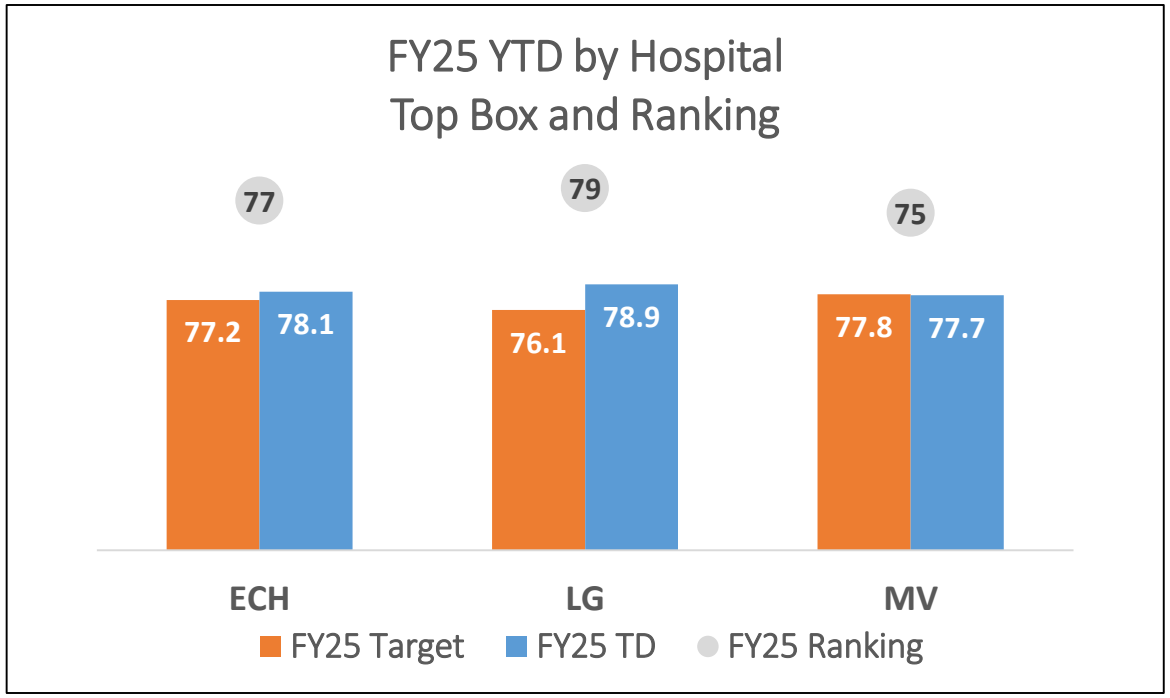
## Performance & Action Items

- Enterprise: below target by 1.1
- Mountain View at target
- Los Gatos performing under target by 6.4

**Action Plan**:

- Call light system updated in Los Gatos
- Focus on Nurse Communication (highly correlated with LTR) and expand Nursing Excellence Program to Mother / Baby LG
- Patient education materials updated
- Engaging patients in decision making regarding birth preferences & treatment plan
- In Mountain View, Labor & Delivery unit construction phase nearing end in early March
- Continue work with Environmental Services and Facilities regarding environment

# ECH Emergency Room




ECH Target: 77.2
ECH Top Box: 78.1
**Exceeded by 0.9**

## Performance & Action Items

- Enterprise: above target by 0.9
- Mountain View below target by 0.1
- Los Gatos above target by 2.8

**Action Plan**:

- Key driver in the ED in teamwork & communication. LG green in all key driver metrics
- Mountain View Teamwork plan:
  - Physician engagement & communication
  - Update on delays & keeping patient informed
  - Leader round improves perception of teamwork and increases LTR

# FY25 Updates

# HCAHPS Changes

- CMS has implemented changes to the HCAHPS (Hospital Consumer Assessment of Healthcare Providers & Systems) survey beginning with January 2025 discharges (FY2027 payment determination)
- Changes include:
  - New web-first modes of survey implementation that will allow web-first mode to be 'reportable'
  - Extend data collection period from 42 – 49 days
  - Remove the survey's prohibition on proxy respondents
  - Limit the number of supplemental survey questions to 12
  - Require use of Spanish translation for Spanish language-preferring patients
- For FY25, we are continuing with our current / paper and e-survey mode to avoid disruption of our current target and goal setting

# Schwartz Rounds

- Schwartz Rounds were started by Ken Schwartz, an attorney who was diagnosed with advanced lung cancer at age 40. During his ordeal, Ken came to realize that what mattered most to him were the human connections he made with his caregivers and how “the smallest acts of kindness” made “the unbearable bearable.”

- At the end of his life, Ken founded The Schwartz Center for Compassionate Healthcare. – the goal of which was simple but compelling: to promote compassionate care in a way that provides hope to the patient, support to caregivers and sustenance to the

*“Schwartz Rounds are a place where people who don’t usually talk about the heart of the work are willing to share their vulnerability, to question themselves. The program provides an opportunity for dialogue that doesn’t happen anywhere else in the hospital.”*


Schwartz Rounds | Sponsored by Patient Experience & Spiritual Care

Schwartz Rounds®

The Schwartz Rounds sessions are multidisciplinary forums where all healthcare workers (clinical and non-clinical) are invited to explore the social and emotional aspects of patient care.

the schwartz center FOR COMPASSIONATE HEALTHCARE

A Patient I Will Never Forget!

February 21, 2025, 12 noon

Mountain View, Conference Rooms E,F, & G

Los Gatos, Conference Room 2 & 3

Lunch will be provided. Open to all El Camino Health and El Camino Health Medical Network employees and providers.

Please join us! Scan the QR code to RSVP

For more information, please contact Debbie_torrey@elcaminohealth, 650-988-8296 or Kelly_Waggoner@elcaminohealth.org, 650-988-7688

General learning objectives for the Schwartz Center Rounds program as a result of participating in this activity, Learners will be able to:

a. Describe the social, emotional, ethical, and personal issues that arise during the care of patients and their impact on care
b. Demonstrate enhanced communication with patients, family members and colleagues.
c. Value opportunities to explore and understand multiple perspectives across disciplines.
d. Value opportunities to provide and receive support from other members of our healthcare community.
e. Model for learners behaviors of nonjudgmental listening and respect.

El Camino Hospital is accredited by the California Medical Association (CMA) to provide continuing medical education for physicians. El Camino Hospital designates this live presentation for a maximum of 1.0 AMA PRA Category 1 Credit(s) ™. Physicians should only claim credit commensurate with the extent of their participation in the activity. None of the planners or faculty for this educational activity have relevant financial relationships to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. You must complete an evaluation form to qualify for CME credit.

RSVP required.
Scan the QR code:

El Camino Health

elcaminohealth.org

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# Patient Experience Summit


As a successful family medicine physician, medical group leader, and clinician coach, Dr. Stephen Beeson's has pioneered an approach to care for those who care for our communities by scaling coaching to every care team member.

Dr. Beeson founded Practicing Excellence in 2013 to tap the power of systemic skill development to improve healthcare at both an organizational and national level. Currently, Dr. Beeson serves as a national thought leader, speaker and author in the field of human development mapping to healthcare challenges and priorities.

# Questions

El Camino Health

El Camino Health

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

**To:** Quality, Patient Care, and Patient Experience Committee
**From:** Shreyas Mallur, M.D, Chief Quality Officer and Lyn Garrett, MHA, MS, CPHQ
**Date:** March 3, 2025
**Subject:** Enterprise Quality, Safety, and Experience Dashboard FY25 through January 2025

**Purpose:**

To update the Quality, Patient Care, and Patient Experience Committee on quality, safety, and experience measure performance through **January 2025** (unless otherwise noted).

**Summary:**

Situation: The FY 25 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks eighteen quality measures.

Assessment:

**Hospital Acquired Conditions:**

a. **C. Difficile Infection:** There have been 19 (2.71 cases per month) (Goal: </= 27 infections FY 2025 or less than 2.25 cases/month) Hospital Acquired C=Diff infections YTD FY2025. Areas of focus to decrease C. Diff are three fold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program has been implemented. Third, a robust antibiotic stewardship program is in place. (Timeline for improvement: We will need to have less than the monthly average to meet the goal)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 8 CAUTI YTD FY2025 with a goal to have less than ten for the fiscal year. Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team reviews every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. (Timeline for improvement: We are likely not to meet the target for FY 25. However, the processes put in place over the last few months should have us improving and show sustained improvement from Q1 FY2026)

c. **Central Line Associated Blood Stream Infection (CLABSI)**. We have had 3 CLABSI YTD FY 2025 to a target of 5. Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. (Timeline for improvement: We are on track to meet target)

1. **Surgical Site Infection**. The number of cases/month of surgical site infections for YTD FY2025 (4 cases) is unfavorable to target (2.5). A taskforce including SPD, OR staff, physicians has been instituted to reinforce best practices, enforce normothermia, timing of preoperative antibiotics and clean closure tray utilization in the OR and perioperative areas.

(Timeline for improvement: We anticipate that our SSI rate will go down by Q4 of FY 2025/ Q1 of FY 2026. This is a major focus for the organization, and we have devoted significant resources to understand and implement any changes needed)

2. **Hand Hygiene Combined Compliance rate:** Performance for Q2 FY2025 is unfavorable (84.1 %) to target of 85%. (Timeline for improvement: We are reemphasizing with staff on the importance of hand hygiene compliance to prevent HAIs)

3. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for Q2 FY2025 is favorable (100%) to target of 80% of units.

4. **Serious Safety Event Rate:** Performance YTD FY2025 (Through September 2024) is favorable (0.56) compared to baseline of 1.93 FY 2024.

5. **30 Day Readmission Observed Rate:** Performance through Q2 FY2025 (9.6%) is favorable to target (</=9.8%). El Camino Health remains committed to ensuring timely follow-up care for patients under primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital. In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital. (Timeline for improvement: We are on track to achieve target for FY 2025)

6. **Complications- Inpatient Hip & Knee Observed rate:** Performance through Q2 FY 2025 is unfavorable (4.5%) to target of <= 3.5%. We are tracking this measure since this is a CMS metric used for VBP, Star rating and benchmarking of health systems. (Timeline for improvement: Q1 FY2026. We will continue to focus on reducing hip/knee SSIs in addition to engaging with surgeons to understand causes of complications)

7. **Risk Adjusted Mortality Index.** Performance YTD FY 2025 (0.99) is favorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. Though we are on track for this metric, we will be closely monitoring this since the system changes introduced in documentation integrity, reduction in clinical variation and institution of earlier hospice and GIP are just in the initial phases of implementation. (Timeline for improvement: We are on track to achieve this target for FY 2025, expect significant improvement in FY 2026 after implementation of changes to documentation and GIP)

8. **Sepsis Mortality Index.** Performance for YTD FY2025 (1.10) is unfavorable to target (1.00). Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program. (Timeline for improvement: The GIP program is planned for go-Live in Q4 of FY 2025. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation.)

9. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY25 performance (154 minutes) is favorable to the target of 160 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street). (Timeline for improvement: We are on track to achieve this target for FY 2025).

10. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. FY 2025 performance through November of 2024 (25.9% is unfavorable) to target of 23.9%. We have seen a decrease year over year in the metric, though not at target. This is a big reduction year over year and is attributed to our MCH team's focus and efforts. The MCH team shares data quarterly with the medical staff regarding individual physician NTSV rates. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of 2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: This metric will likely improve or stay steady at the present rate through FY 2025)

11. **PC-05: Exclusive Breast Milk Feeding:** Performance for FY 2025 YTD for Enterprise is favorable (77.7%) to target of 65.1%. Performance for FY 2025 for LG is favorable (86.6%) to target of 70%. There has been an intense effort by the MCH department and to improve this measure over the last year. (Timeline for improvement: We are on track to achieve this goal for FY 2025)

12. **Inpatient HCAHPS Likelihood to Recommend Percentile.** Performance for FY2025 is favorable and above target for January and for FY25 with a percentile ranking of 86%. Mountain View continues to perform in the top decile. For Los Gatos, the key drivers are nurse communication and we have had a slight decline during our high census and respiratory season. We have a focused plan to increase nurse leader rounding, bedside shift report and purposeful rounding to improve our nurse communication scores. We should see improvement in this metric for Los Gatos in March.

13. **Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** Performance for YTD FY2025 is unfavorable (80.9) to target of (82.0). However, we continue to perform above the 80$^{th}$ percentile nationally. In Mountain View, there is ongoing construction and our new Labor and Delivery units will be complete in early March.

14. **ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend".** Performance for YTD FY2025 is favorable (78.1) to target of (77.2). We continue to focus on the key driver of teamwork and staff worked together and communication about wait times.

15. **El Camino Health Medical Network: Likelihood to Recommend Clinic Top Box Rating of "Yes, Definitely likely to Recommend".** Performance for YTD FY2025 is unfavorable (81.8) to target of (83.4) despite improvements in both primary care and specialty care. Access for primary care appointments improved substantially including ease of getting desired

appointment. Focus is on low scoring PCP clinics and our highest volume specialty care clinics.

**Attachments:**

1. Enterprise Quality Dashboard FY 25 through January 2025.

El Camino Health

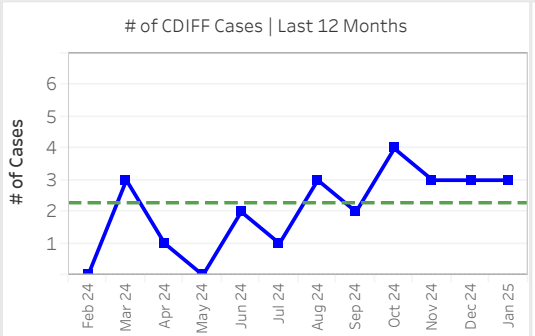
# FY25 Enterprise Quality, Safety and Experience Dashboard

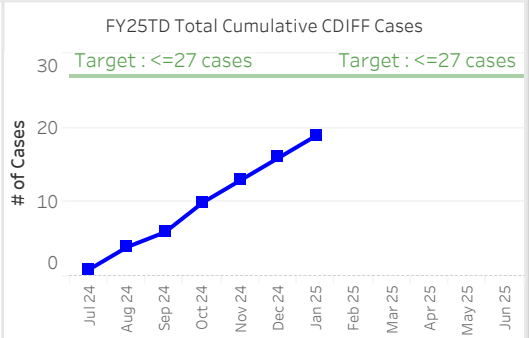
January 2025 (unless other specified)

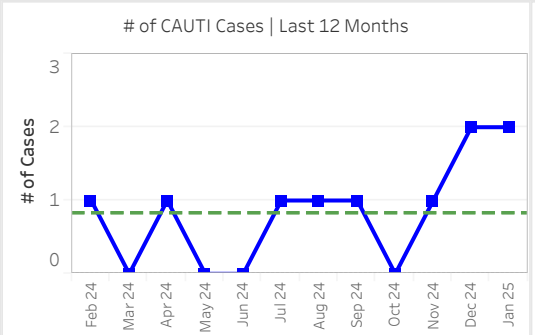
Month to Board Quality Committee : March 2025

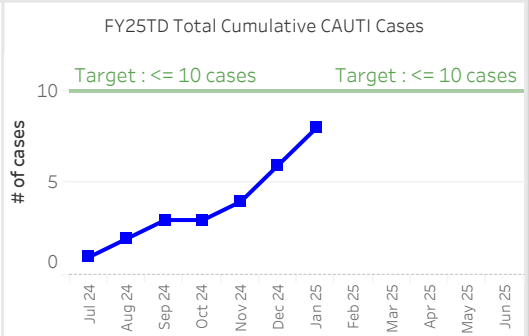


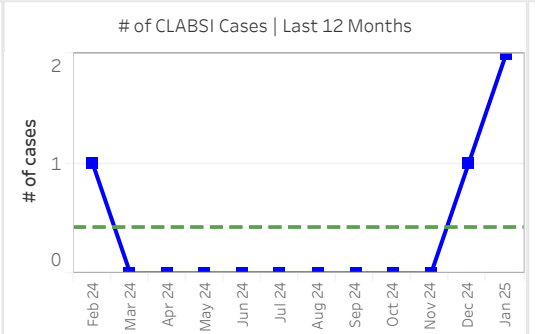
| Measure | FY25 Performance | | Baseline FY24 Actual | FY 25 Target | Trend | FYTD or Rolling 12 Month Average |
|---|---|---|---|---|---|---|
| | Latest Month | FYTD | | | | |
| *Organizational Goal<br>Clostridium Difficile Infections (C-Diff) cases<br>Latest Month : January 2025 | 3 cases | 2.71 cases/mo | 2.33 cases/mo | 2.25 cases/mo | BETTER | BETTER |
| *Organizational Goal<br>Catheter Associated Urinary Tract Infection (CAUTI) cases<br>Latest Month : January 2025 | 2 cases | 1.14 cases/mo | 0.92 cases/mo | 0.83 cases/mo | BETTER | BETTER |
| Central Line Associated Blood Stream Infection (CLABSI) cases<br>Latest Month : January 2025 | 2 cases | 0.43 cases/mo | 0.25 cases/mo | 0.42 cases/mo | BETTER | BETTER |

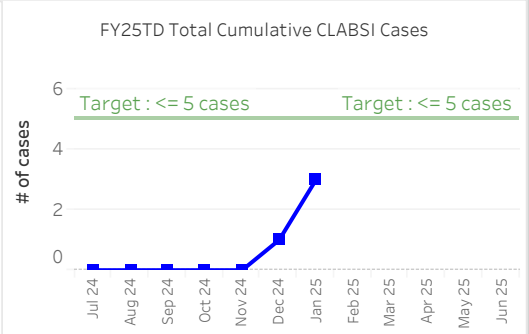



Quality Department | Note : updated as of February 19, 2025

| Measure | Definition Owner | Metric Definition | Data Source |
|---|---|---|---|
| *Organizational Goal<br>Clostridium Difficile Infections (C-Diff) cases | C. Nalesnik | 1) Based on NHSN defined criteria<br>2) Exclusions : ED & OP | **Numerator:** Infection control Dept.<br>**Denominator**: EPIC Report |
| *Organizational Goal<br>Catheter Associated Urinary Tract Infection (CAUTI) cases | C. Nalesnik | 1) Based on NHSN defined criteria<br>2) Exclusions : ED & OP | **Numerator:** Infection control Dept.<br>**Denominator**: EPIC Report |
| Central Line Associated Blood Stream Infection (CLABSI) cases | C. Nalesnik | 1) Based on NHSN defined criteria<br>2) Exclusions : ED & OP | **Numerator**: Infection control Dept.<br>**Denominator**: EPIC Report |

El Camino Health

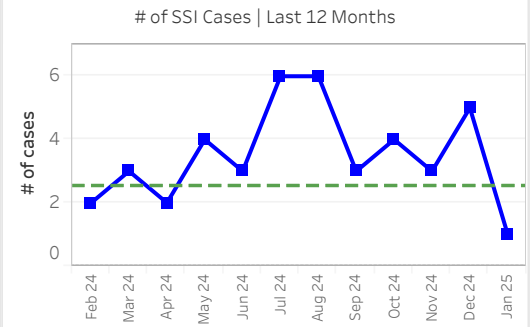
# FY25 Enterprise Quality, Safety and Experience Dashboard

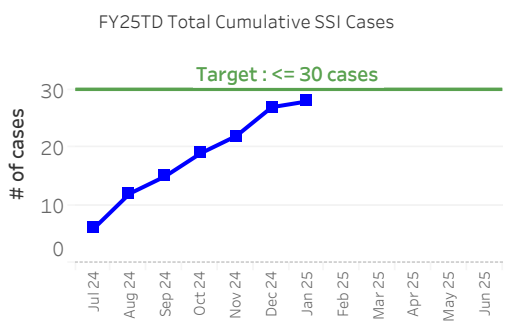
January 2025 (unless other specified)

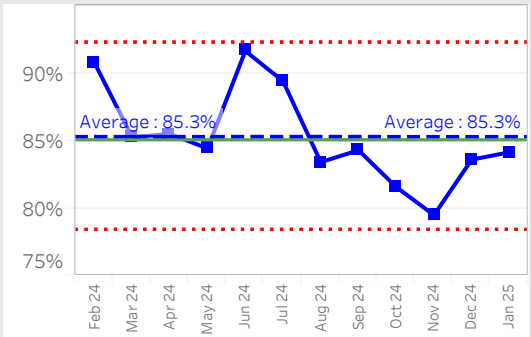
Month to Board Quality Committee : March 2025

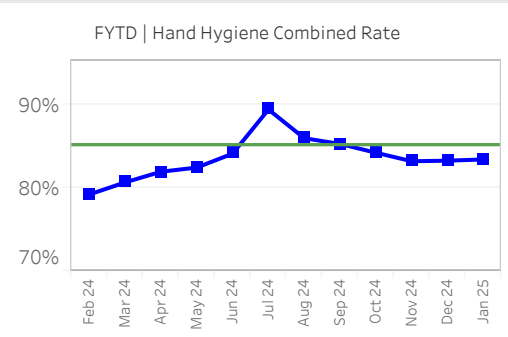


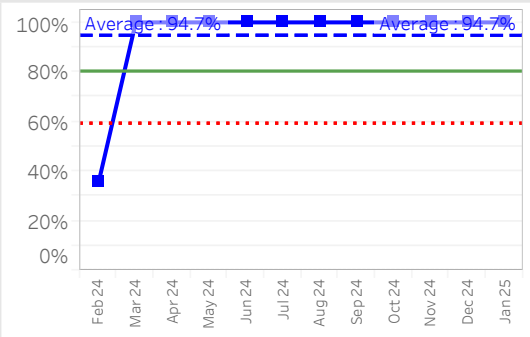
| Measure | FY25 Performance | | Baseline FY24 Actual | FY 25 Target | Trend | FYTD or Rolling 12 Month Average |
|---|---|---|---|---|---|---|
| | Latest Month | FYTD | | | | |
| Surgical Site Infections (SSI) cases<br>Latest Month : January 2025 | 1 cases | 4.00 cases/mo | 3.17 cases/mo | 2.50 cases/mo | BETTER | BETTER |
| Hand Hygiene Combined Compliance Rate<br>Latest Month : January 2025 | 84.1% ( 15747 / 18716 ) | 83.4% ( 94022 / 112748 ) | 84.1% ( 64956 / 77245 ) | 85% | BETTER | BETTER |
| Hand Hygiene % of Departments Meeting Target<br>Latest Month : January 2025 | 100.0% ( 25 / 25 ) | 100.0% ( 175 / 175 ) | 54.7% ( 164 / 300 ) | 80% of units | BETTER | BETTER |

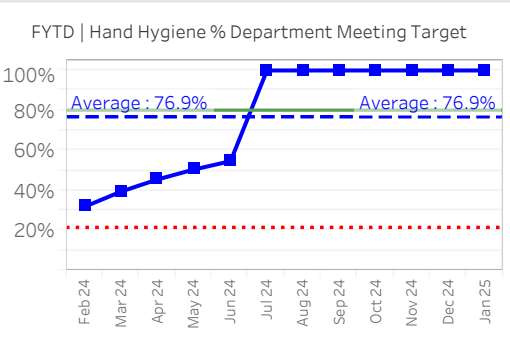



Quality Department | Note : updated as of February 19, 2025

| Measure | Definition Owner | Metric Definition | Data Source |
|---|---|---|---|
| Surgical Site Infections (SSI) cases | C. Nalesnik | 1) Based on NHSN defined criteria<br>2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class"<br>3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty".<br>4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable.<br>5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change. | **Numerator:** Infection control Dept.<br>**Denominator**: EPIC Report |
| Hand Hygiene Combined Compliance Rate | S. Mallur, MD / Lyn Garrett | % of yes Cleaning Before Entering or Exit | Hand Hygiene Audit from Laudio Audit Tool<br><br>Hand Hygiene Leapfrog Tableau Dashboard maintained by:<br>**Hsiao-Lan Shih** |
| Hand Hygiene % of Departments Meeting Target | S. Mallur, MD / Lyn Garrett | Number of Unit done Audit according to their Target (Only Leapfrog units) | Hand Hygiene Audit from Laudio Audit Tool<br><br>Hand Hygiene Leapfrog Tableau Dashboard maintained by:<br>**Hsiao-Lan Shih** |

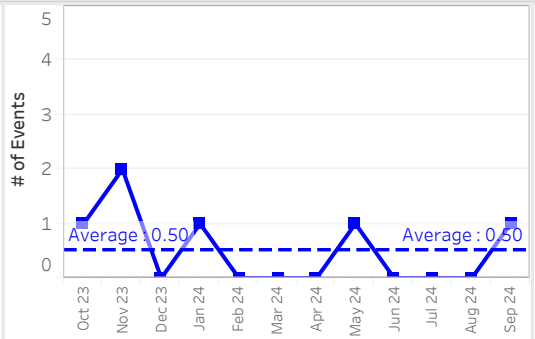
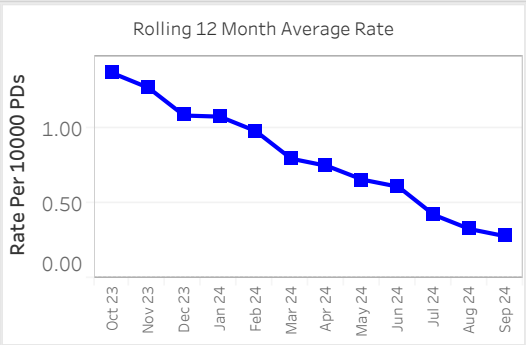
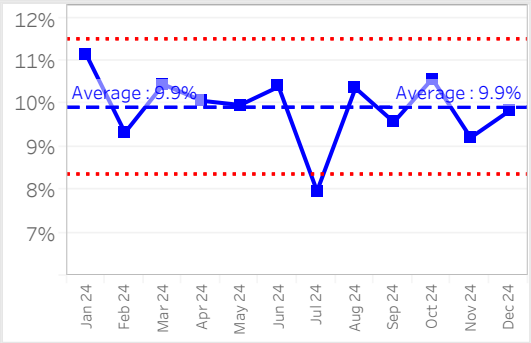
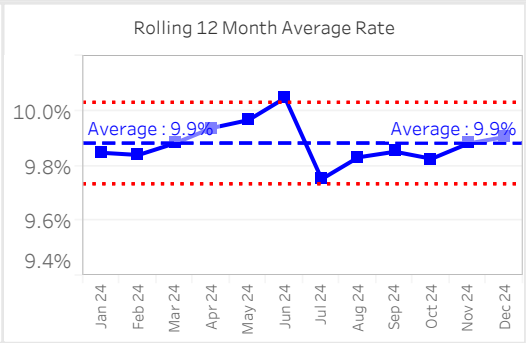
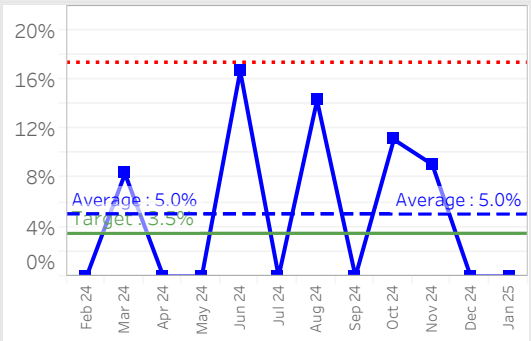
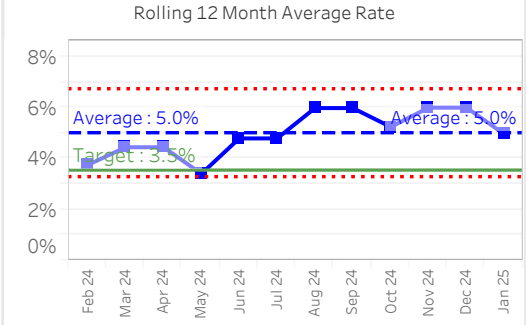
El Camino Health

# FY25 Enterprise Quality, Safety and Experience Dashboard

January 2025 (unless other specified)

Month to Board Quality Committee : March 2025



| Measure | FY25 Performance | | Baseline FY24 Actual | FY 25 Target | Trend | FYTD or Rolling 12 Month Average |
|---|---|---|---|---|---|---|
| | Latest Month | FYTD | | | | |
| Serious Safety Event Rate (SSER)<br>Latest Month : September 2024 | 1 events | 0.56 ( 1 / 17964 ) | 1.93 ( 41 / 212460 ) | n/a |  |  |
| 30-Day Readmission Observed Rate<br>Vizient Risk Model<br>Latest Month : December 2024 | 9.8% ( 138 / 1404 ) | 9.6% ( 757 / 7884 ) | 9.8% ( 1519 / 15552 ) | <= 9.8% |  |  |
| Complications - Inpatient Hip & Knee Observed Rate<br>(within 90 days of procedure)<br>Latest Month : January 2025 | 0.0% ( 0 / 8 ) | 4.5% ( 3 / 66 ) | 5.9% ( 5 / 85 ) | <= 3.5% |  |  |







Quality Department | Note : updated as of February 19, 2025

| Measure | Definition Owner | Metric Definition | Data Source |
|---|---|---|---|
| Serious Safety Event Rate (SSER) | S. Shah | 1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient.<br>2) Inclusions: events determined to be serious safety events per Safety Event Classification team<br>3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs<br>4) Denominator: EPSI Acute Adjusted Patient Days<br>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.<br>New classification rules in effect as of 7/1/22 | HPI Systems<br><br>Safety Event Tableau Dashboard maintained by: **Michael Moa** |
| 30-Day Readmission Observed Rate<br>Vizient Risk Model | S. Mallur, MD | 1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause).<br>2) Based upon Vizient Risk Model 2023 Community + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned').<br>3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn | Vizient Clinical Database<br><br>Readmission Tableau Dashboard maintained by: **Steven Sun** |
| Complications - Hip & Knee Observed Rate<br>Vizient Risk Model | S. Mallur, MD | Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthoplasty (THA), total knee arthoplasty (TKA) procedure.<br>Numerator : Distinct count of patients having complications / Total Cases. Patients with complications are counted in the numerator only once, regardless of the number or type of complication.<br>Denominator : Eligible index admissions who have undergone a qualifying elective primary THA or TKA procedure.<br>2.) Based upon Vizient Risk Model 2023 Community + AHRQ Version 2023<br>3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate & Normal Newborn) | Vizient Clinical Database |

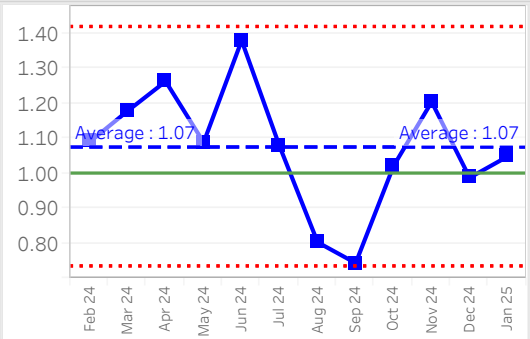
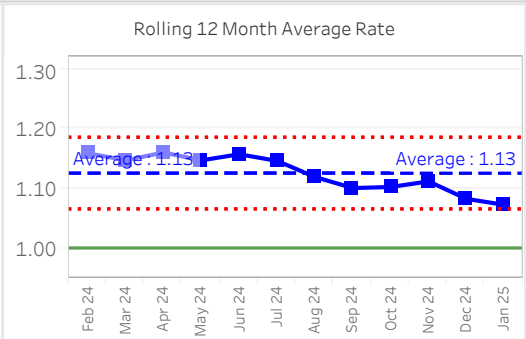
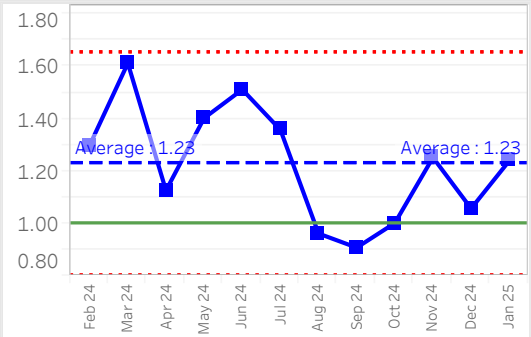
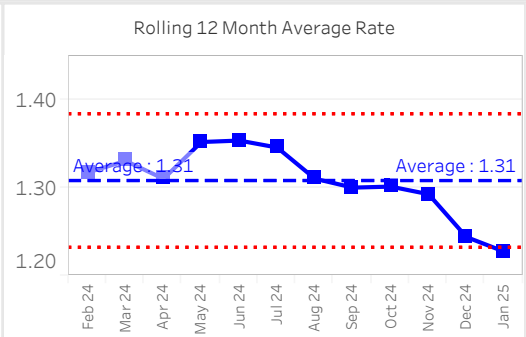
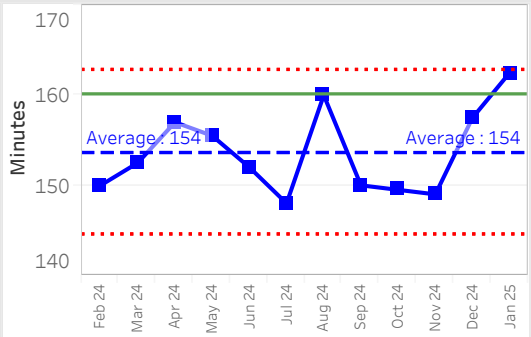
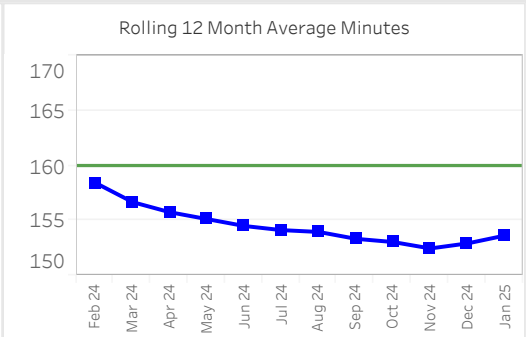
El Camino Health

# FY25 Enterprise Quality, Safety and Experience Dashboard

January 2025 (unless other specified)

Month to Board Quality Committee : March 2025



| Measure | FY25 Performance | | Baseline FY24 Actual | FY 25 Target | Trend | FYTD or Rolling 12 Month Average |
|---|---|---|---|---|---|---|
| | Latest Month | FYTD | | | | |
| Mortality Index Observed / Expected<br>Vizient Risk Model<br>Latest Month :<br>January 2025 | 1.05 ( 2.90% / 2.77% ) | 0.99 ( 2.18% / 2.21% ) | 1.16 ( 2.55% / 2.20% ) | 1.00 |  |  |
| Sepsis Mortality Index Observed / Expected<br>Vizient Risk Model<br>Latest Month :<br>January 2025 | 1.24 ( 13.68% / 11.04% ) | 1.10 ( 10.48% / 9.51% ) | 1.35 ( 13.37% / 9.91% ) | 1.00 |  |  |
| Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)<br>Latest Month :<br>January 2025 | MV : 174 mins<br>LG : 151 mins<br>ENT : 163 mins | MV : 170 mins<br>LG : 138 mins<br>ENT : 154 mins | MV : 174 mins<br>LG : 135 mins<br>ENT : 155 mins | MV ED = 180 min<br>LG ED = 140 min<br>ENT = 160 min |  |  |

Quality Department | Note : updated as of February 19, 2025

| Measure | Definition Owner | Metric Definition | Data Source |
|---|---|---|---|
| Mortality Index Observed / Expected<br>Vizient Risk Model | S. Mallur, MD | 1) Based upon Vizient Risk Model 2023 Community for expected risk used by O/E ratio.<br>2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn<br><br>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero. | Vizient Clinical Database |
| Sepsis Mortality Index Observed / Expected<br>Vizient Risk Model | S. Mallur, MD<br>Maria Consunji | 1) Numerator inclusions: Patient Type = Inpatient (exclude Rehab, Hospice, Nonviable Neonate & Normal Newborn + Behavioral Health (based on Vizient Service Line = Behavioral Health), Prin or 2nd diagnosis of sepsis (SEP-1 list of codes) & age 18+ yrs<br>2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB)<br><br>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. | Vizient Clinical Database |
| Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) | J. Baluom | ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED.<br><br>Time stamp is used for this calculation:<br>ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table)<br>ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table | EDSBAR Tableau Dashboard;<br>EDOC Monthly Meeting Dashboard<br><br>ED Tableau Dashboard maintained by:<br>**Hsiao-Lan Shih** |

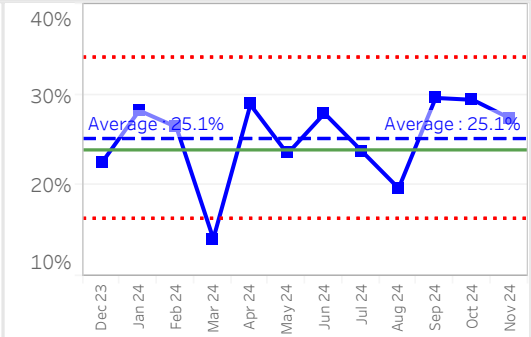
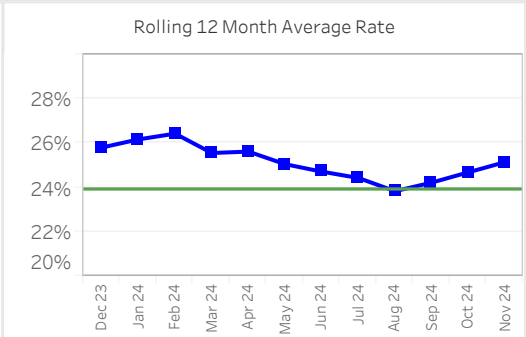
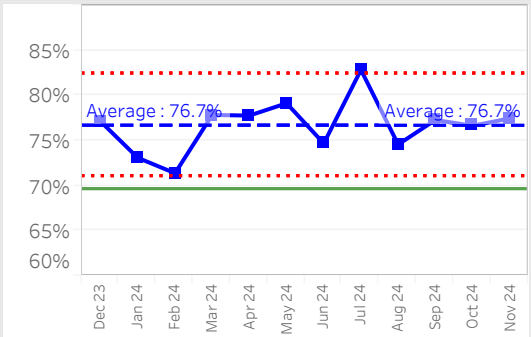
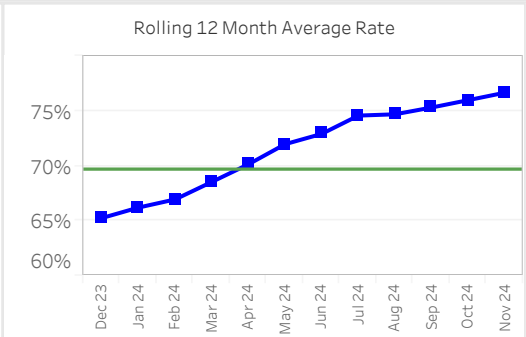
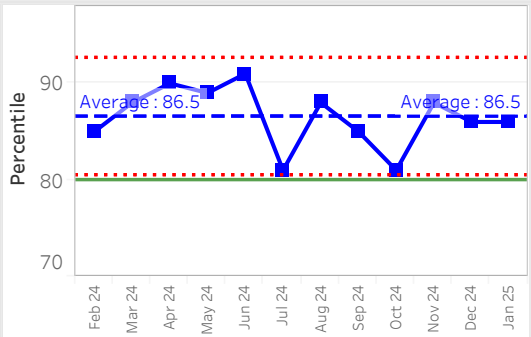
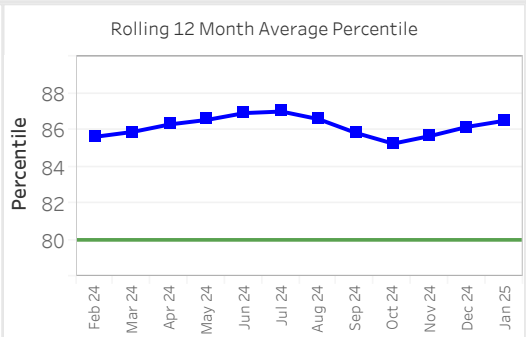
El Camino Health

# FY25 Enterprise Quality, Safety and Experience Dashboard

January 2025 (unless other specified)

Month to Board Quality Committee : March 2025



| Measure | FY25 Performance | | Baseline FY24 Actual | FY 25 Target | Trend | FYTD or Rolling 12 Month Average |
|---|---|---|---|---|---|---|
| | Latest Month | FYTD | | | | |
| PC-02 : Cesarean Birth | MV : 31.5% ( 52 / 165 ) | MV : 27.0% ( 212 / 786 ) | MV : 27.6% ( 516 / 1870 ) | 23.9% (FY24 ENT Target) |   |   |
| | LG : 6.3% ( 2 / 32 ) | LG : 20.0% ( 29 / 145 ) | LG : 19.4% ( 62 / 320 ) | | | |
| Latest Month : November 2024 | ENT : 27.4% ( 54 / 197 ) | ENT : 25.9% ( 241 / 931 ) | ENT : 26.4% ( 578 / 2190 ) | | | |
| PC-05 : Exclusive Breast Milk Feeding | MV : 76.4% ( 227 / 297 ) | MV : 76.0% ( 1100 / 1447 ) | MV : 58.1% ( 1998 / 3437 ) | 65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target) |   |   |
| | LG : 82.8% ( 48 / 58 ) | LG : 86.6% ( 245 / 283 ) | LG : 68.4% ( 428 / 626 ) | | | |
| Latest Month : November 2024 | ENT : 77.5% ( 275 / 355 ) | ENT : 77.7% ( 1345 / 1730 ) | ENT : 59.7% ( 2426 / 4063 ) | | | |
| *Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted | 86 | 84 | 86 | 80%ile |   |   |
| Latest Month : January 2025 | | | | | | |

Quality Department | Note : updated as of February 19, 2025

| Measure | Definition Owner | Metric Definition | Data Source |
|---|---|---|---|
| PC-02 : Cesarean Birth | H. Freeman | 1) **Numerator**: Patients with cesarean births<br>2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation | CMQCC |
| PC-05 : Exclusive Breast Milk Feeding | H. Freeman | 1) **Numerator**: Newborns that were fed breast milk only since birth<br>2) **Denominator**: Single term newborns discharged alive from the hospital | CMQCC |
| *Organizational Goal<br>IP Units - HCAHPS LTR<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted | C. Cunningham | 1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey.<br>2) Inclusions: Inpatient nursing units; excludes: MBU.<br>3) Data run criteria, 'Top Box, Received Date, and Adjusted'<br><br>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. | HCAHPS |

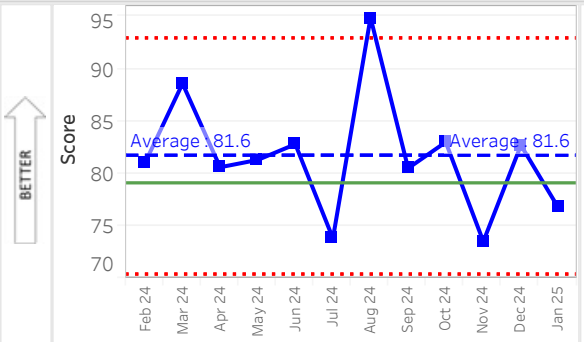
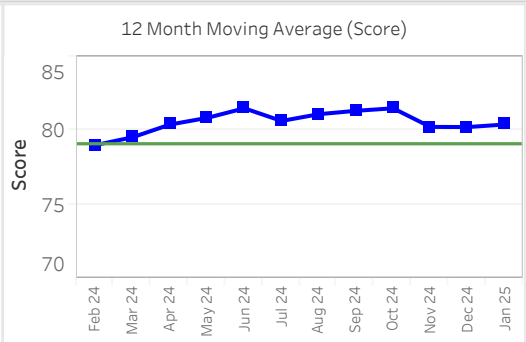
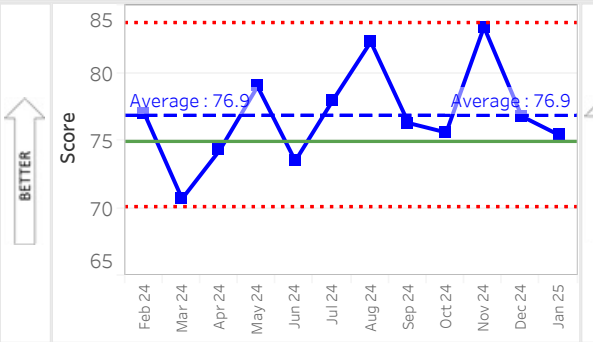
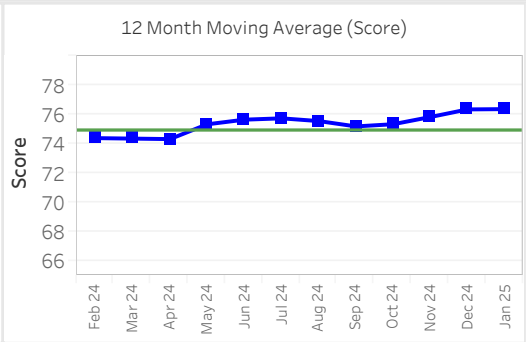
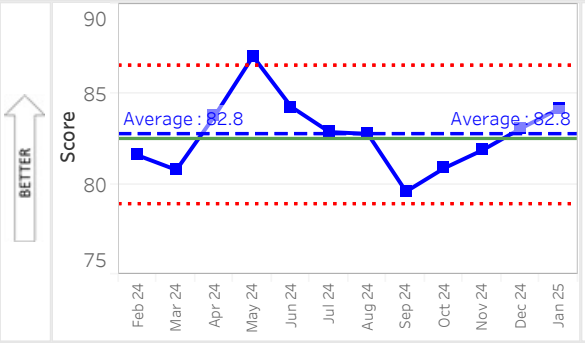
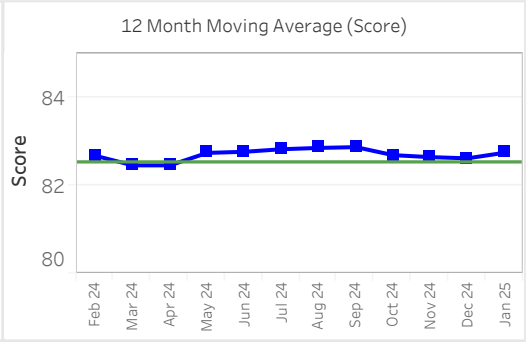
El Camino Health

# FY25 Enterprise Quality, Safety and Experience Dashboard

January 2025 (unless other specified)

Month to Board Quality Committee : March 2025



| Measure | FY25 Performance | | Baseline FY24 Actual | FY 25 Target | Trend | FYTD or Rolling 12 Month Average |
|---|---|---|---|---|---|---|
| | Latest Month | FYTD | | | | |
| IP MCH - HCAHPS LTR<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted<br>Latest Month :<br>January 2025 | 76.7 | 80.9 | 82.0 | 82.0 |  |  |
| ED Likelihood to Recommend<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted<br>Latest Month :<br>January 2025 | 75.4 | 78.1 | 75.5 | 77.2 |  |  |
| ECHMN Likelihood to Recommend<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted<br>Latest Month :<br>January 2025 | 84.2 | 81.8 | 82.1 | 83.4 |  |  |

Quality Department | Note : updated as of February 19, 2025

| Measure | Definition Owner | Metric Definition | Data Source |
|---|---|---|---|
| IP MCH - HCAHPS LTR<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted | C. Cunningham | Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only.<br>Data run criteria, 'Top Box, Received Date, and Adjusted'<br><br>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. | HCAHPS |
| ED Likelihood to Recommend<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted | C. Cunningham | ED Likelihood to Recommend - PressGaney data (not part of HCAHPS)<br>Data run criteria, 'Top Box, Received Date, and Adjusted'<br><br>For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. | Press Ganey |
| ECHMN Likelihood to Recommend<br>Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted | C. Cunningham | Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards<br>'Top Box, Received Date, and Unadjusted'<br><br>For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. | Press Ganey |

El Camino Health

**El CAMINO HOSPITAL**
**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE**
**AGENDA MEMORANDUM**

**To:** El Camino Hospital Quality, Patient Care, and Patient Experience Committee
**From:** Theresa Fuentes, Chief Legal Officer
Anne Yang, Executive Director, Governance Services
**Date:** March 3, 2025
**Subject:** Proposed FY26 Committee Meeting Dates

**Recommendation:**

Quality, Patient Care, and Patient Experience Committee (QC) consideration of proposed FY26 meeting dates and medical staff credentials and privileges review.

**Summary:**

In response to recommendations identified through various governance and committee assessments, a comprehensive review by staff and executive sponsors was conducted to identify potential streamlining opportunities for the FY26 board and committee calendar. Opportunities were identified through: (1) restructuring the calendar so that most committee meetings are held in the first two weeks of the same months; (2) moving the board meetings to later in the month so there is sufficient time and opportunity to flow committee materials to the board for approval; and (c) reducing the number of committee meetings and, over a multi-year period, standardizing committees to a quarterly schedule if possible.

The QC currently meets eight times a year. This is the largest number of meetings for any of the board committees.[1] The proposed FY26 calendar for QC consideration reflects a possible reduction in QC meetings from eight per year to five per year.

One of the reasons for the frequency of QC meetings is QC's role in reviewing the medical staff credentials and privileges report. Listed below are several options for streamlining the credentials review, for QC consideration.

To comply with regulatory requirements, medical staff credentials and privileges must be reviewed and approved by the hospital's governing body upon recommendation from the Medical Executive Committee (MEC). Per the current process, after review by the MEC, the credentials are approved by the QC, followed by the hospital board. This multi-level review by QC and the board is not required, and the board is permitted to delegate this function to a committee of the board. We recently surveyed a number of health systems and confirmed that many hospital boards utilize a subcommittee of the board to approve the credentials and privileges.

[1] The Executive Compensation, Governance, and Investment Committees meet quarterly. The Compliance and Audit Committee met five times in FY25, and the current proposal is to meet quarterly starting in FY26 for consistency with the other committees. The Finance Committee met six times in FY25 (in addition to joint meeting with Investment Committee), and the current proposal is to meet five times in FY26 (in addition to joint meeting with Investment Committee).

There are a few options for consideration by the QC:

1. The board can delegate approval of the credentials and privileges report to a subcommittee consisting of the three board members who are also on the QC. This subcommittee can meet immediately before or after either the QC meeting or the hospital board meeting for the sole purpose of reviewing and approving the credentials. Although this would create another committee, it would also eliminate the need for review and approval by both the QC and the board, and would help streamline the flow of materials, and reduce the number of QC meetings that are needed each year to review credentials.
2. The board can delegate approval to the QC, and the QC can review and approve in those months when the QC meets. The board would need to approve the credentials in months when the QC does not meet. There may be operational and consistency concerns if two different bodies are responsible for reviewing and approving the credentials report.
3. The full board can review and approve the credentials each month, as it currently does, with or without QC review first.

**Next Steps**

Staff will incorporate QC recommendations into the master FY26 calendar and seek delegation from the board for approval of credentials and privileges, as appropriate.

**Attachment:** Proposed FY26 Meeting Dates

El Camino Health

# Quality Committee
## Proposed FY2026 Meeting Dates

| FY25 QC MEETING DATES | RECOMMENDED QC DATES | CORRESPONDING HOSPITAL BOARD DATE |
|---|---|---|
| Monday, August 5, 2024 | **Monday, September 8, 2025** | Wednesday, September 24, 2025 |
| Monday. September 3, 2024 | **Monday, November 3, 2025** | Wednesday, November 19, 2025 |
| Monday, November 4, 2024 | **Monday, March 2, 2026** | Wednesday, March 25, 2026 |
| Monday, December 2, 2024 | **Monday, May 4, 2026** | Wednesday, May 27, 2026 |
| Monday, February 3, 2025 | **Monday, June 1, 2026** | Wednesday, June 24, 2026 |
| Monday, March 3, 2025 | | |
| Monday, May 5, 2025 | | |
| Monday, June 2, 2025 | | |

El Camino Health

**PROPOSED**

# FY26 COMMITTEE GOALS

## Quality, Patient Care, and Patient Experience Committee

**PURPOSE**

The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health ("ECH"). The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

**STAFF**: Chief Quality Officer (Executive Sponsor)

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

| GOALS | TIMELINE | METRICS |
|---|---|---|
| **1.** Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan. | Q4FY25 review and update which measures to include on the FY25 Quality Dashboards. | Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered. |
| **2.** Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets. | Q4FY25 review FY25 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars. | Performance measures on the Quality Dashboards.<br>▪ Monthly Quality Dashboard<br>▪ Quarterly Board Level Quality Dashboard |
| **3.** Identify and reduce health care disparities for ECH patients. | Biannual report to Quality Committee FY26. | Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report". |
| **4.** Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee. | Fiscal Year 2026 | • Attend a minimum of 6 meetings in person.<br>• Actively participate in discussions at each meeting.<br>• Review of annual committee self-assessment results |
| **5.** Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics. | Fiscal Year 2026 | Attend a conference and/or session with a subject matter expert.<br>• Verbal/Written report of key learnings to the Quality Committee. |

**Chair:** Carol Somersille, MD
**Executive Sponsor**: Shreyas Mallur, MD, Chief Quality Officer

**PROPOSED**

# Quality, Patient Care, and Patient Experience Committee
## FY26 Pacing Plan

| AGENDA ITEM | Q1 | | | Q2 | | | Q3 | | | Q4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
| **STANDING AGENDA ITEMS** | | | | | | | | | | | | |
| Consent Calendar[1] | | | ✓ | | ✓ | | | | ✓ | | ✓ | ✓ |
| Verbal Committee Member Expertise Sharing or Chair's Report | | | ✓ | | ✓ | | | | ✓ | | ✓ | ✓ |
| Patient Experience Story | | | ✓ | | ✓ | | | | ✓ | | ✓ | ✓ |
| Serious Safety Event (as needed) | | | ✓ | | ✓ | | | | ✓ | | ✓ | ✓ |
| Recommend Credentialing and Privileges Report | | | ✓ | | ✓ | | | | ✓ | | ✓ | ✓ |
| Quality Council Minutes | | | ✓ | | ✓ | | | | ✓ | | ✓ | ✓ |
| **SPECIAL AGENDA ITEMS – OTHER REPORTS** | | | | | | | | | | | | |
| Quality & Safety Review of reportable events | | | ✓ | | ✓ | | | | ✓ | | ✓ | |
| Quarterly Board Level Enterprise/ STEEEP Dashboard Review | | | ✓ | | ✓ | | | | ✓ | | ✓ | |
| El Camino Health Medical Network Report | | | ✓ | | ✓ | | | | ✓ | | ✓ | |
| Committee Self-Assessment Results Review | | | | | | | | | | | | ✓ |
| Annual Patient Safety Report | | | ✓ | | | | | | | | | |
| Annual Culture of Safety Survey Report | | | ✓ | | | | | | | | | |
| Patient Experience Report | | | ✓ | | | | | | ✓ | | | |
| Health Equity Report | | | | | ✓ | | | | | | | ✓ |
| Recommend Safety Report for the Environment of Care | | | | | ✓ | | | | | | | |
| PSI Report | | | | | ✓ | | | | | | | |
| Value-Based Purchasing Report | | | | | | | | | ✓ | | | |
| Recommend Quality Improvement & Patient Safety Plan (QIPS) | | | | | ✓ | | | | | | | |
| Refresh Quality/Experience Dashboard measures for FY26 | | | | | | | | | | | | ✓ |
| Artificial Intelligence Report | | | | | ✓ | | | | | | | |
| **COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR** | | | | | | | | | | | | |
| Propose Committee Goals | | | | | | | | | ✓ | | | |
| Recommend Committee Goals | | | | | | | | | | | ✓ | |
| Propose FY Committee Meeting dates | | | | | | | | | ✓ | | | |
| Recommend FY Committee Meeting dates | | | | | | | | | | | ✓ | |
| Propose Organization Goals | | | | | | | | | ✓ | | | |
| Recommend Organization Goals | | | | | | | | | | | ✓ | |
| Propose Pacing Plan | | | | | | | | | ✓ | | | |
| Recommend Pacing Plan | | | | | | | | | | | ✓ | |
| Review & Revise Charter | | | | | | | | | ✓ | | | |
| Recommend Charter | | | | | | | | | | | ✓ | |

1: Includes Approval of Minutes (Open & Closed), Progress Against FY Committee Goals (Quarterly), Current FY Pacing Plan (Quarterly), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

# El Camino Hospital Board of Directors
# Quality, Patient Care, and Patient Experience Committee Charter

## Purpose

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

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

## Authority

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

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

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

## Membership

**Approved as Revised:** 11/12/14, 4/8/15, 11/14/18, 11/6/19; 2/11/20, 04/XX/23, 09/03/24, 02/03/2025

- The Committee shall be comprised of two (2) or more Hospital Board members who shall be appointed and removed pursuant to the El Camino Hospital Board Committee Governance Policy.

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

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

- All Committee members, Chairs and Vice Chairs shall be appointed and removed in accordance with the El Camino Hospital Board Committee Governance Policy.

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## Executive Support and Participation

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

## General Responsibilities

The Committee will collaborate with management to identify opportunities for quality and safety improvement. The Committee will support the implementation and monitoring of process improvement plans to address and close quality and safety gaps. Members of the Quality Committee will model behaviors, attitudes and actions consistent with the Organization's tenets of a High Reliable Organization, specifically, focusing on creating strong relationships between everyone on the team to engender a culture of psychological safety which promotes our Organization's mission to achieve zero patient harm. The management team shall develop dashboard metrics that will be used to measure and track quality, safety and patient experience performance for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make

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

recommendations to the Board. The Committee is responsible for 1) ensuring performance metrics meet the Board's expectations; 2) aligning those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring communication to the Board and external constituents is well executed.

## Specific Duties

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

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

Specific duties of the Committee include the following:

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

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

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

    - Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - Organization-wide patient safety goals and hospital performance relative to patient safety targets.
    - Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
    - Organization-wide patient satisfaction and patient experience surveys.
- Organization-wide provider satisfaction surveys.Ensure the organization demonstrates proficiency through full compliance with regulatory requirements including, but not limited to The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).

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

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

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

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

**Approved as Revised:** 11/12/14, 4/8/15, 11/14/18, 11/6/19; 2/11/20, 04/XX/23, 09/03/24, 02/03/2025

El Camino Health

## Committee Effectiveness

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

## Meetings and Minutes

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

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

**Approved as Revised:** 11/12/14, 4/8/15, 11/14/18, 11/6/19; 2/11/20, 04/XX/23, 09/03/24, 02/03/2025