El Camino Health

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

Monday, September 8, 2025 – 5:30 pm
El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 996 9232 1041 # 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 Quality Committee Chair		**5:30 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:30 pm**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
5.	**VERBAL INTRODUCTION OF NEW QUALITY COMMITTEE MEMBERS** a. Erica Jiang b. Barbara Pelletreau c. Diane Schweitzer	Carol Somersille, MD Quality Committee Chair	Information	**5:30 – 5:35**
6.	**CONSENT CALENDAR ITEMS** a. Approve Minutes of the Open Session of the Quality Committee Meeting (06/02/2025) b. FY2026 Pacing Plan c. Progress against FY2026 Goals d. Recommend Quality Improvement and Patient Safety Plan (QIPS) for Hospital Board Approval e. Receive Class Assignments for Community Members of Quality Committee	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:35 – 5:45**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	f. Receive Revised Committee Governance Policy			
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**5:45 – 5:55**
8.	**Q4 FY25 STEEEP DASHBOARD REVIEW/ FY26 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**5:55 – 6:15**
9.	**EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT**	Jaideep Iyengar, MD, FAAOS Peter Goll, Chief Administrative Officer, ECHMN Kirstan Smith, BSN, CPHQ, Director of Clinical Quality, ECHMN	Discussion	**6:15 – 6:35**
10.	**PATIENT EXPERIENCE REPORT**	Ryan Lockwood, Vice President, Patient Experience	Discussion	**6:35 – 6:55**
11.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:55 – 6:56**
12.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (06/04/2025) b. Quality Council Minutes (08/06/2025) *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**
13.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (06/02/2025)** *Report involving Gov't Code Section 54957.2 for Closed Session Minutes.*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:01 – 7:06**
14.	**Q4 FY25 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS** *Health and Safety Code section 32155 – Deliberations Concerning Reports on Medical Staff Quality Assurance Committee*	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**7:06 – 7:16**
15.	**MEDICAL STAFF AND EMPLOYEE SURVEY RESULTS** *Gov't Code Section 54957(b) for Discussion and Report on Personnel Performance Matters*	Mark Adams, MD, Chief Medical Officer	Discussion	**7:16 – 7:21**
16.	**ANNUAL PATIENT SAFETY REPORT** *Health and Safety Code section 32155 – Deliberations Concerning Reports on Medical Staff Quality Assurance Committee*	Mark Adams, MD, Chief Medical Officer Sheetal Shah, MD, Senior Director, Risk Management and Patient Safety	Discussion	**7:21 – 7:41**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
17.	**RECOMMEND FOR APPROVAL CREDENTIALING AND PRIVILEGES REPORT** *Health and Safety Code Section 32155 and Gov't Code Section 54957 – Deliberations concerning reports on Medical Staff quality assurance committee and report regarding personnel performance of the Medical Staff*	Mark Adams, MD, Chief Medical Officer	**Motion Required**	**7:41 – 7:51**
18.	**VERBAL SERIOUS SAFETY EVENT REPORT** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**7:51 – 7:56**
19.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:56 – 7:57**
20.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:57 – 7:58**
21.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:58 – 8:05**
22.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**8:05**

Next Meetings: November 3, 2025; December 1, 2025; February 2, 2025; March 2, 2025; May 4, 2025; June 1, 2025

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, June 2, 2025
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Staff Present
Carol Somersille, MD, Chair	**Pancho Chang**	**Dan Woods,** CEO
Melora Simon, Vice Chair **		**Mark Adams, MD,** CMO
Shahram Gholami, MD		**Shreyas Mallur, MD,** CQO
Jack Po, MD		**Cheryl Reinking**, DPN, RN CNO
Krutica Sharma, MD**	**Guests Present**	**Tracey Lewis Taylor,** COO
Steven Xanthopoulos, MD	**Erica Jiang**	**Christine Cunningham,** Chief
John Zoglin	**Barbara Pelletreau**	Experience and Performance
	Diane Schweitzer	Improvement Officer
	Sharon Richmond**	**Ryan Lockwood**, VP, Patient Experience
		AJ Reall, VP, Strategy
		Lyn Garrett, Senior Director, Quality
		Anne J. Yang, Executive Director, Governance Services
		Corneliu Delogramatic, Director, Health
	**via teleconference	Equity and Clinical Integrity
		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 **5:32 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present.	**Call to order at 5:32 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Chair Somersille asked if any Committee members were participating remotely. Mr. Fernandez confirmed that Dr. Sharma was participating remotely under standard Brown Act requirements for teleconferencing with her address on the agenda. Ms. Simon was participating remotely under AB2449 with Just Cause for the caregiving needs of her child. She confirmed that there were no individuals over the age of 18 in the room with her. Chair Somersille reminded Ms. Simon that her camera must remain on for the duration of the meeting.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the members of the public.	
5. RECOGNITION OF QUALITY COMMITTEE	Chair Somersille recognized Melora Simon for her decade of service on the Quality Committee, noting that this meeting marked her final participation. Chair	

MEMBER MELORA SIMON	Somersille expressed appreciation for Ms. Simon's long-standing dedication, leadership, and thoughtful contributions since joining the Committee in 2015. Her insight and commitment to advancing quality of care have had a lasting impact on both the Committee and the broader organization. The Committee extended its sincere gratitude and well wishes, acknowledging that she will be greatly missed.	
6. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Chair Somersille requested to remove item a) Open Session Minutes of the Quality Committee Meeting (05/05/2025). Director Zoglin removed items (d) Progress against Committee Survey Results, and (e) Leapfrog for further discussion. a) Chair Somersille requested an update on the previously discussed follow-up item regarding the statistical significance of changes in ECHMN patient experience scores, specifically the Top Box scores. Ms. Lewis Taylor reported that the necessary tools to assess confidence intervals have not yet been provided by Press Ganey. The management team committed to presenting the report at the September meeting. d) Director Zoglin requested further discussion on the Committee Survey Results. Chair Somersille summarized key findings: committee effectiveness, the need for recruiting new members, and ensuring relevant expertise, which will be addressed with upcoming onboarding. Chair Somersille also raised the topic of integrating the Committee's work with organizational strategic planning. Ms. Simon and other members expressed interest in more interactive strategic planning discussions, including joint committee meetings. Director Po noted that the medical network may lack clarity on the organization's strategy. e) Director Zoglin requested clarification on Leapfrog scores. Dr. Mallur explained that Leapfrog incorporates certain CMS measures and applies its own scoring methodology, with some measures reported separately by campus. The team reviews z-scores to assess performance and identify areas for improvement. Discussion focused on the importance of preventing harm and infections, and understanding next steps for quality improvement. Director Po questioned Nurse Communication scores, and Mr. Lockwood noted that while care communication is strong, explanations for patient understanding could improve. The Committee	***Consent Calendar Approved*** ***ACTION:*** *Staff to provide ECHMN Top Box statistical significance to September QC meeting.* ***ACTION:*** *Request 2-way meeting on strategic planning; joint Committee and Board meeting.* ***ACTION:*** *The Committee requested better understanding of the Leapfrog scores in relation to the overall strategy.*

	discussed the need to better understand and prioritize Leapfrog scores within their overall strategy. **Motion**: To approve consent calendar (a) Minutes of the Open Session Minutes of the Quality Committee Meeting (05/05/2025). **Received**: (b) FY25 Pacing Plan, (c) Progress against FY2025 Goals, (d) Progress against Committee Survey Results, and (e) Leapfrog memo. **Movant**: Zoglin **Second**: Po **Ayes**: Somersille, Simon, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang **Recused**: None	
7. INTERVIEW NOMINEES FOR QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE	Dr. Sharma reported on the Ad Hoc Committee's search for new members, focused on high reliability and patient care experience. Nineteen candidates were reviewed, and seven were interviewed. Erica Jiang introduced her background in technology and customer experience, with personal experience in patient care. She discussed opportunities to apply tech principles to healthcare. Barbara Pelletreau highlighted her nursing and patient safety experience, including 25 years at Dignity Health, and her motivation to contribute to the Committee. Diane Schweitzer shared her experience at the Gordon Moore Foundation. She also expressed interest in leveraging her background to support El Camino Health. Sharon Richmond, via Zoom, described her work with hospital leadership teams and her interest in improving healthcare processes, particularly in response to post-COVID challenges.	
8. SELECT NOMINEES FOR QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE FOR RECOMMENDATION	The Committee discussed whether to appoint three or four candidates. Dr. Somersille inquired about appointing three or four candidates, and Dr. Sharma invited questions for the Ad Hoc Committee. Director Zoglin and several members expressed concerns about integrating four new members at once, suggesting two or three may be preferable. Dr. Xanthopoulos and Dr. Gholami	***ACTION: Recommend for Board Approval at June meeting, 3 nominees for QC community***

TO THE HOSPITAL BOARD	emphasized the value of diverse backgrounds but cautioned against adding too many voices. Director Po noted quorum challenges and supported a higher number, while Ms. Simon pointed out the Committee could have up to nine members and suggested sequencing appointments. Dr. Sharma highlighted the need for balance between directors and community members. Dr. Mallur and Dr. Gholami reiterated concerns about meeting productivity with four new members. **Motion**: To recommend Hospital Board approval of the appointment of Erica Jiang, Barbara Pelletreau, and Diane Schweitzer as Quality, Patient Care and Patient Experience Committee members. **Movant**: Gholami **Second**: Po **Ayes**: Somersille, Simon, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang **Recused**: None	***member: Erica Jiang, Barbara Pelletreau, and Diane Schweitzer***
9. PATIENT STORY	Ms. Reinking shared a letter from a patient and discussed the patient's positive experience at the Acute Rehabilitation Center at the El Camino Health Los Gatos Campus. The letter highlighted the staff's consistent warmth, positivity, and genuine care, crediting the team for fostering a healing environment and supporting the patient's journey to independence. The Committee recognized this as an example of exceptional patient experience and effective teamwork at the Los Gatos campus.	

10. HEALTH CARE EQUITY	Mr. Delogramatic, Director of Healthcare Equity, presented on his team's project addressing social drivers of health and the nursing navigator screening tool. The initiative, launched in December, involves nursing staff screening all patients for social needs, with training provided to support implementation. Director Po asked about follow-up for positive screens; Mr. Delogramatic explained that care coordination and social work teams are engaged, with automatic referrals for interpersonal safety concerns. The Committee discussed nurse training, time management, and data attribution by location. Ms. Reinking reported no concerns about screening time, and Mr. Delogramatic noted that prevalence data is still being collected. The Committee discussed the program's naming, with suggestions to use "SDOH" rather than "Health Equity," reflecting the program's focus.	
11. REFRESH STEEEP DASHBOARD MEASURES FOR FY2026	Dr. Mallur presented proposed updates to the STEEEP Dashboard, including the addition of homeless discharge compliance. The Committee inquired about the removal of voice interpretation metrics; Dr. Mallur explained that these were removed due to a lack of benchmarks, though tracking continues off-dashboard. He clarified that the dashboard shown was a mock-up for FY24 and FY25. Mr. Delogramatic reported approximately 130 homeless patients per month and significant use of interpretation services. Director Zoglin asked about KPIs for these areas, and Mr. Delogramatic responded that evaluation will occur next year. The Committee supported the proposed changes.	
12. FY2025 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur presented the updated dashboard, highlighting measures related to CAUTI, C. Diff, and surgical site infections. He noted that, while some indicators remain above target, trends are improving compared to the previous year. Evidence-based practices have been implemented to address surgical site infections, and the Committee is encouraged by the downward trend in monthly rates. Dr. Somersille noted that overall performance is better than last year, including improvements in the mortality index.	

13. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:26 p.m. **Movant**: Gholami **Second**: Xanthopoulos **Ayes**: Somersille, Simon, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang **Recused**: None	***Recessed to Closed Session at 7:26 p.m.***
14. AGENDA ITEM 19: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee 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 May 5, 2025 meeting.	***Reconvened Open Session at 7:40 p.m.***
15. AGENDA ITEM 20: COMMITTEE ANNOUNCEMENTS	There were no Committee announcements.	
16. AGENDA ITEM 21: ADJOURNMENT	**Motion**: To adjourn at 7:41 p.m. **Movant**: Gholami **Second**: Xanthopoulos **Ayes**: Somersille, Simon, Gholami, Po, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Chang **Recused**: None	***Meeting adjourned at 7:41 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; Anne Yang, Executive Director, Governance Services

APPROVED BY QC
06/02/2025

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						✓						
Leapfrog Education Session						✓						
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

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 FY26 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 FY26 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ 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 5 meetings in person. • Actively participate in discussions at each meeting. • 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	Committee attendance rate at conference and/or session with a subject matter expert of at least 50%. • 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 BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care, and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: September 8, 2025
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QIPS) for 2026

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

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

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

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

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

Outcome: The Committee will approve the QIPS Plan. There are no changes to the plan to report or review. Some update for FY 26 includes:

- Updated Quality Organizational Goals for FY26:
  - CDIFF
  - CAUTI
  - HAPI
  - Hand Hygiene compliance
- Minor updates to Patient Experience, PI, & Patient Safety sections with edits for FY 26

List of attachments:

1. Quality Improvement and Patient Safety Plan with referenced QIPS addendums.

Status **Pending** PolicyStat ID **18507752**

Origination	05/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	08/2025
Next Review	1 year after approval
Owner	Michael Coston: Director Quality and Public Reporting
Area	Quality
Document Types	Plan

FY2026 Quality Improvement & Patient Safety (QIPS) Plan

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a ~~275~~292-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip, Knee, & Shoulder, Hip Fracture, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center, in Joint Replacement for Hip, Knee & Shoulder, Spinal Fusion, Sepsis and Patient Blood Management, and as a "baby friendly hospital" by WHO/UNICEF.

The ECH Medical Staff includes over ~~1100~~1400 active, telemedicine, provisional ~~and~~ consultant, ~~353~~and affiliate physicians~~, and 116 independent practitioners~~ with representation covering ~~nearly every~~over seventy (70) clinical ~~specialty~~specialties (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

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

El CAMINO HEALTH VISION

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

El CAMINO HOSPITAL VALUES

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

Safety: We put safety first in each decision and process, to achieve our mission of zero harm for our patients, visitors and team members.

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

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

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

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

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

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

DEFINITIONS:

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

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

SERVICES/PROGRAMS

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

Acute Inpatient Services:	Emergency Services	Outpatient Services
Acute Rehabilitation	Basic	Advanced Care & Diagnostics Center

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

Section I Quality Improvement Plan

PURPOSE

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

OBJECTIVES

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

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

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

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

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

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

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

Medical Executive Committee (MEC)

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

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

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

Medical Staff Departments and Divisions

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

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

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

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

Leadership and Support

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

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

Medical Staff, Employees, and Contracted Services

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

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is chaired by the delegated Medical Staff Leader, and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY ~~2025~~2026 includes the reduction of C.difficile and CAUTI infections, Hospital Acquired Pressure Injuries (HAPI) , and increased Hand Hygiene ~~audits~~compliance. Quality Council receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY ~~25~~26 Quality Council report schedule.

Quality Services Department

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

The Quality Services Department is also responsible for:

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

and safety data

Hospital Services

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

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

IMPROVING ORGANIZATIONAL PERFORMANCE

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

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

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

Performance Processes

A. **Design**
The design of processes is in conjunction with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

B. **Measurement**
ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and safety. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.
Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

1. Consistent with the organization's mission, vision, goals, objectives, and plans;
2. Meeting the needs of individuals served, staff and others;
3. Clinically sound and current;
4. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
5. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
6. Incorporated into the results of performance improvement activities.
7. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs
   Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:
   a. Establish a performance baseline;
   b. Describe process performance or stability;
   c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
   d. Identify areas for more focused data collection to achieve and sustain improvement.

C. **Analysis**
Data shall be analyzed on an ongoing basis to identify performance improvement opportunities.

Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.
a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

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

Improvement Model and Methodology

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

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

The model has two parts:

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

B. ~~***The Plan-Do-Study-Act (PDSA) Cycle***~~**The Plan-Do-Study-Act (PDSA) Cycle**
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning

it, trying it, observing the results, and acting on what is learned.

~~**Step 1: Plan**~~

~~Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?~~

~~**Step 2: Do**~~

~~Try out the test on a small scale. What did we observe that was not a part of our plan?~~

~~**Step 3: Study**~~

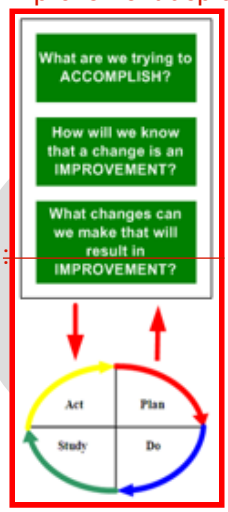
~~Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?~~

~~Summarize and reflect on what was learned.~~

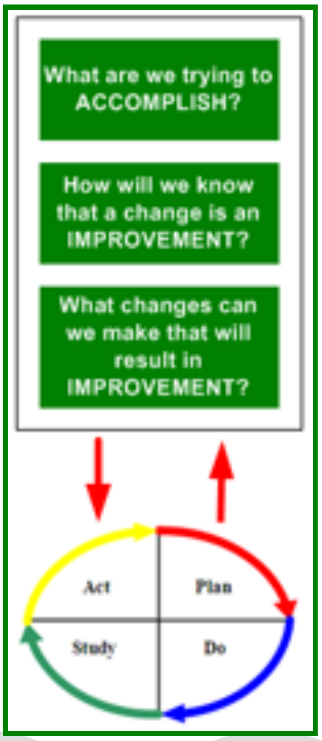
~~**Step 4: Act**~~

~~Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.~~

~~In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:~~



1. **Step 1: Plan**
   Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
2. **Step 2: Do**
   Try out the test on a small scale. What did we observe that was not a part of our plan?
3. **Step 3: Study**
   Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
   Summarize and reflect on what was learned.
4. **Step 4: Act**
   Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous. In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



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

1. ~~S.M.A.R.T.~~ **S.M.A.R.T.** Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.

   The acronym stands for:

   S – Specific
   When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
   Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
   What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
   When – You'll get more specific about this question under the "time-bound" section of defining S.M.A.R.T. goals, but you should at least set a time frame.
   Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
   Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking

business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

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

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

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

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

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

Process Improvement

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. As a High Reliability Organization, we deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Process Improvement department has been in existence since 2012. Our goal is to support a culture of continuous improvement to create problem-solvers at every level and together to make health care better using Lean methodology and techniques as the foundation of our interventions. We also use tools from Six Sigma, Change Management, and PDSA to achieve both incremental and breakthrough improvements.

The Process Improvement department provides resources to the organization for problem solving, as well as deployment of our Daily Engagement System. Our dedicated team is comprised of Process Improvement Advisors and Project Managers with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization. The PI team partners with Executive leaders in the Strategic Goal Deployment and Catchball process that support leaders in cascading and translating organizational targets to the front line. In this way we enhance the ability of all employees to feel connected to our True North Strategic Goals.

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

The success and sustainment of Process Improvement is dependent on robust education and training programs. We provide focused training of Lean /~~PI~~ Process Improvement tools and methods within improvement projects and workshops throughout the enterprise. We also offer specific topic training sessions via PI ~~Talks~~Topic talks to teams and small groups designed to encourage and support our culture of continuous improvement.

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

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

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in two areas: quality & safety, and service. See below for the Fiscal Year ~~2025~~2026 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the FY ~~25~~26 Organization Quality Goals ECH formed ~~three~~four teams to address opportunities with C. Difficile infections, Catheter-Associated Urinary Tract Infection (CAUTI), Hospital Acquired Pressure Injuries (HAPI), and Hand Hygiene ~~Audits~~compliance rate. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

~~Fiscal Year 2025 Goals~~

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

Fiscal Year 2026 Goals

Pillar	Goal	Target
Quality & Safety	C.Diff	≤ 26
	CAUTI	≤ 12
	HAPI	≤ 14
	Hand Hygiene Compliance	≥ 84%
Services	Likelihood to Recommend (LTR) Composite Score	≥ 83.4
People	Employee Engagement	4.23
Finance	Operating EBIDA	$251 M

Commitment to Patient Experience

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

~~To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare~~

~~service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.~~

At El Camino Health (ECH), delivering an exceptional patient experience is foundational to everything we do. We strive to build trusting partnerships between patients, families, and our care teams—partnerships that are proven to improve outcomes, safety, and satisfaction.

To ensure the voice of our patients and families is always present, ECH regularly collects feedback through comment cards and satisfaction surveys. This input is shared with departments and service lines to recognize outstanding care and guide improvement efforts. Listening to the patient experience across the care continuum is essential to our journey toward high reliability.

To support our goal of delivering exceptional, personalized care, ECH has implemented the WeCare service standards. These standards guide how we communicate and interact—with patients, families, and one another—and emphasize empathy, personalization, and trust. Through consistent coaching and monthly messaging, the WeCare standards remain central to our culture and reinforce our commitment to compassion and respect in every interaction.

SECTION II: Patient Safety Plan

PURPOSE

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

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

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

GUIDING PRINCIPLES

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

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

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

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

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

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

OBJECTIVES

A. Deliver high quality safe care for every patient.

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

C. Promote a culture of safety.

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

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

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

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

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

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

J. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions. Where available, patient safety data shall be evaluated by socio demographic data such as age, race, ethnicity, gender identity, sexual orientation, preferred language spoken, disability status, payor and sex, that is voluntarily provided by patients.

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

L. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

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

Governing Board

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

Quality Committee of the Board

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

Enterprise Hospital Committees

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

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

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

Risk Management and Patient Safety Department

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

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

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

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

PATIENT SAFETY PLAN

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

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

    1. Staff are encouraged to report patient safety concerns involving allegations of racism

and discrimination of patients. These events shall be reviewed by relevant leadership and interventions taken as needed.

B. All staff and medical staff upon hire are provided training on Safety First/Mission Zero safety program which includes training on SAFETY skills. Staff receive annual refreshers and medical staff receive refreshers at time of recredentialing. The Board of Directors receive training on patient safety curriculum.

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

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

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

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

F. Patient Safety Priorities are based on the following:

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

Patient Safety Initiatives

• Safety First Mission Zero SAFETY skill program • Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis • Hand Hygiene Audits • Monthly Leader and Executive Rounding using 4C	

SAFETY skill scripts • New hire and manager Orientation to include SAFETY skill education • HeRO Recognition and Award Program	
Quality Indicators of Patient Safety:	
• Nurse Sensitive Indicators (Medication Safety, Falls) • Healthcare Associated Infections • Surgical site infections • Surgical Safety Checklist	• Pressure Injuries • Transfusion reactions/ blood/blood product administration • Use of Restraints • Employee Safety • Serious Safety Event Rate • Culture of Safety Survey results
Safety Programs:	
• Central Safety Committee • Emergency Preparedness Committee • Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Antibiotic Stewardship Program • Radiation Safety Committee
Data from Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

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

Confidentiality

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

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

Annual Evaluation

Patient Safety: The Senior Director of Risk Management and Patient Safety shall provide an annual evaluation and presentation of the Patient Safety program to the Patient and Employee Safety Committee, the Quality committee of the Board, and the Governing Board. The annual appraisal shall address the program's effectiveness in preventing harm to patients and visitors, improving patient care and safety, resolving problems, and achieving program objectives.

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

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

~~Attachments~~

ATTACHMENTS:

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY~~25~~26)

Att C Enterprise Quality, Safety and Experience Dashboard FY25

Att D Board Quality and Safety Dashboard FY25

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicators

Att G Patient and Employee Safety Dashboard (FY~~25~~26) (FY26 dashboard wont be approved until this coming September)

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

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

Attachments

- Att A - Governance Information Flow.pdf
- Att B - Quality Council Reporting Calendar (FY26)
- Att C - Enterprise Quality, Safety and Experience Dashboard.pdf
- Att D - STEEEP FY26 MOCK (Exclude ED and MCH LTR).pdf
- Att E - Abbrev Registries List.pdf
- Att F - External Regulatory Compliance Indicator.pdf
- Att H - Leader Skills Toolkit.pdf
- Att I - Universal Skills Toolkit.pdf
- Att J - HPI Classification Tools for SEC.pdf
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Approval Signatures

Step Description	Approver	Date
Quality Council	Michael Coston: Director Quality and Public Reporting	Pending

Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	07/2025
	Michael Coston: Director Quality and Public Reporting	07/2025

El Camino Health

EL CAMINO HOSPITAL
QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE MEMO

To: El Camino Quality, Patient Care, and Patient Experience Committee
From: Anne Yang, Executive Director, Governance Services
Date: September 8, 2025
Subject: Receive Class Assignments for Community Members of Quality Committee

Recommendation: Receive Class Assignments for Community Members

Authority: In alignment with the Committee Governance Policy, we are implementing Class Assignments for Community Members of each Advisory Committee. These are reviewed and approved by each Committee Chair and received by each respective Committee at the subsequent meeting.

Summary: In June 2024, the Governance Committee initiated standardization across all Advisory Committees to streamline membership appointments, terms, attendance, and meeting standards, resulting in the Committee Governance Policy. The policy states that Community Members serve for 3-year renewable terms. The Governance Committee also recommended staggered terms for Community Members. The reason behind the staggered terms was to implement best governance practices, and to alleviate the potential need to recruit multiple new members in a given year. The policy was approved by the Board in FY25, and now being implemented for the first time for FY26.

The Class assignment tenure dates are as follows:

1. Class 1: Current term expires June 30, 2025; new term is July 1, 2025 through June 30, 2028
2. Class 2: Current term expires June 30, 2026; new term is July 1, 2026 through June 30, 2029
3. Class 3: Current term expires June 30, 2027; new term is July 1, 2027 through June 30, 2030

In general, the methodology for assigning a Class year was based on the following prioritization:

1. Member's tenure
2. Alphabetical order with the purpose of staggering the terms particularly for members who joined in the same year
3. Class 1 was assigned to new members of a Committee for FY26 (Quality and Finance)
4. Class 2 was assigned for a potential new recruit for Governance Committee, to allow time for the Committee's search efforts

List of Attachments:
1. Class Assignments for Community Members

Community Member Class Assignments

Name	Member	Chair/Vice Chair	Officer Start Date	Committee	Date Appointed	Class Assignment*	3Y Committee Term Expires	Committee Reappointment Term Expires
Barbara Pelletreau	Community Member			Quality	1-Jul-25	Class 1	n/a	30-Jun-28
Diane Schweitzer	Community Member			Quality	1-Jul-25	Class 1	n/a	30-Jun-28
Erica Jiang	Community Member			Quality	1-Jul-25	Class 1	n/a	30-Jun-28
Krutica Sharma, MD	Community Member			Quality	21-Aug-19	Class 2	30-Jun-26	30-Jun-29
Pancho Chang	Community Member			Quality	15-Feb-23	Class 3	30-Jun-27	30-Jun-30

*Note that Class Assignments are to be approved by the Committee Chair and received by each Committee.

The purpose is to stagger all committee member terms (Class 1 expires June 30, 2025, Class 2 expires June 30, 2026, Class 3 expires June 30, 2027).

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: El Camino Hospital Quality, Patient Care, and Patient Experience Committee
From: Anne Yang, Executive Director, Governance Services
Date: September 8, 2025
Subject: Committee Governance Policy

Recommendation: To receive the revised El Camino Hospital Committee Governance Policy ("Committee Governance Policy").

Authority: The Board of Directors approved the revised Committee Governance Policy on June 11, 2025. The marked and clean versions are included in this packet to be received by the Committee.

Summary: The updates below were made to the Committee Governance Policy and approved by the Board in June 2025.

1. Director Member Advisory Committee terms updated to 1 year from 3 years. This allows for greater flexibility for Director Members to move to different assignments for a given year.
2. Community Member terms will remain 3 years. Both Director Member and Community Member terms are renewable.

We also consolidated the Committee Governance Policy with the Nomination & Selection Policy and the Nomination & Selection Procedures, and these policies were sunset by the Board on June 11, 2025. The revised Committee Governance Policy now captures all relevant points from the nomination and selection process. The remaining items in the Nomination and Selection procedures were not currently used in practice or no longer relevant/needed.

- Each Advisory Committee determines minimum qualifications and competencies for members
- Nominations may be received from any source
- A candidate shall submit an application stating reasons, qualifications, and disclosures
- Ad Hoc Committee will interview candidates and either select the final candidates for Committee interviews or recommend for Board appointment in accordance with the Bylaws
- Community Members may also be reassigned to another Committee at the recommendation of the CEO, Board Chair and the receiving Committee Chair. The appointment would be subject to Committee and Board approval in accordance with the Bylaws.

List of Attachments:

- El Camino Hospital Board Committee Governance Policy as Approved by the El Camino Health Board on June 11, 2025 (Redline and Clean)

El Camino Health

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

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

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

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

Nomination and Selection of Community Members:
Each Advisory Committee shall determine minimum qualifications and competencies for its Members. Committees may fill Community Member vacancies through an open recruitment process coordinated by Governance Services. Candidates may be nominated by any source and must submit an application with reasons to serve, relevant qualifications, and disclosures. An Ad Hoc Committee appointed by the Committee Chair, in consultation with the Executive Sponsor and Governance Services, shall review applications, interview initial candidates, and may recommend finalists. The full Committee may choose to interview finalists or proceed based on the Ad Hoc Committee's report. Final appointments are made by the Committee and submitted to the Board for approval in accordance with the Bylaws.

Reassignment of Existing Community Members:
In some cases, an existing Community Member may be reassigned from one Committee to another at the recommendation of the CEO, Board Chair, and the receiving Committee Chair. This reassignment shall be made in consultation with the Committee's Executive Sponsor, with notice to Governance

El Camino Health

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

Services. The reassigned Community Member must be formally appointed to the new Committee by a majority vote of that Committee, and submitted for Board approval in accordance with the Bylaws.

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

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

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

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

Director Members serve a term of one year or partial fiscal years depending on date of appointment and eligibility to serve. Director Member appointments shall be reviewed annually by the Board Chair (or Chair Elect).

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

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

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

Attendance:

El Camino Health

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

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

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

Meetings:

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

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

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

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

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

All committee communications must go through the designated committee Chair.

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

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August 14, 2024
CURRENT APPROVAL:	ECHB June 11, 2025

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

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

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

Nomination and Selection of Community Members:
Each Advisory Committee shall determine minimum qualifications and competencies for its Members. Committees may fill Community Member vacancies through an open recruitment process coordinated by Governance Services. Candidates may be nominated by any source and must submit an application with reasons to serve, relevant qualifications, and disclosures. An Ad Hoc Committee appointed by the Committee Chair, in consultation with the Executive Sponsor and Governance Services, shall review applications, interview initial candidates, and may recommend finalists. The full Committee may choose to interview finalists or proceed based on the Ad Hoc Committee's report. Final appointments are made by the Committee and submitted to the Board for approval in accordance with the Bylaws.

Reassignment of Existing Community Members:
In some cases, an existing Community Member may be reassigned from one Committee to another at the recommendation of the CEO, Board Chair, and the receiving Committee Chair. This reassignment shall be made in consultation with the Committee's Executive Sponsor, with notice to Governance

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August 14, 2024
CURRENT APPROVAL:	ECHB June 11, 2025

Services. The reassigned Community Member must be formally appointed to the new Committee by a majority vote of that Committee, and submitted for Board approval in accordance with the Bylaws.

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

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

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

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

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

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

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

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August 14, 2024
CURRENT APPROVAL:	ECHB June 11, 2025

Attendance:

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

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

Meetings:

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

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

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

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

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

All committee communications must go through the designated committee Chair.

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

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: September 8, 2025
Subject: Patient Voice/Patient Safety Story

Purpose: To provide the Committee with patient experience and patient safety stories illustrating the patient experience and patient safety activities occurring at El Camino Health.

Summary:

1. Situation: There are two stories provided for the committee. These two stories were found to be deserving of a HeRO Award which is awarded to a team or individual who have demonstrated the use of the Universal Safety skills taught as an integral component of El Camino Health's High Reliability Organization Program.

2. Authority: To provide the QC Board with insight into patient safety stories.

3. Background: The first story illustrates the quick action of the MV Labor and Delivery staff who quickly recognized a post C-Section patient was experiencing the rare condition of malignant hyperthermia (MH) and acted quickly to respond and provide the medication necessary to reverse the effects of MH for the postpartum mother. The mother recovered fully, and the baby was unharmed. The second story demonstrates the questioning attitude of one of our pathologists who recognized a specimen that she was preparing to read did not seem correct. Her questioning attitude led to the identification of a contaminated specimen that should not be used for diagnosis.

4. Assessment: The two stories demonstrate the use of the safety skills that all physicians and staff learn and the ongoing focus on HRO skills everyday in our practice environments.

5. Outcomes: Both of these stories reflected a "good catch" leading to the expected outcomes for our patients.

6. List of Attachments: See patient comment.

Suggested Committee Discussion Questions:

1. Who receives HRO training now that the initial training is done? And, how is it delivered?
2. How does the hospital keep the skills alive in the organization?

Patient Story
September 8, 2025

Patient Comment: Press Ganey 1/19/2024

“Labor and Delivery Room was clean but out of date. The construction noise was awful and made the experience of labor that much harder”.

Patient Comment: Press Ganey 11/7/23

“New wing for L&D was lovely. The bed, both couch/bed were better than expected. Some directions on how to use the lights could have been helpful”

Two Patient Safety Stories

Story #1

Recently, the Labor and Delivery team in Mountain View — Nada Ishmaiel, MD, Samantha Chao, MD, Larry Yee, MD, Meredith Green, MD, Breanna Moore, RN, Kristine Hansen, RN, Angela Esporlas,RN, Denise Guzman, RN, Rachel Maddox, RN, Jamie Bancuk, RN, Melissa Wong Wong, RN, Lana Leung, RN, Brittni Goldenberg, RN, Justin Stewart, RN, David Katsanes, RT, Indira Mackay, Manager, Janna Ben-Zvi, RN and Selene Awa, AHM — **used safety skills** ARCC — Ask a question, Request a change, voice a Concern and if needed use Chain of command — and SBAR—Situation, Background, Assessment, Recommendation — **to save the life of a new mom**.

Using these skills, the staff was able to quickly recognize, coordinate response, and use clear communication to intervene in a **critical situation called Malignant Hyperthermia**, a very rare condition, only happening in one in 100,000 surgeries. Due to the efforts of the team, they were able to coordinate and deliver effective lifesaving care to new mom.

Story#2

Dr. Ng used **QVV** — Qualify, Validate, Verify — when she was presented with a suspicious specimen. Thanks to Dr. Ng's focus and diligence, she was able to identify contamination with the specimen. Pathology had received a specimen from endoscopy and began to process it. Upon examining the slide, Dr. Ng observed that two of the three tissue fragments appeared inconsistent and did not match what she would have expected from the specimen source. Instead, it was more in line with another pathologist's case. In order to check the source to validate and verify her suspicions, tissue DNA fingerprinting was conducted and confirmed specimen contamination.

Dr. Ng's attention to detail and speaking up prevented delays in specimen processing. Thank you, Dr. Ng, for using **QVV** and putting our patients first!

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, MBA Chief Quality Officer and Lyn Garrett, MHA, MS, CPHQ
Date: September 8, 2025
Subject: Enterprise Quality, Safety and Experience and STEEEP Dashboards through July 2025

Purpose:

To provide the Quality, Patient Care, and Patient Experience Committee with an update on quality, safety, and patient experience performance through July 2025 (unless otherwise noted). This memo summarizes results from both the STEEEP and Enterprise Quality Dashboards and includes the final FY25 STEEEP data.

Summary:

Situation: The FY 25 Enterprise Quality, Safety, and Experience Dashboard is updated monthly and tracks eighteen quality measures. The STEEEP dashboard is updated each quarter and contains seventeen measures. The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter. Most measures are tracked on both the Enterprise monthly and STEEEP quarterly dashboards.

Assessment:

Safe Care

a. **C. Difficile Infection:** There have been 2 (2 cases per month) (Goal: </= 26 infections FY 2026 or less than 2.17 cases/month) Hospital Acquired C=Diff infections YTD 2026. Areas of focus to decrease C. Diff are four-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. Fourth, testing of C. Diff samples will follow CDC and IDSA guidelines. (Timeline for improvement: We have measures described above in place which we believe will impact this rate. The benchmarked C Diff rate is per 10,000 patient days.)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 0 CAUTI cases year-to-date in FY2026, against a target of ≤12 for the fiscal year. Our process improvement efforts focus on:
Removing catheters promptly when clinically appropriate.
Ensuring best practices are followed for insertion and maintenance.
To reduce catheter duration, the infection prevention team reviews every patient with a catheter in place for more than three days. They collaborate with the nurse

and physician to confirm clinical indications and emphasize the importance of timely removal.
. (Timeline for improvement: While we are currently on track to meet the FY2026 goal, we continue to implement additional measures aimed at sustaining and further improving performance in the next fiscal year. Ongoing monitoring remains essential).

c. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for YTD FY2026 (0) is favorable to target of 5 cases for FY 26 (0.42 cases per month). (Timeline for improvement: We are on track to meet target)

1. **Surgical Site Infection**. The number of cases/month of surgical site infections for FY 26 (1) is favorable to target of </= 34 cases (2.83 cases/month). Process improvement has included implementing evidence based best practices shown to decrease SSIs: maintain Perioperative normothermia, timing and choice of preoperative antibiotics, clean closure tray utilization in the OR and glucose control in diabetics. (Timeline for improvement: We are seeing a downward trend in the last few months and are confident that this will continue)

2. **Hand Hygiene Combined Compliance rate:** Performance for YTD FY2026 is Unfavorable (83.7%) to target of 84%. (Timeline for improvement: We are instituting real time coaching for failures in compliance, as well as socializing this in our nursing and physician councils)

3. **Hand Hygiene % of Departments Meeting Audit Compliance target:** Performance for FY26 YTD is favorable (100%) to target of 80% of units.

B. Timely

1. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance YTD FY 2025 (73.9%) is unfavorable to target (84%). The root cause of the delays relates to multiple factors, primary being radiology staffing issues experienced by the contracted vendor. In addition, there have been issues with the transfer of images and interface with our system which are being worked on. (Timeline for improvement: Realistically, we anticipate improvement in the Turnaround times by Q3 2026)

C. Effective

1. **30 Day Readmission Observed Rate:** Performance through FY26 (10.3%) is unfavorable 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: This is only one month of data, however we are confident we will continue to maintain our FY 25 trend)

2. **Risk Adjusted Mortality Index.** Performance YTD FY25 (1.10) is unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. 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. In addition, we are optimizing O/E measure to accurately reflect the acuity of illness of our patients. (Timeline for improvement: Q1-Q2 FY 2026. The trendline over the last few months has been positive for this index.)

3. **Sepsis Mortality Index.** Performance through FY2025 (1.11) 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 first week of September 2025. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation. This alone, “Palliative care consult” increases the expected risk of mortality 6-fold)

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV). FY25 performance through May of 2025 (26.4%) is unfavorable to target of 23.9%. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: This metric has been challenging for the organization as well as like hospitals in California. We will continue with our efforts to reduce this metric)

D. Efficient

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency

achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance FY25 is (1.02) is at target of (1.02). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams are optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:

- Within Epic a centralized care plan was created that pulls together important information about the patients care plan. This tool increased efficiency and allows the care team to obtain pertinent information in a timely way. Additionally, interdisciplinary team members can track internal and external delays which will offer insight into the primary reasons for delays in patient throughput.
- Since the initiation of Multidisciplinary rounds (MDR) in December 2023, there have been significant improvements in LOS within the pilot program for patients who stay in nursing unit 2C. The data indicates a noteworthy decrease of -1.1 days in LOS. The MDR process has been rolled out to multiple units in the hospital and is showing sustained benefits.
- We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements. (Timeline for improvement: We anticipate improvement due to the changes implemented by Q4 of 2025)

2. **Median Time from ED Arrival to ED Departure (Enterprise).** Performance through FY25 (152.4 minutes) is favorable to the target of < 160 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

E. Equitable

1. Social Drivers of Health Screening rate: FY 25 performance YTD is (41.3%) is unfavorable to target of 50%. This is a new measure and steps taken to improve our screening rate includes creating a new tool for staff to document required elements of the metric. Our team including care coordinators, nurses and informatics teams are working to implement this tool in the next few months. (This metric continues to improve and we should be on track to meet this target by Q2 FY26)

2. Voyce Interpretation Minutes Used: FY 2025 performance (515,606 minutes). We are in the process of establishing a target for this metric. This is the first year that we are using this metric, hence there is no benchmark either locally or nationally. We believe that this metric is an important proxy for communication with patients who do not have English as their primary language.

3. Homeless Planning Discharge Compliance Rate: New measure for FY26. This measure was chosen because of new CMS regulations on monitoring our efforts on homeless discharge compliance rates.

F. Patient Centered:

1. FY25 Performance Highlights

Domain	National Percentile	California Percentile	Bay Area Percentile
Inpatient (HCAHPS)	84th	81st	92nd
Medical Network (ECHMN)	26th	36th	34th

FY25 closed with mixed performance across El Camino Health (ECH) and El Camino Health Medical Network (ECHMN). ECH inpatient performance remained nationally competitive, while ECHMN continues to improve, and is aiming to be at the 50th percentile by the end of FY27. FY26 targets have been established using statistically valid methodologies, with a focus on achievable improvement. New initiatives—including the Patient Experience Action Team, updated Playbook, and reestablishment of Patient and Family Advisory Groups—aim to strengthen system-wide accountability and culture around patient experience.

2. Patient Comments and Feedback Process

- Identify feedback type (positive, negative, safety, staff-specific)
- Escalate service concerns immediately and initiate service recovery using WeCare standards
- Distinguish isolated versus recurring issues; systemic concerns prompt corrective action plans
- Close the loop by communicating back to patients and sharing themes with staff

3. Fiscal Year 2026 Patient Experience Focus Areas

- Patient Experience Action Team – multi-disciplinary oversight body
- PX Playbook – standardized guide for leaders and staff
- Patient and Family Advisory Groups – reestablished to amplify patient voice
- Refresher Training – WeCare service recovery training for all employees
- PX Reporting – creation of comprehensive, system-level reports
- Physician Partnership Program – engagement of providers in PX improvement

Attachments:

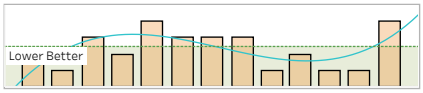
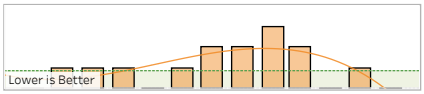
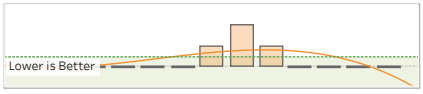
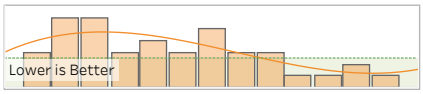
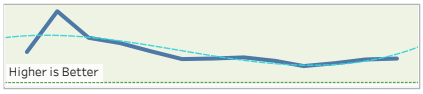
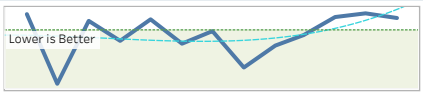
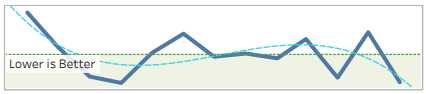
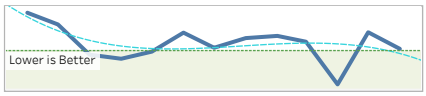
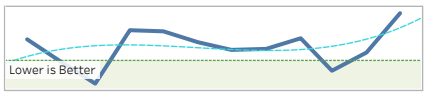
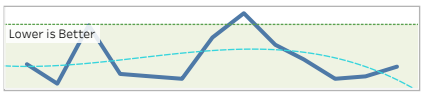
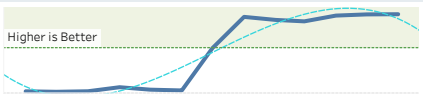
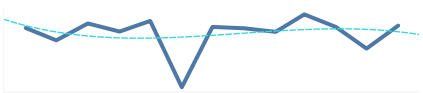
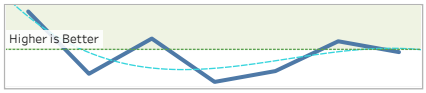
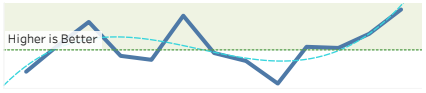
1. Enterprise Quality Dashboard through July of 2025
2. STEEEP Dashboard through June of 2025 and the updated STEEEP Dashboard FY26

El Camino Health Quality Board: FYTD25 STEEEP

El Camino Health

Show Filter

Date: 7/1/2024 06/30/2025

Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator		Last 12 Months Trend
Safe Care	FY 25Q1	FY 25Q2	FY 25Q3	FY 25Q4	FY24	FYTD25			Trend Chart Period: 7/1/2024 to 06/30/2025
C-Diff Clostridioides Difficile Infection	6	10	6	6	28	**28**		<= 27 cases	
CAUTI (Catheter-Associated Urinary Tract Infection)	3	3	7	1	11	**14**		<=10 cases	
CLABSI (Central Line-Associated Bloodstream Infection)	0	1	3	0	3	**4**		<=5 cases	
SSI (Surgical Site Infection)	15	12	7	4	38	**38**		<=30 cases	
Hand Hygiene Audit Compliance (Leapfrog measure)	85.3%	81.5%	80.9%	86.6%	84.1%	**83.2%**		>=85%	
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	74.0%	69.4%	77.7%	76.9%	77.7%	**74.6%**		>=84.0%	
Effective									
30-Day Readmission Rate (Based on Vizient Risk Model)	9.2%	9.8%	9.1%	10.4%	9.8%	**9.6%**		<=9.8%	
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	0.87	1.06	1.04	0.92	1.16	**0.98**		<= 1.0	
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.06	1.10	1.17	0.96	1.35	**1.07**		<=1.0	
NTSV Cesarean Section (CMS PC-02 Measure)	24.2%	27.5%	25.4%	29.1%	24.7%	**26.4%**		<=23.9%	
Efficient									
Length of Stay (LOS) O/E Index (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.01	1.03	1.03	0.98	1.03	**1.01**		1.02	
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	151	152	154	153	155.8	**152.4**		<=160	
Equitable									
Social Driver of Health (SDOH) Screening Rate	4.0%	21.0%	82.6%	87.8%	2.1%	**41.3%**		50%	
Voyce Interpretation Minutes Used	57,925	53,919	60,025	57,337	617,023	**687,616**		TBD	
Patient-Centered									
Inpatient Hospital: Likelihood to Recommend Press Ganey	80.7	81.5	82.0	89.0	86	**84**		81.9	
ED: Likelihood to Recommend Press Ganey	78.9	78.3	75.1	80.7	75.5	**78.2**		77.2	
MCH - INPATIENT Press Ganey	82.8	80.5	83.0	76.3	82.0	**80.8**		82.0	

El Camino Health Quality Board: FYTD26 STEEEP

El Camino Health

Show Filter

Date: 10/1/2024 09/30/2025

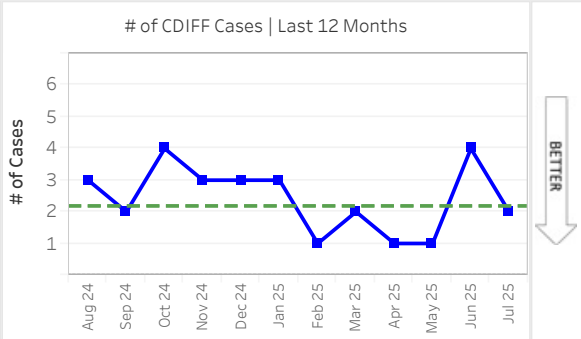
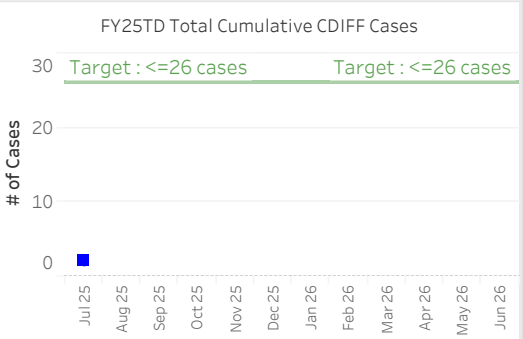
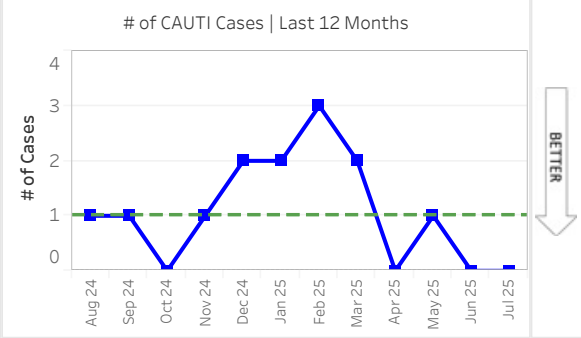
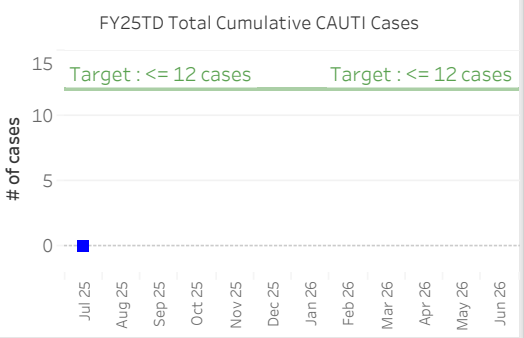
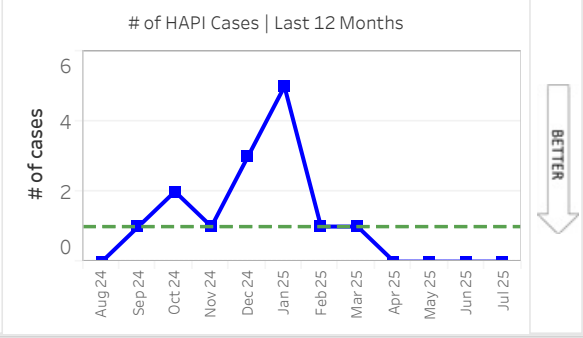
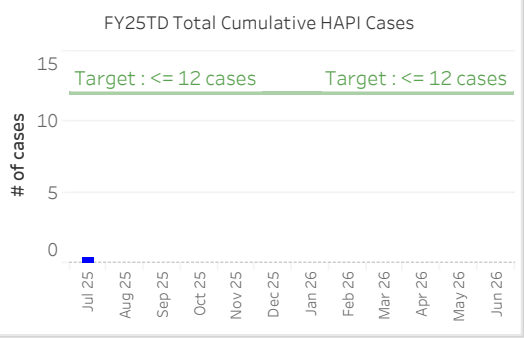
Measures	Last 4 Fiscal Quarters				Baseline	FYTD Result	Target Indicator	Last 12 Months Trend
Safe Care	FY 25Q2	FY 25Q3	FY 25Q4	FY 26Q1	FY25	FYTD26		Trend Chart Period: 10/1/2024 to 09/30/2025
C-Diff Clostridioides Difficile Infection	10	6	6	2	28	**2**	<= 26 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	3	7	1	0	14	**0**	<=12 cases	Lower is Better
HAPI (Stage 3, 4 & Unstageable)	6	7	0	0	14	**0**	<= 12 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	1	3	0	0	4	**0**	<=5 cases	Lower is Better
SSI (Surgical Site Infection)	12	7	4	1	38	**1**	<=34 cases	Lower is Better
Hand Hygiene Audit Compliance (Leapfrog measure)	81.5%	80.9%	86.6%	83.7%	83.2%	**83.7%**	>=84%	Higher is Better
Timely								
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	69.4%	77.7%	76.9%		73.9%		>=84.0%	Higher is Better
Effective								
30-Day Readmission Rate (Based on Vizient Risk Model)	9.8%	9.1%	10.4%		9.6%		<=9.8%	Lower is Better
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.06	1.04	0.92	1.10	0.98	**1.10**	<= 0.97	Lower is Better
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.10	1.17	0.96	1.19	1.11		<= 1.00	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	27.5%	25.4%	29.1%		26.4%		<=23.9%	Lower is Better
Efficient								
Length of Stay (LOS) O/E Index (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	1.03	1.04	0.99	0.99	1.02		1.02	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	152	154	153	155	152.4	**154.5**	<=160	Lower is Better
Equitable								
Social Driver of Health (SDOH) Screening Rate	21.0%	82.6%	87.8%		41.3%		50%	Higher is Better
Homeless Planning Discharge Compliance Rate	21.0%	82.6%	87.8%	(Mock Data)	41.3%		TBD	
Patient-Centered								
LTR Composite Score Press Ganey	81.5	82.0	89.0	(Mock Data)	86	**84**	81.9	Higher is Better

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases Latest Month : July 2025	2 cases	2.00 cases/mo	2.33 cases/mo	2.17 cases/mo		
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : July 2025	0 cases	0.00 cases/mo	1.17 cases/mo	1.00 cases/mo		
*Organizational Goal Hospital Acquired Pressure Injury (HAPI) cases Latest Month : July 2025	0 cases	0.00 cases/mo	1.17 cases/mo	1.00 cases/mo		

Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Dashboard Managed by
Quality Data Analyst : **Jeffery Jair**
jeffery_jair@elcaminohealth.org

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Hospital Acquired Pressure Injury (HAPI) cases	Ann Aquino	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Epic Report** (ECH Pressure Injuries - By Department (RWSQL) with manual chart reviews

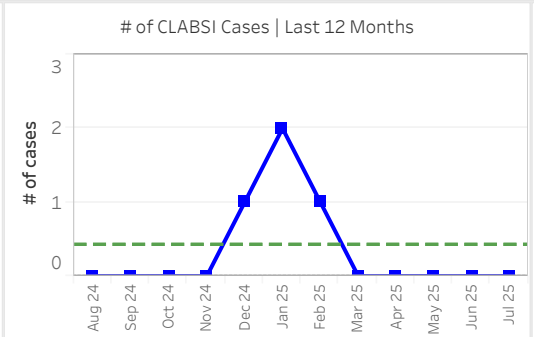
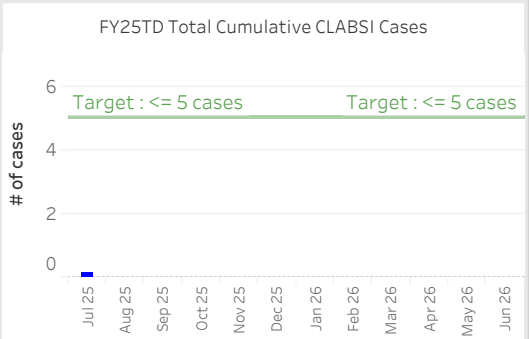
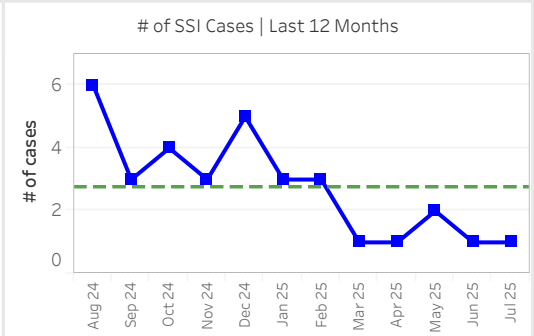
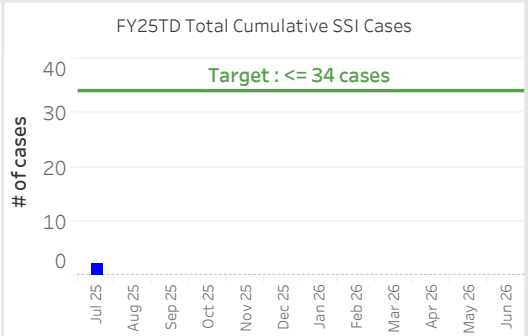
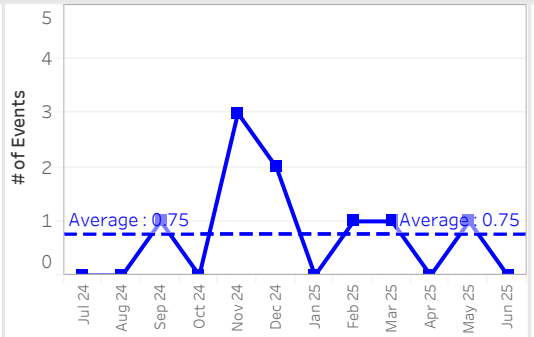
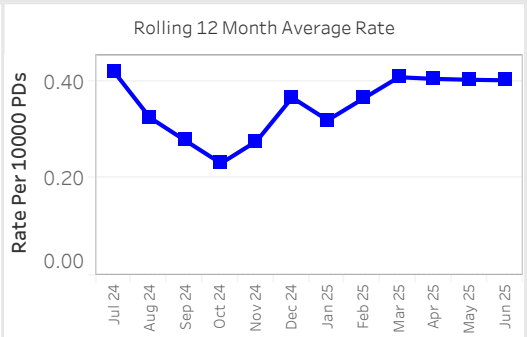
Quality Department | Note : updated as of August 20, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Central Line Associated Blood Stream Infection (CLABSI) cases Latest Month : July 2025	0 cases	0.00 cases/mo	0.33 cases/mo	0.42 cases/mo		
Surgical Site Infections (SSI) cases Latest Month : July 2025	1 cases	1.00 cases/mo	3.17 cases/mo	2.83 cases/mo		
Serious Safety Event Rate (SSER) Latest Month : June 2025	0 events	0.40 (9 / 223616)	0.61 (13 / 214277)	n/a		

Quality Department | Note : updated as of August 20, 2025

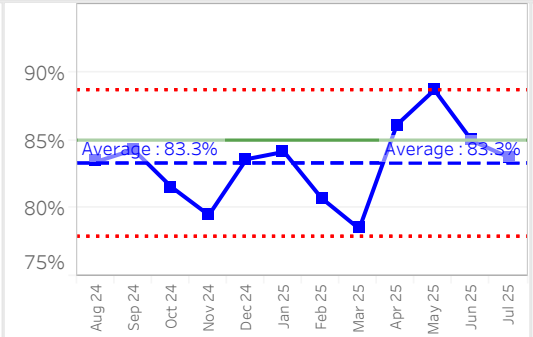
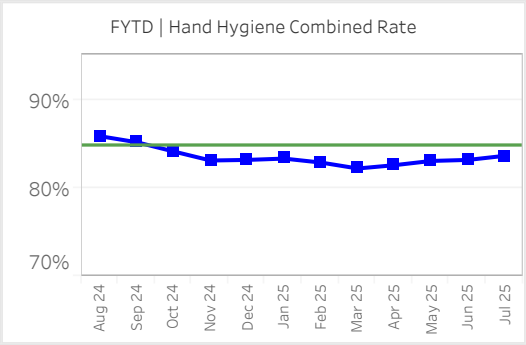
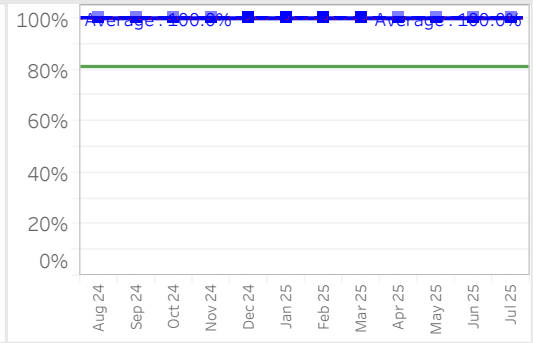
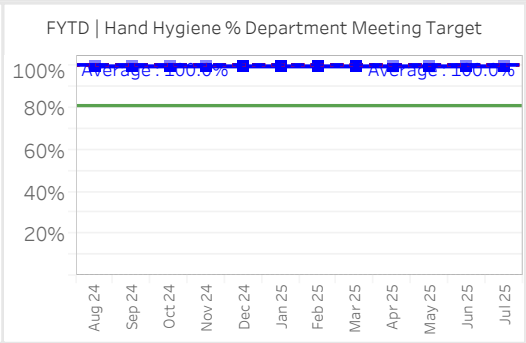
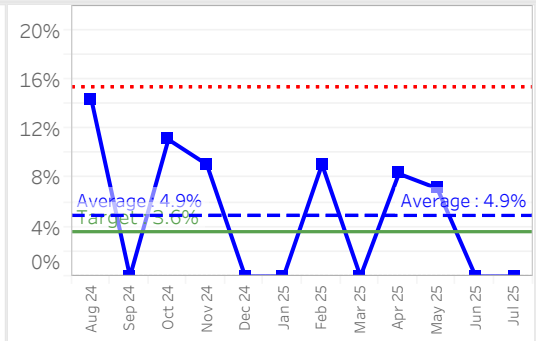
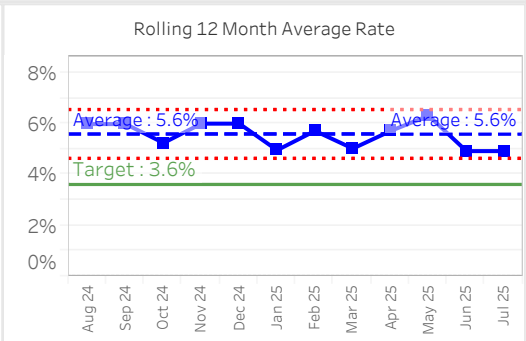
Measure	Definition Owner	Metric Definition	Data Source
Central Line Associated Blood Stream Infection (CLABSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Surgical Site Infections (SSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 2) Inclusions: events determined to be serious safety events per Safety Event Classification team 3) NOTE: the count of SSE HAPIs MAY differ from internally-tracked HAPIs 4) Denominator: EPSI Acute Adjusted Patient Days For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero. New classification rules in effect as of 7/1/22	HPI Systems Safety Event Tableau Dashboard maintained by: **Indu Adhikary**

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Hand Hygiene Combined Compliance Rate Latest Month : July 2025	83.7% (8700 / 10393)	83.7% (8700 / 10393)	83.2% (171444 / 205958)	>=84% (1% improve of FY25)		
Hand Hygiene % of Departments Meeting Target Latest Month : July 2025	100.0% (25 / 25)	100.0% (25 / 25)	100.0% (300 / 300)	80% of units		
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : July 2025	0.0% (0 / 6)	0.0% (0 / 6)	4.8% (6 / 126)	<= 4.3% (10% reduction of FY25)		

Quality Department | Note : updated as of August 20, 2025

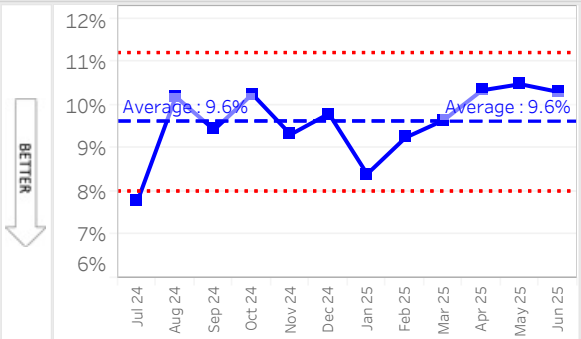
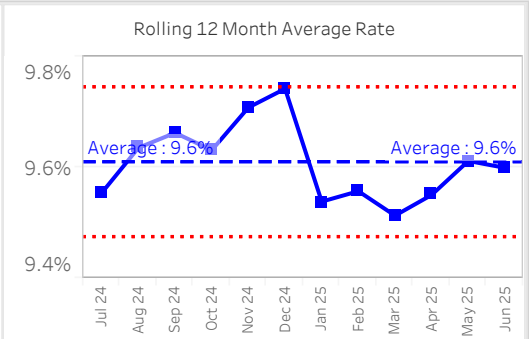
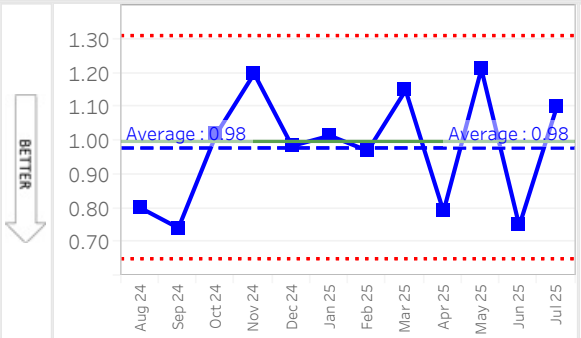
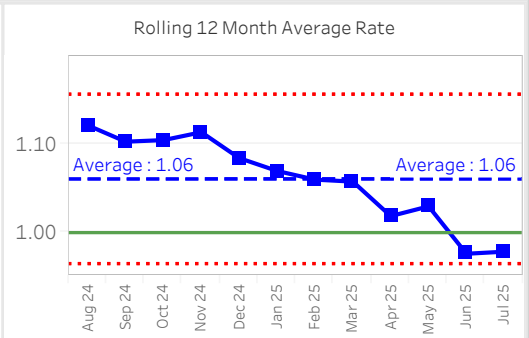
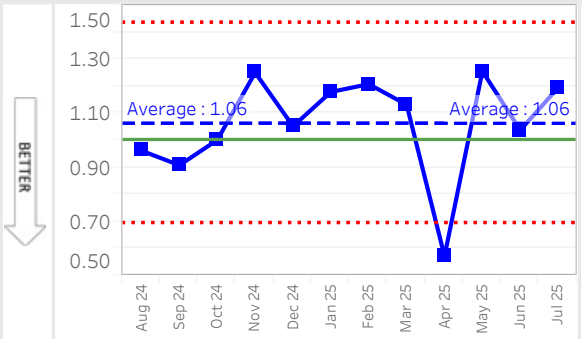
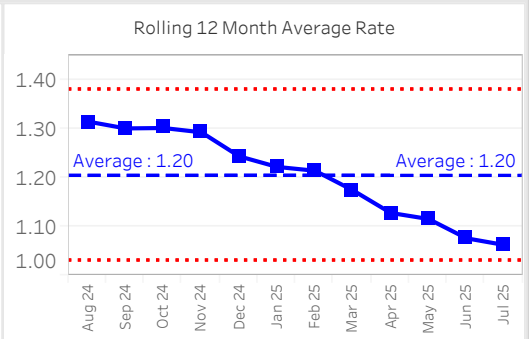
Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Hand Hygiene Combined Compliance Rate	S. Mallur, MD / Lyn Garrett	% of yes Cleaning Before Entering or Exit	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: Hsiao-Lan Shih
Hand Hygiene % of Departments Meeting Target	S. Mallur, MD / Lyn Garrett	Number of Unit done Audit according to their Target (Only Leapfrog units)	Hand Hygiene Audit from Laudio Audit Tool Hand Hygiene Leapfrog Tableau Dashboard maintained by: Hsiao-Lan Shih
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure)	S. Mallur, MD	Based on the Center for Medicare and Medicaid Services (CMS) Metric criteria, complications following an elective primary total hip arthoplasty (THA), total knee arthoplasty (TKA) procedure. Numerator : Distinct count of patients having complications / Total Cases. Patients with complications are counted in the numerator only once, regardless of the number or type of complication. Denominator : Eligible index admissions who have undergone a qualifying elective primary THA or TKA procedure. 2.) Based upon Vizient Risk Model 2024 Community + AHRQ Version 2024 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Nonviable Neonate & Normal Newborn)	Vizient Clinical Database

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : June 2025	10.3% (133 / 1291)	9.6% (1562 / 16264)	9.8% (1624 / 16488)	<= 9.8%		
Mortality Index Observed / Expected Vizient Risk Model Latest Month : July 2025	1.10 (2.49% / 2.26%)	1.10 (2.49% / 2.26%)	0.98 (2.22% / 2.27%)	<= 0.97		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : July 2025	1.19 (11.29% / 9.45%)	1.19 (11.29% / 9.45%)	1.07 (10.63% / 9.98%)	<= 1.00		

Quality Department | Note : updated as of August 20, 2025

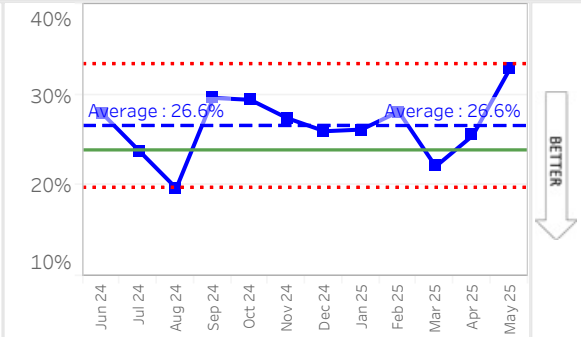
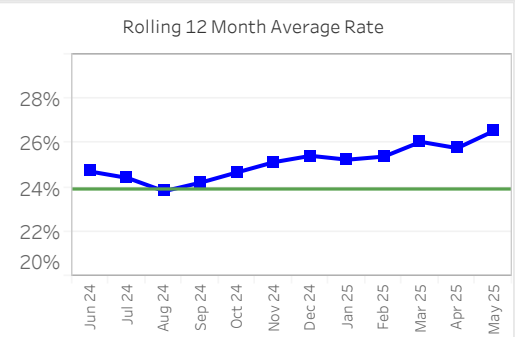
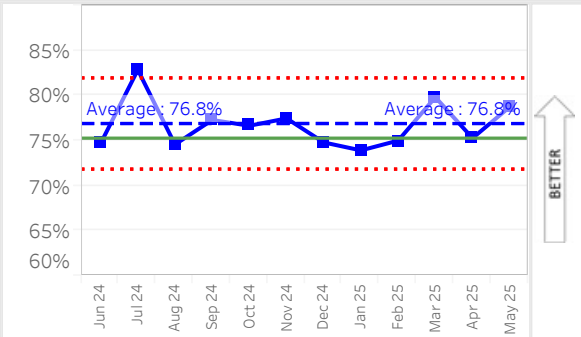
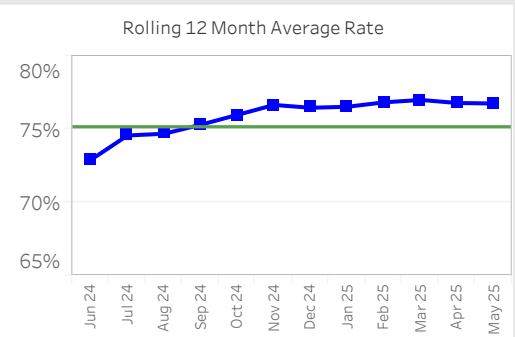
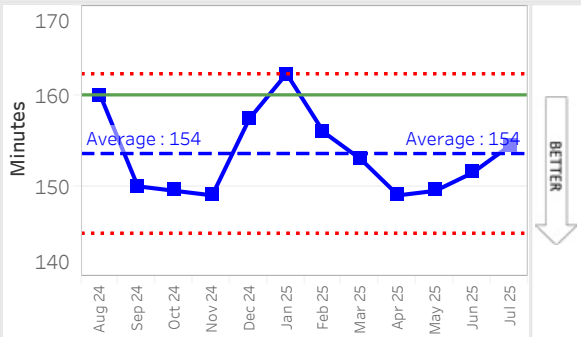
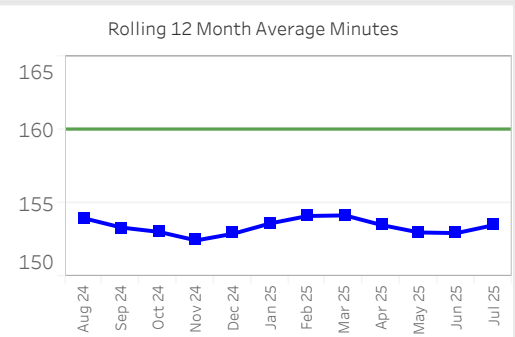
Measure	Definition Owner	Metric Definition	Data Source
30-Day Readmission Observed Rate Vizient Risk Model	S. Mallur, MD	1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Vizient Risk Model 2024 Community + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn)	Vizient Clinical Database Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD	1) Based upon Vizient Risk Model 2024 Community for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient (excluding Hospice, Rehab, Behavioral Health (defined Vizient Service Line = Behavioral Health), Nonviable Neonate & Normal Newborn) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Vizient Clinical Database
Sepsis Mortality Index Observed / Expected Vizient Risk Model	S. Mallur, MD Maria Consunji	1) Numerator inclusions: Patient Type = Inpatient (exclude Rehab, Hospice, Nonviable Neonate & Normal Newborn + Behavioral Health (based on Vizient Service Line = Behavioral Health), Prin or 2nd diagnosis of sepsis (SEP-1 list of codes) & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB) For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Vizient Clinical Database

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 33.3% (55 / 165)	MV : 27.2% (471 / 1729)	MV : 27.6% (516 / 1870)	23.9% (FY24 ENT Target)		
	LG : 30.3% (10 / 33)	LG : 21.9% (69 / 315)	LG : 19.4% (62 / 320)			
Latest Month : May 2025	ENT : 32.8% (65 / 198)	ENT : 26.4% (540 / 2044)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding	MV : 77.7% (247 / 318)	MV : 75.5% (2427 / 3214)	MV : 58.1% (1998 / 3437)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 84.1% (53 / 63)	LG : 84.6% (509 / 602)	LG : 68.4% (428 / 626)			
Latest Month : May 2025	ENT : 78.7% (300 / 381)	ENT : 76.9% (2936 / 3816)	ENT : 59.7% (2426 / 4063)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	MV : 167 mins	MV : 167 mins	MV : 169 mins	FY25 Goals = MV ED = 180 min LG ED = 140 min ENT = 160 min Goals still TBD by ED Leadership		
	LG : 142 mins	LG : 142 mins	LG : 137 mins			
Latest Month : July 2025	ENT : 155 mins	ENT : 155 mins	ENT : 153 mins			

Quality Department | Note : updated as of August 20, 2025

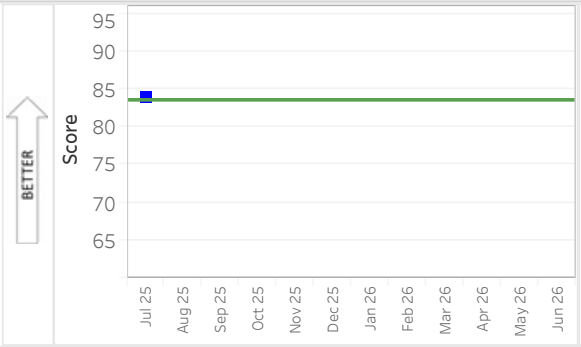
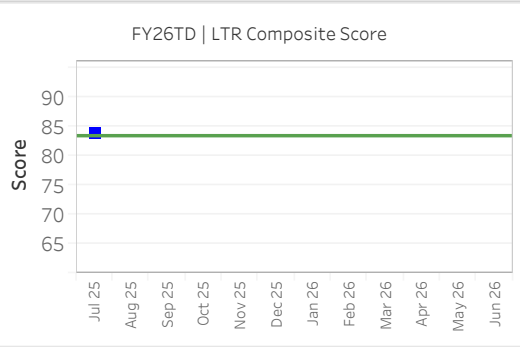
Measure	Definition Owner	Metric Definition	Data Source
PC-02 : Cesarean Birth	H. Freeman	1) **Numerator**: Patients with cesarean births 2) **Denominator**: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	CMQCC
PC-05 : Exclusive Breast Milk Feeding	H. Freeman	1) **Numerator**: Newborns that were fed breast milk only since birth 2) **Denominator**: Single term newborns discharged alive from the hospital	CMQCC
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	J. Baluom	ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table	EDSBAR Tableau Dashboard; EDOC Monthly Meeting Dashboard ED Tableau Dashboard maintained by: **Hsiao-Lan Shih**

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

July 2025 (unless other specified)

Month to Board Quality Committee : Sept 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
LTR Composite Score Latest Month : July 2025	83.8	83.8	83.4	>= 83.4		

Quality Department | Note : updated as of August 20, 2025

Measure	Definition Owner	Metric Definition	Data Source
LTR Composite Score	Ryan Lockwood	The LTR Composite Score is a single, combined performance goal that reflects multiple metrics or data points - such as department-level patient experience scores - aggregated into one overall score for the fiscal year. It is calculated based on Likelihood to Recommend (LTR) performance from the previous fiscal year. Weighting is applied based on patient volume or prioerity areas to ensure a fair representation of each department's contribution.	HCAHPS

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To:	El Camino Hospital Board Quality, Patient Care and Patient Experience Committee "ECHB Quality Committee"
From:	Dr. Jaideep Iyengar, MD, FAAOS, ECHMN Quality Chair, Peter Goll, Chief Administrative Officer, and Kirstan Smith, BSN, CPHQ, Vice President of Clinical Quality
Date:	September 8, 2025
Subject:	El Camino Health Medical Network Quality Report

Purpose:

Provide the ECHB Quality Committee with a quarterly update on the status of quality of care within the El Camino Health Medical Network (ECHMN).

Summary:

As the healthcare landscape continues to shift toward value-based care, our organization has taken strategic steps to modernize our Quality Program for calendar year 2025 and will continue evolving it in years to come. Our focus is twofold: maintaining excellence under the current fee-for-service model while simultaneously aligning with Medicare and commercial health plan quality standards. This dual approach ensures that we continue to deliver high-quality care, remain financially sustainable, and stay prepared for evolving regulatory requirements.

In anticipation of Medicare's transition away from traditional MIPS toward MIPS Value Pathways (MVPs), we are proactively redesigning our quality infrastructure. While CMS has not formally announced a sunset date for traditional MIPS, it has proposed a phase out by 2029, after which MVPs would serve as the primary framework for clinical quality reporting. MVPs emphasize value over volume and align quality measures by specialty or clinical condition.

Quality measures for the network were chosen for their alignment with health plan priorities and their clinical significance. Each measure was mapped to MVPs with many included in multiple MVPs, demonstrating their relevance across various specialties and reinforcing our transition to value-based care. For performance year 2024, we successfully submitted three MVPs. In 2025, we plan to expand our MVP participation to a minimum of 6 pathways, further integrating quality reporting into everyday clinical workflows.

We acknowledge that a substantial portion of our provider compensation and performance metrics remains tied to fee-for-service models. Our revised Quality Program is designed to support both priorities:

- Support ongoing revenue from fee-for-service encounters by promoting high-quality, measurable care
- Align with commercial and Medicare Advantage health plan requirements, many of which are increasingly modeled on CMS' quality frameworks

We are also actively integrating feedback from providers, national performance benchmarks, and payer requirements to ensure our quality measures are current and clinically meaningful, achievable, and relevant to our patient population.

The Quality Department has developed a detailed implementation plan that includes:

- Development of network-wide performance dashboards for individuals and groups
- Increased continuous education and feedback loops for providers to drive engagement and improvement
- Establishing a structured onboarding program for new providers and managers, including clearly defined check-in milestones
- Quarterly clinic support visits to foster hands-on collaboration, address operational needs, and reinforce best practices

2025 Quality Program Enhancements:

- 11 shared network goals and 3 additional measures related to specialists and pediatrics
- Uniform performance across all care categories to encourage shared accountability
- MIPS attribution-based reporting, improving alignment, reporting, and payer consistency

The Network's quality measures reset annually to align with health plan and Medicare tracking standards, with the goal of sustaining them by year-end. The data presented in the slides follows the calendar year for the 11 shared network goals. While specialists have become more involved in quality efforts, the measures primarily align with PCP practice. Specialist and urgent care providers' contributions are tracked through performance dashboards and continue to support system-wide quality goals. For the calendar year to date, through July 31, 2025, the network is currently meeting 5 of 11 goals. All measures show positive trends towards meeting their targets. Targeted interventions are underway, including outreach for measures not meeting target.

We are currently in a transitional phase with our Quality Program and associated measures. The future goal is to align specialists with metrics that are directly relevant to their specialty areas, ideally within a corresponding MVP. Since CMS has not yet released relevant MVPs for some specialties, a hybrid reporting approach is being utilized this year and may continue in future program years.

In parallel with our quality initiatives, the Quality Department is advancing a culture of safety through the launch of a network-wide risk management and incident reporting program. These initiatives are essential to safeguarding patient wellbeing, enhancing staff preparedness, and reducing organizational risk. In FY26, we are:

- Rolling out bimonthly clinical support meetings with clinic leadership
- Launching a user-friendly electronic incident tracking system to improve documentation, root cause analysis, and response time
- Supporting suicide prevention and mental health first aid initiatives by certifying designated clinic and call center staff in mental health response and crisis support

The Future of Quality in the IPA:

Leadership teams from both the IPA and the network have initiated early discussions regarding the integration of quality improvement initiatives within the IPA structure. The goal of this collaborative approach is to shift towards outcome-based evaluations, placing a strong emphasis on improving patient outcomes and leveraging data to inform clinical and operational

decisions. However, several significant challenges have been identified, including the presence of EMR systems across participating practices and inconsistencies in data accessibility. These barriers complicate efforts to standardize quality metrics and hinder the ability to aggregate and analyze data effectively. Addressing these issues will be critical for the successful implementation of quality-focused strategies within the IPA.

In conclusion, our 2025 Quality Program reflects a deliberate and forward-looking strategy: maintaining excellence in fee-for-service care while accelerating readiness for value-based, health-plan-aligned quality performance. By expanding specialist engagement, integrating MVPs, updating attribution models, and strengthening safety infrastructure, we are well-positioned to thrive in a rapidly evolving healthcare environment. Our commitment remains rooted in improving patient care, reducing administrative burden across our network, and fostering a culture of continuous innovation.

List of Attachments:

PowerPoint presentation to be reviewed beforehand, to support and serve as a reference during the discussion.

Suggested Committee Discussion Questions:

What additional information would be helpful for the ECHB Quality Committee to receive in the quarterly reports from ECHMN?

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El Camino Health Medical Network 2025 Quality Program

Presented by:
Jaideep Iyengar, MD, FAAOS, Chair, ECHMN Quality
Peter Goll, CAO
Kirstan Smith BSN, RN, CNN, CPHQ, Vice President of Quality Performance

September 8, 2025

El Camino Health Medical Network

Agenda

- ECHMN 2025 Quality Program
  - Program Framework
  - Program Roadmap
- 2025 YTD Performance
  - YTD 2025 Quality Measure Performance and Action Items
- Quality in the IPA
- Appendix

ECHMN 2025 Quality Program

CY 2025 Quality Program Framework

- Addressing prior meeting question: Clarifying our quality strategy for 2025
- Dual focus:
  - Maintain excellence in fee-for-service care
  - Proactively transition to value-based care, aligning with Medicare and commercial health plan quality standards
- We are currently in a transitional phase with our quality program and associated measures. Looking ahead, our goal is to align specialists with metrics that are directly relevant to their specialty areas, ideally within a corresponding MIPS Value Based Pathway (MVP).

Quality Program Roadmap

- Because CMS has not yet released applicable MVPs for certain specialties, a hybrid reporting approach is being used this year and one that may continue into future program years.
- Quality measures were selected based on alignment with health plan priorities and clinical impact. Each measure was cross-walked with MIPS Value Pathways (MVPs), with many appearing in multiple MVPs, highlighting their relevance across specialties and supporting our shift toward value-based care.
- All selected ECHMN 2025 quality measures are included in at least one of the 21 available MVPs, with most designated as high priorities by our partner health plans. *This is illustrated on the following slide.*

Quality Measure Comparison Across 21 MVPs for 2025

ECHMN Quality Measures	Is this measure a high priority for health plans?	How many 2025 MVPs include this measure? (higher is better)
Breast Cancer Screening	YES	1
Diabetes – Glycemic Status	YES*	2
Colorectal Cancer Screening	YES	1
Tobacco - Screening and Cessation Intervention	NO#	7
Screening for Future Fall Risk	YES	1
Controlling Blood Pressure	YES*	3
Statin Therapy (ASCVD)	YES	2
Documentation of Current Medications	NO	7
Screening for Depression and Follow-Up	NO	7
Kidney Health Evaluation	YES	1
Cervical Cancer Screening	YES	1

*Triple-weighted for health plans
DHCS QIP Program measure

Quality Measures Across Potential 2025 ECHMN MVP Submissions

ECHMN Quality Measures	# MVPs that include this measure	MVP Specialty
Breast Cancer Screening	1	Women's Health
Diabetes – Glycemic Status	2	Primary Care, Kidney Health
Colorectal Cancer Screening	1	Gastroenterology
Tobacco - Screening and Cessation Intervention	3	Ophthalmologic Care, Women's Health, Gastroenterology
Screening for Future Fall Risk	1	Urologic Conditions
Controlling Blood Pressure	1	Primary Care
Statin Therapy (ASCVD)	1	Primary Care
Documentation of Current Medications	4	Kidney Health, Ophthalmologic Care, Gastroenterology, Rheumatology
Screening for Depression and Follow-Up	5	Primary Care, Advancing Cancer Care, Women's Health, Care for Heart Disease, Rheumatology
Kidney Health Evaluation	1	Kidney Health
Cervical Cancer Screening	1	Women's Health

*Eligible clinicians and data collection methods (CQMs vs. eCQMs) determine the potential for submission.

2024 Traditional MIPS Score vs. MVP Quality Score

Traditional MIPS Performance for the Network	MVP Performance by Subgroup
85.7%	**90.1%** (Primary Care)* **92.5%** (Women's Health) **87.8%** (Kidney Health)

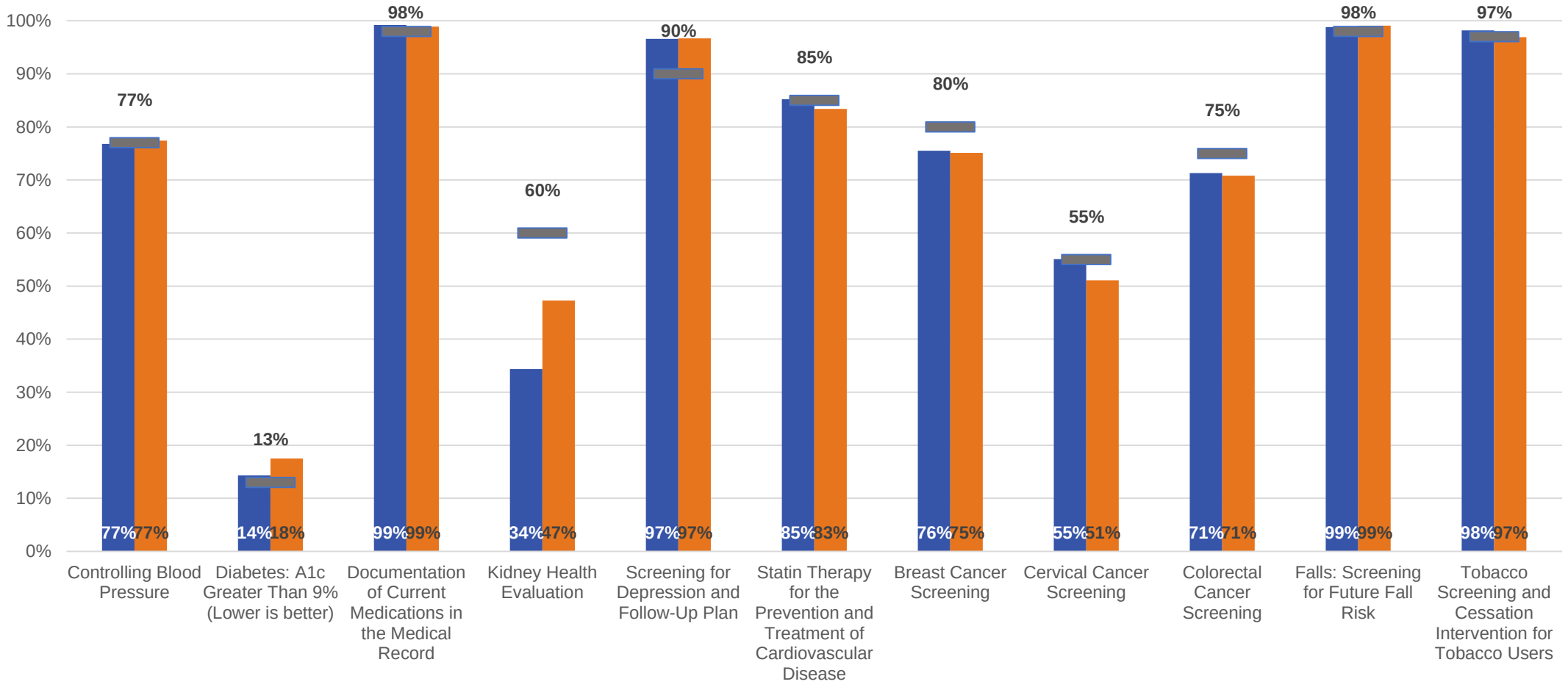
- The chart above compares 2024 quality category scores for traditional MIPS and MVP subgroups. In 2024, we saw higher scores across all submitted MVP subgroups compared to traditional MIPS, due to MVPs better representing the quality measures specific to each specialty.
- The Primary Care MVP does not solely reflect the contributions of primary care providers, since we had to group together every eligible clinician lacking an MVP that bills under our TIN. **Of the 45 physicians reported under the MVP, 28 were not primary care providers.***

2025 Year-to-Date Performance

YTD Performance

- The data presented on the following slides highlights the 11 shared network goals for calendar year 2025.
- As of July 31, 2025, the network is meeting 5 out of 11 goals year-to-date; the remaining measures are showing positive trends and are on track to meet the established targets.

ECHMN Primary Overall Performance YTD thru July 31



Current Performance: 5 of 11 Measures Met

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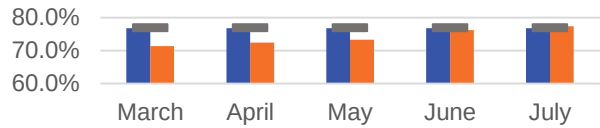
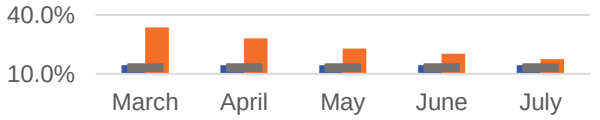
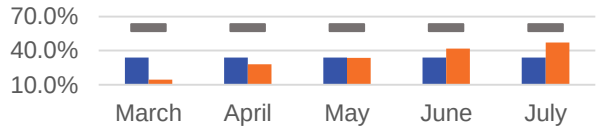
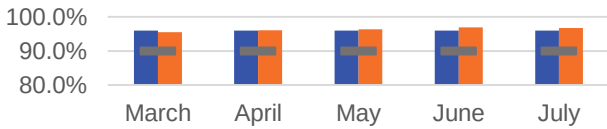
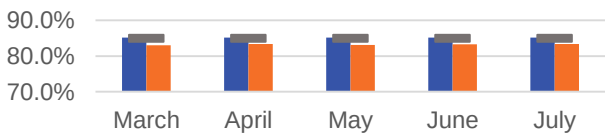
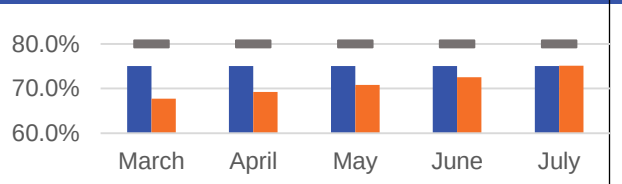
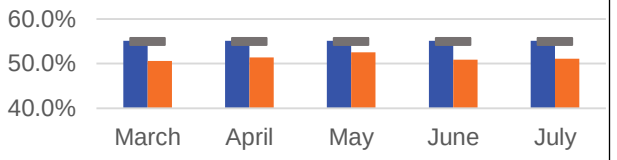
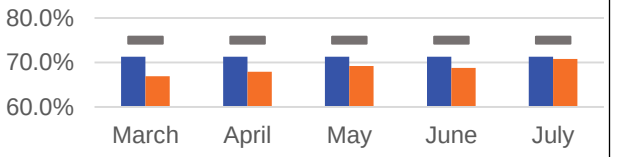
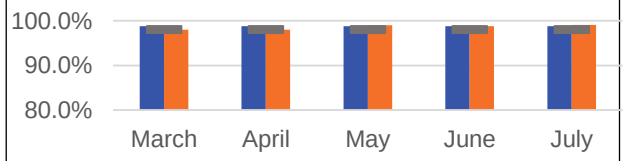
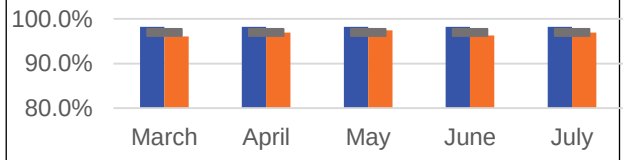
Q2 Quality Metric Performance and Action Items (YTD thru 7/31/25)

Measure	YE 2024	Goal	July YTD	To Goal	Pts to Goal	% Increase	YTD Trend	Action Plan
Controlling Blood Pressure	76.8%	77%	**77%**	--	+33	4%		• "MyChart Home Blood Pressure Self-Report Campaign will be launched at the beginning of Q4. • MA outreach to patients
Glycemic Status Assessment	14.3%	13%	**18%**	-5%	146	-5%		• Quality team will provide outlier lists for MA and provider outreach to patients not meeting the measure. • Point of Care Testing (POCT) is available at all primary care locations.
Documentation of Current Medications	99.2%	98%	**99%**	--	+438	0%		• Identify outliers and provide training to providers and staff to ensure medications are reviewed at every visit and marked as reviewed on the day of the encounter.
Kidney Health Evaluation	34.4%	60%	**47%**	13%	433	14%		• Developed a tip sheet to guide providers in selecting the correct kidney health lab orders. • Lists were shared with providers and clinic leadership identifying patients who are not meeting the measure.
Screening for Depression + Follow Up Plan	96.6%	90%	**97%**	+1%	+1780	1%		• Identify outliers and provide training to providers and staff.
Statin Therapy- Patients w/ ASCVD	85.2%	85%	**83%**	2%	73	0%		• Provide out of target report to providers. • Verify the accuracy of mapping and ensure exclusions and exceptions are being appropriately captured.

Q2 Quality Metric Performance and Action Items (YTD thru 7/31/25)

Measure	YE 2024	Goal	July YTD	To Goal	Pts To Goal	% Increase	YTD Trend	Action Plan
Breast Cancer Screening	75.5%	80%	**75%**	5%	265	4%		• Chart abstraction planned for Q3 2025. • BCS outlier lists were distributed to all primary care providers and clinic leadership for outreach. • Review proper measure capture in Epic
Cervical Cancer Screening	55.1%	55%	**51%**	4%	312	-1%		• Provide out of target report to providers. • Review proper measure capture in Epic.
Colorectal Cancer Screening	71.3%	75%	**71%**	4%	539	2%		• Chart abstraction planned for Q3 2025 • Propose Cologuard bulk order to be completed Q3 2025. • Provide out of target report to providers. • Review proper measure capture in Epic
Falls: Screening for Future Fall Risk	98.8%	98%	**99%**	--	+100	0%		• Identify outliers and provide training to providers and staff.
Tobacco Screening and Cessation Intervention	98.2%	97%	**97%**	--	+21	0%		• Identify outliers and provide training to providers and staff. • Review proper measure capture in Epic

Quality in the IPA

The Future of Quality in the IPA

- While the IPA does not impact the network’s quality performance due to its PPO structure, we are committed to developing a meaningful quality program aligned with the broader network's standards and goals.
- Leadership teams from both the IPA and the network have initiated early discussions regarding the integration of quality improvement initiatives within the IPA structure.
- The goal of this collaborative approach is to shift towards outcome-based evaluations, placing a strong emphasis on improving patient outcomes.

Appendix

Change in Data Reporting Structure

2024

- Data was reported at the overall network level but was heavily focused on primary care performance.
- Panel-based. The denominator remained relatively consistent throughout the year.
- “Provider Attribution Model” for primary care was used, which attributes patients to a provider if they were seen by that provider at least twice within the past 18 months.
- 10 core measures and 2 radar measures for the entire network.

2025

- Data is now reported by relevant practice, encompassing specialist performance as well.
- MIPS is visit based. Patients are added to the denominator as they come in for visits. It is not valid to compare the data from the prior framework.
- MIPS Attribution Model is defined by any patient seen by any provider during the calendar year.
- 14 quality measures, including core and radar for CY 2025. Although each practice group has its own set of measures, the targets remain consistent across all groups.

ECHMN 2025 Calendar Year – Quality Measures

Measures	Measure Description	2025 Targets
Breast Cancer Screening	Percentage of women **50-74** years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period. The patient should be screened for either breast cancer on the date of service OR there should be documentation that the patient was screened for breast cancer at least once within 27 months prior to the end of the calendar year.	80%
Diabetes – Glycemic Status Assessment >9%	Percentage of patients **18-75** years of age with diabetes who had a Hemoglobin A1c >9% in the measurement period. This measure is to be submitted a minimum of once per calendar year.	13%
Colorectal Cancer Screening	Percentage of adults **45-75** years of age who had appropriate screening for colorectal cancer. Patients due for a colorectal cancer screening should complete one of the following tests: colonoscopy(every 10 years), flexible sigmoidoscopy(every 5 years), fecal occult blood test(annually), stool DNA with FIT test, or computed tomographic colonography.	75%
Tobacco - Screening and Cessation Intervention	Percentage of patients aged **12** years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention if identified as a tobacco user.	97%
Screening for Future Fall Risk	Percentage of patients aged **65** years and older who are screened for future fall risk during the calendar year.	98%
Controlling Blood Pressure	Percentage of patients **18-85** years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	77%
Statin Therapy (ASCVD)	Percentage of patients considered at high risk of cardiovascular events- who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure who were prescribed or were on statin therapy during the measurement period.	85%

ECHMN 2025 Calendar Year – Quality Measures

Measures	Measure Description	2025 Targets
Documentation of Current Medications in the Medical Record	Percentage of visits for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This measure is to be submitted for each visit during the calendar year regardless of age.	98%
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged **12** years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to 2 days after.	90%
BMI Screening and Follow-Up Plan	Percentage of patients aged **18** years and older with a BMI documented during the current encounter AND who had a follow-up plan documented if most recent BMI was outside of normal parameters: <18.5 or >/=25kg/m2.	85%
Kidney Health Evaluation	Percentage of patients aged **18-85** years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the measurement period.	60%
Cervical Cancer Screening	Percentage of women **21-64** years of age who were screened for cervical cancer using either cervical cytology (every 3 years) or cervical human papillomavirus (every 5 years).	55%
Blood Pressure Remeasurement (2nd check)	Percentage of patients who received a second blood pressure check if the initial reading was equal to or greater than 140/90. The blood pressure should be rechecked at least five minutes after the first reading if the systolic, diastolic or both values are equal to or above 140/90.	80%

ECHMN 2025 Calendar Year – Quality Measures (Pediatrics)

Measures	Measure Description	2025 Targets
Childhood Immunization Status	Percentage of children **2** years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	45%

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Patient Experience Update

Ryan M. Lockwood, MBA, CPXP

September 8, 2025, Mountain View Hospital

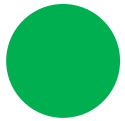
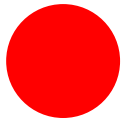
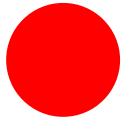
“Setting the standard for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way”

Patient Experience Update –
Agenda

- Fiscal Year 2025's Performance
- Fiscal Year Targets' Statistical Significance
- Fiscal Year 2026's Composite
- Responding to Patient Feedback
- Fiscal Year 2026's Patient Experience Plan

Fiscal Year 2025's Performance

Patient Experience Update –
Fiscal Year 2025's Performance

		FY24 Top Box Percent Score*	FY24 Percentile Rank	FY25 Top Box Percent Score*	FY25 Percentile Rank	Met Target
Inpatient	El Camino Health	81.9%	86th	81.5%	84th	
	Los Gatos	77.1%	72nd	76.1%	67th	
	Mountain View	83.3%	89th	83.5%	88th	
Medical Network	ECHMN	82.1%	26th	82.1%	26th	

FY25's Final Percentile Ranks

HCAHPS

National –	84th
California –	81st
Bay Area –	**92nd**

ECHMN

National –	26th
California –	36th
Bay Area –	**34th**

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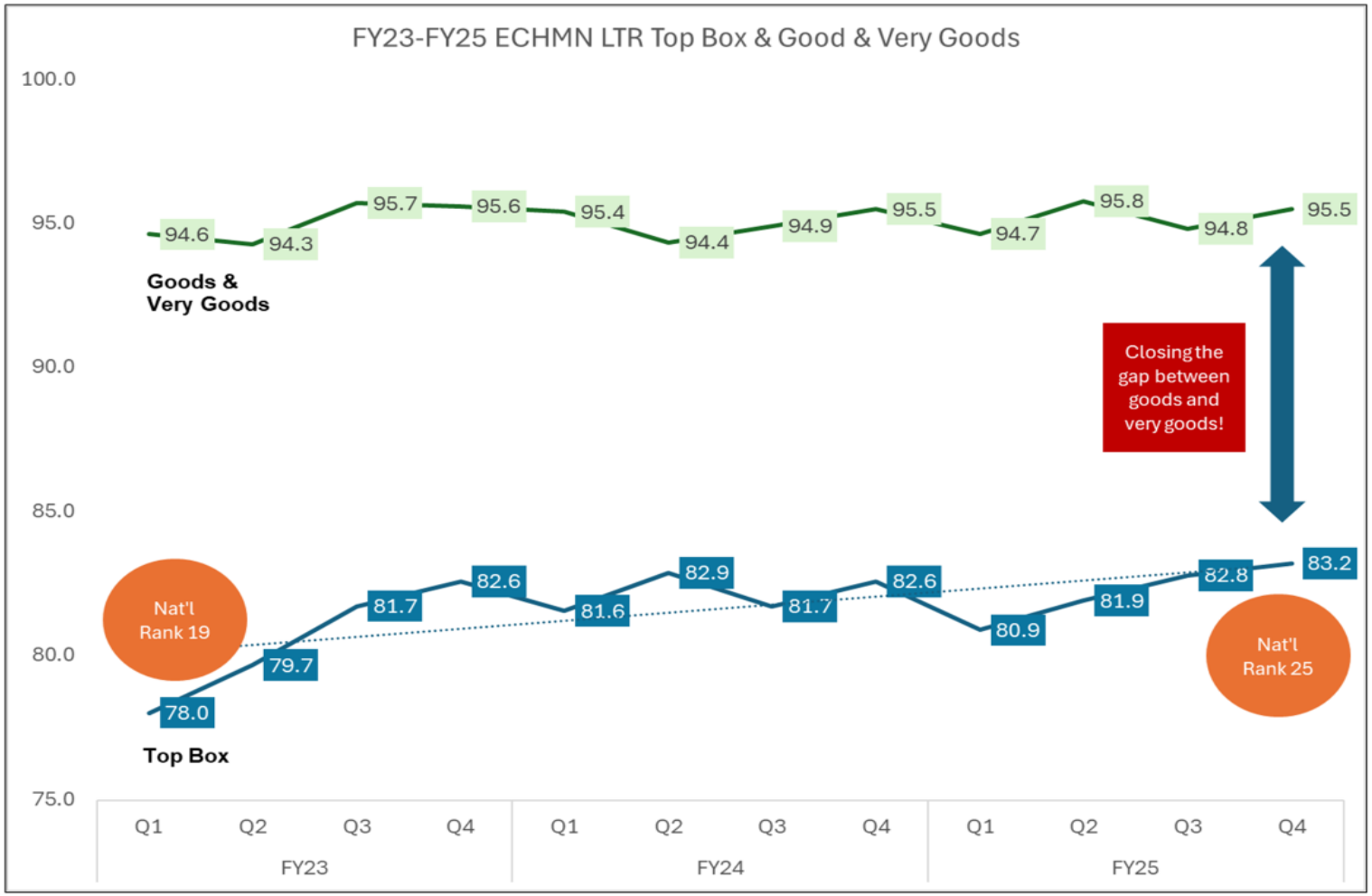
***Top Box Percent Score** reflects only the percentage of patients who select the highest possible rating (e.g., "Definitely Yes" for inpatient, "5 Stars" for Medical Network).

Patient Experience Update –

Fiscal Year 2025's Performance – El Camino Health Medical Network

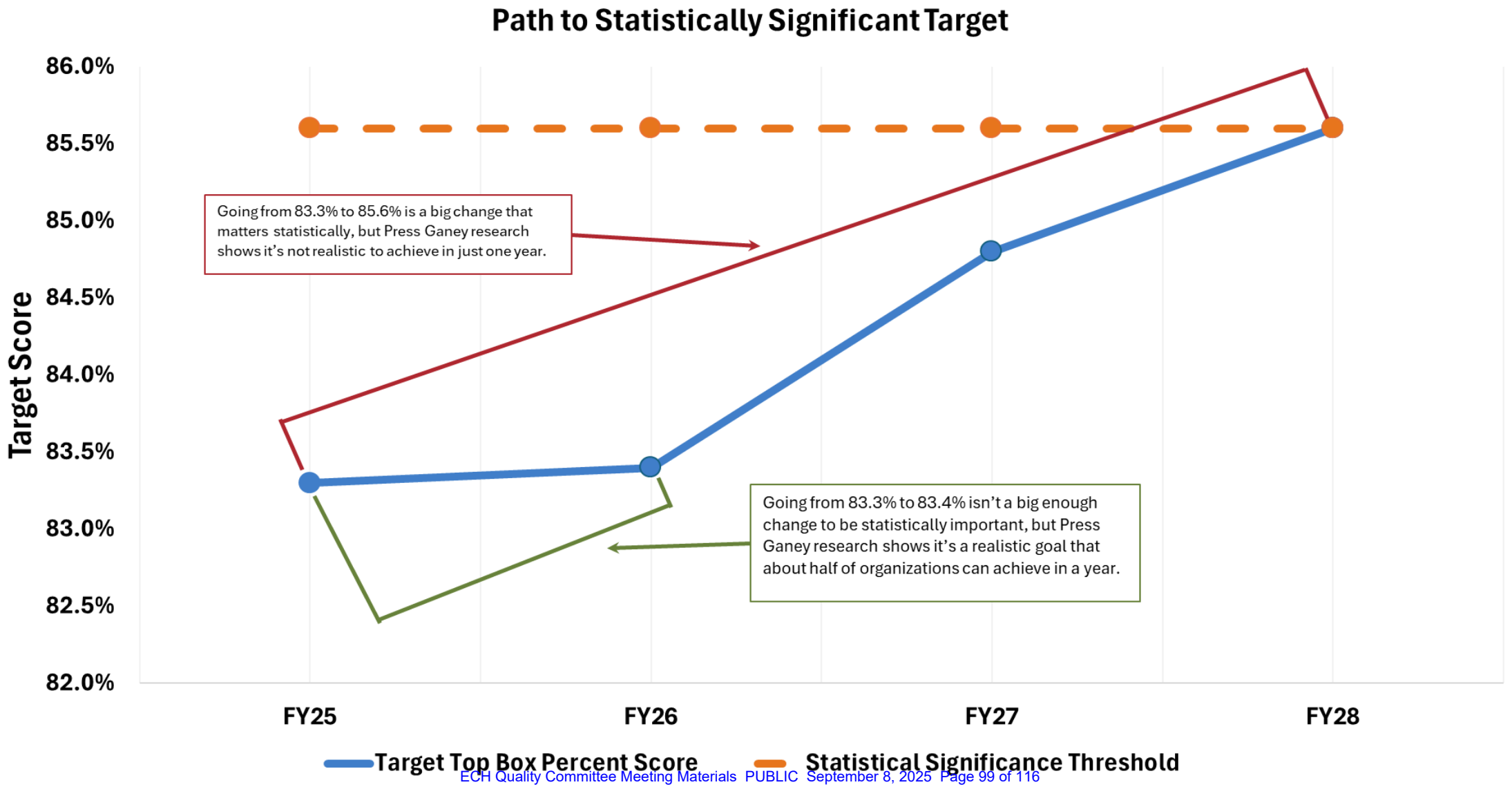
Goal is to move "good" to "very good"



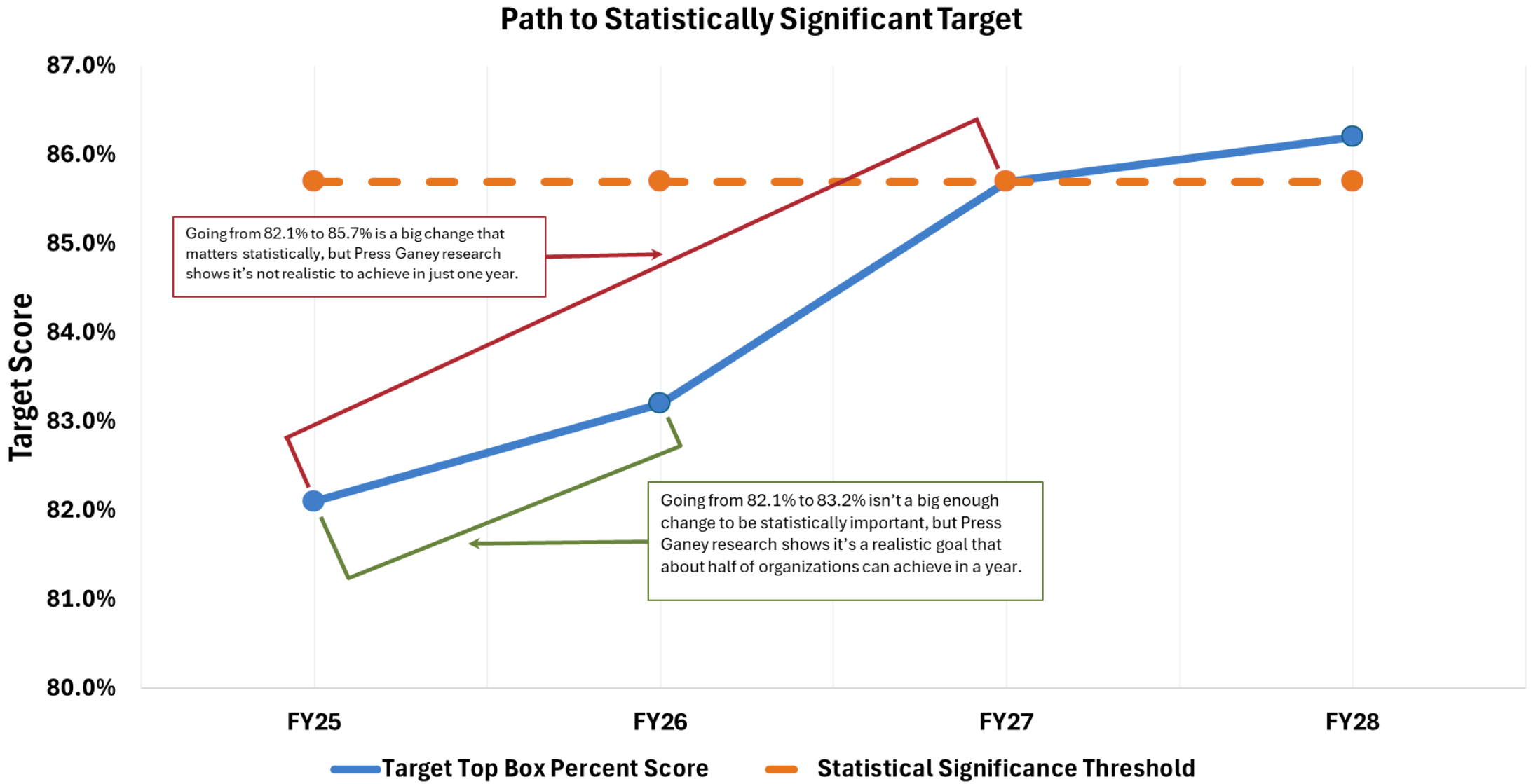
- **Significant Improvement in Top Box**
  - Outperforming top decile of improvers in Press Ganey's database
- **The combination of 'Good' and 'Very Good' responses positions ECHMN within the top decile percentile rank.**

Fiscal Year Targets' Statistical Significance

FY26 El Camino Health's Targets –
Likelihood to Recommend ECH "LTR" Statistically Significant



FY26 El Camino Health's Targets –
Likelihood to Recommend ECHMN "LTR" Statistically Significant



Fiscal Year 2026's Composite

FY26 El Camino Health's Area Composite Targets –
Likelihood to Recommend "LTR"

Area	FY26 "LTR" Targets' Top Box Percent Score	FY26 "LTR" Targets' Percentile Rank
IP	81.9%	86th
MCH	82.0%	86th
ED	78.2%	72nd
OP Surg	88.5%	62nd
OP Services	87.2%	57th
OP Oncology	90.7%	52nd
Composite	83.4%	69th

Composite Target

Top Box Percent Score

83.4%

FY26 targets are based on FY25 performance. If a department met or exceeded its FY25 target, the FY26 target will reflect that performance.

However, if FY25 performance was below target, the FY26 target will remain the same as the original FY25 target.

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FY26 El Camino Health Medical Network Targets –
Likelihood to Recommend “LTR”

Area	FY 26 "LTR" Targets' Top Box Percent Score	FY26 "LTR" Targets' Percentile Rank
Primary Care	82.9%	25th
Specialty Care	85.2%	38th
Urgent Care	81.7%	69th
ECHMN	83.2%	29th

ECHMN goal is to achieve or exceed 50th percentile by 2027

FY2026 ECHMN All target threshold set at PG 50% of improvers

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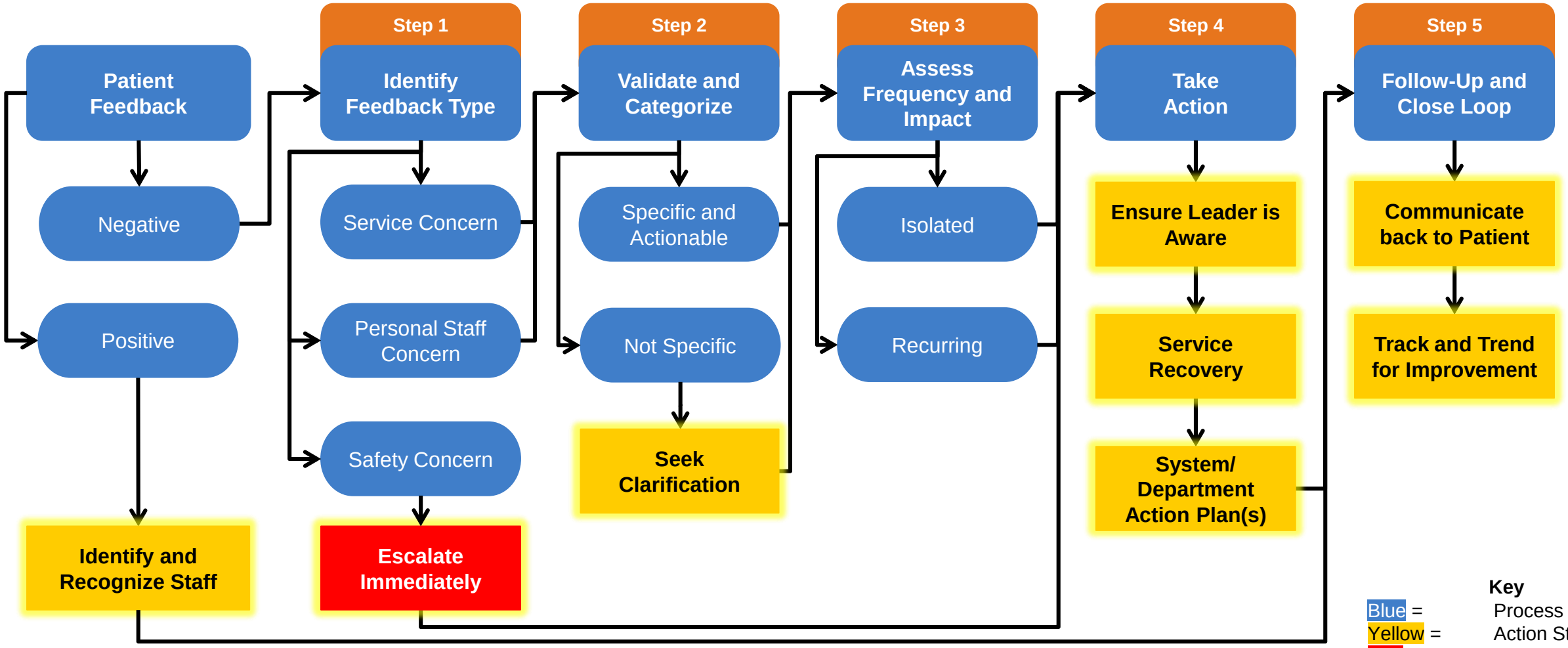
Responding to Patient Feedback

FY26 El Camino Health Medical Network Targets –
Responding to Patient Feedback



Key

Blue = Process Step
Yellow = Action Step
Red = Immediate Action

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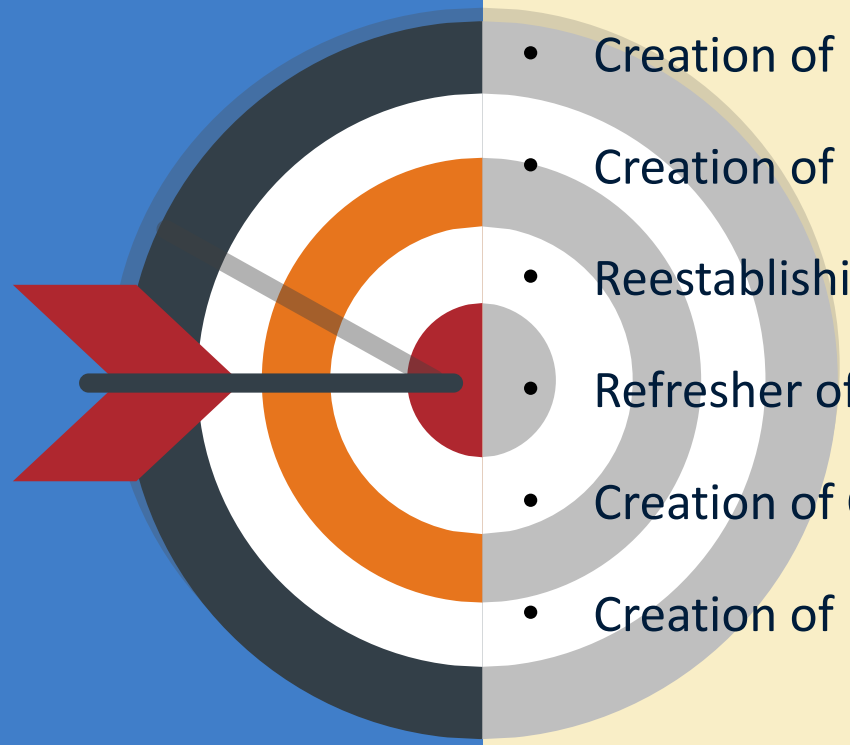
Fiscal Year 2026's Plan

Patient Experience Update
Fiscal Year 2026 Patient Experience Focuses



- Creation of El Camino Health's Patient Experience Action Team
- Creation of El Camino Health's Patient Experience Playbook
- Reestablishing Patient and Family Advisory Groups
- Refresher of WeCare Service Recovery Training for all employees
- Creation of Comprehensive Patient Experience Reports
- Creation of Physician Partnership Program

Questions?

Appendix

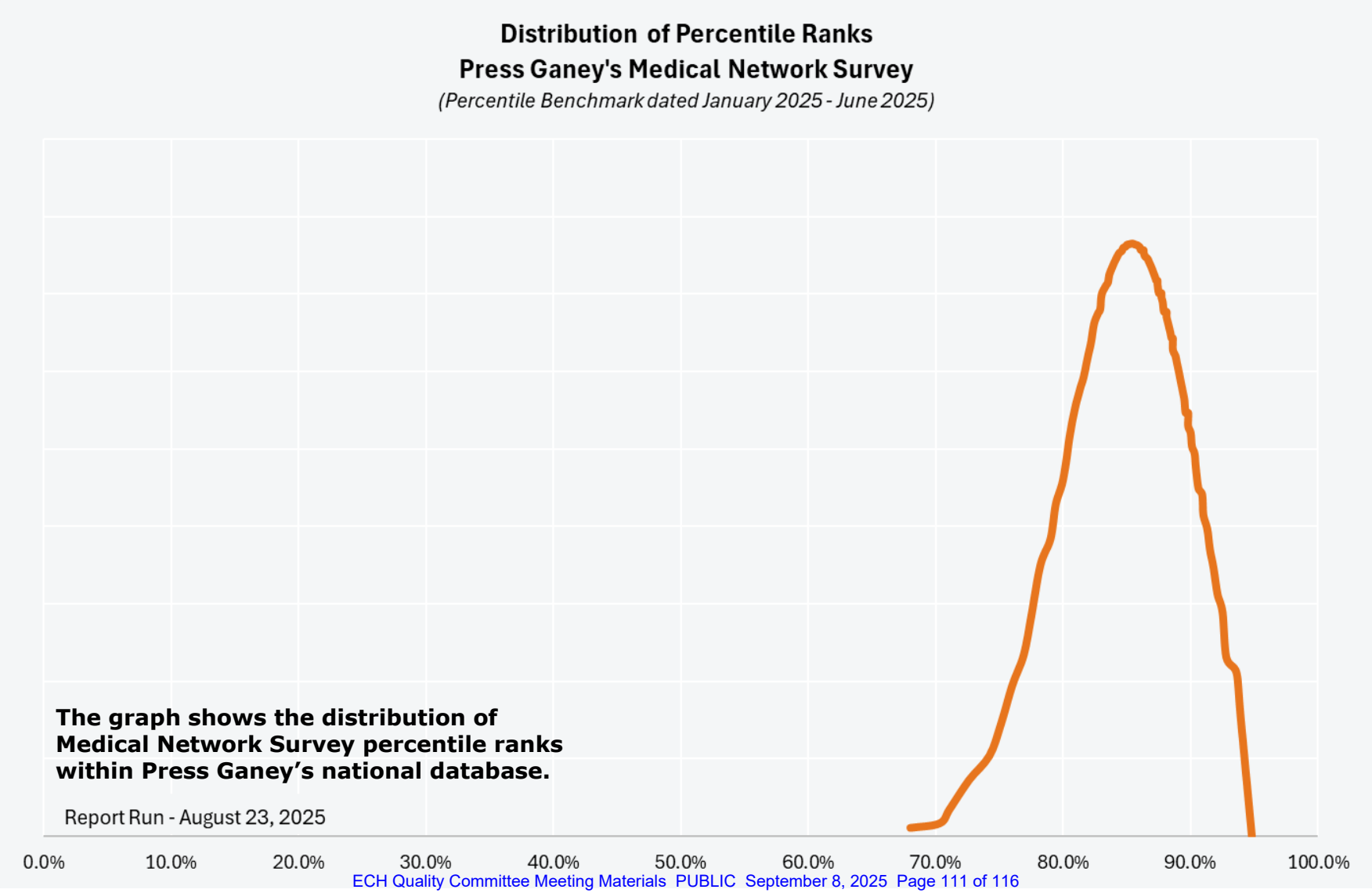
Patient Experience Update

Listening to the Power of our Patients and Loved Ones' Voice

The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

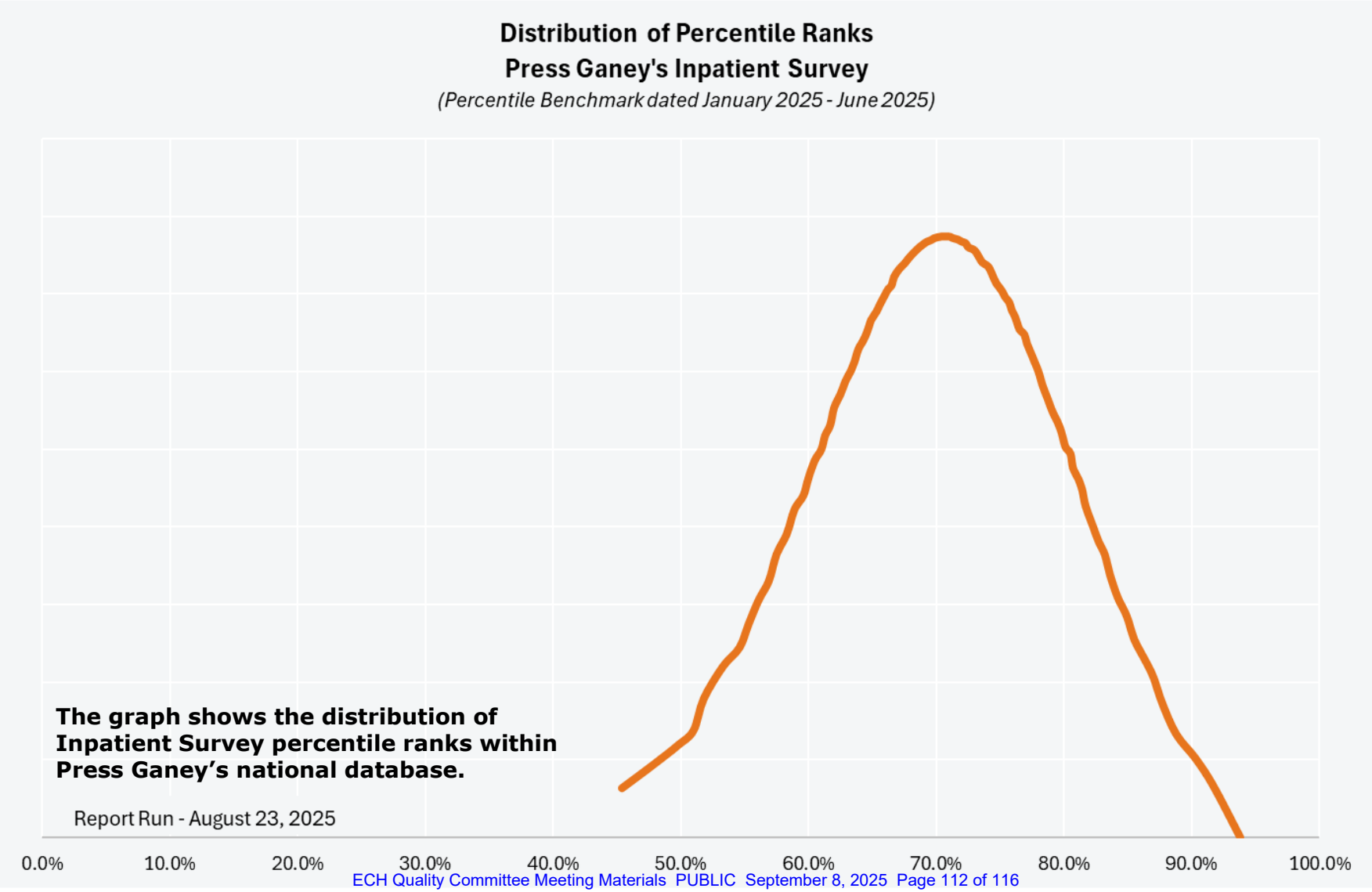
Patient Experience Update

Distribution of Percentile Ranks – Medical Network Survey



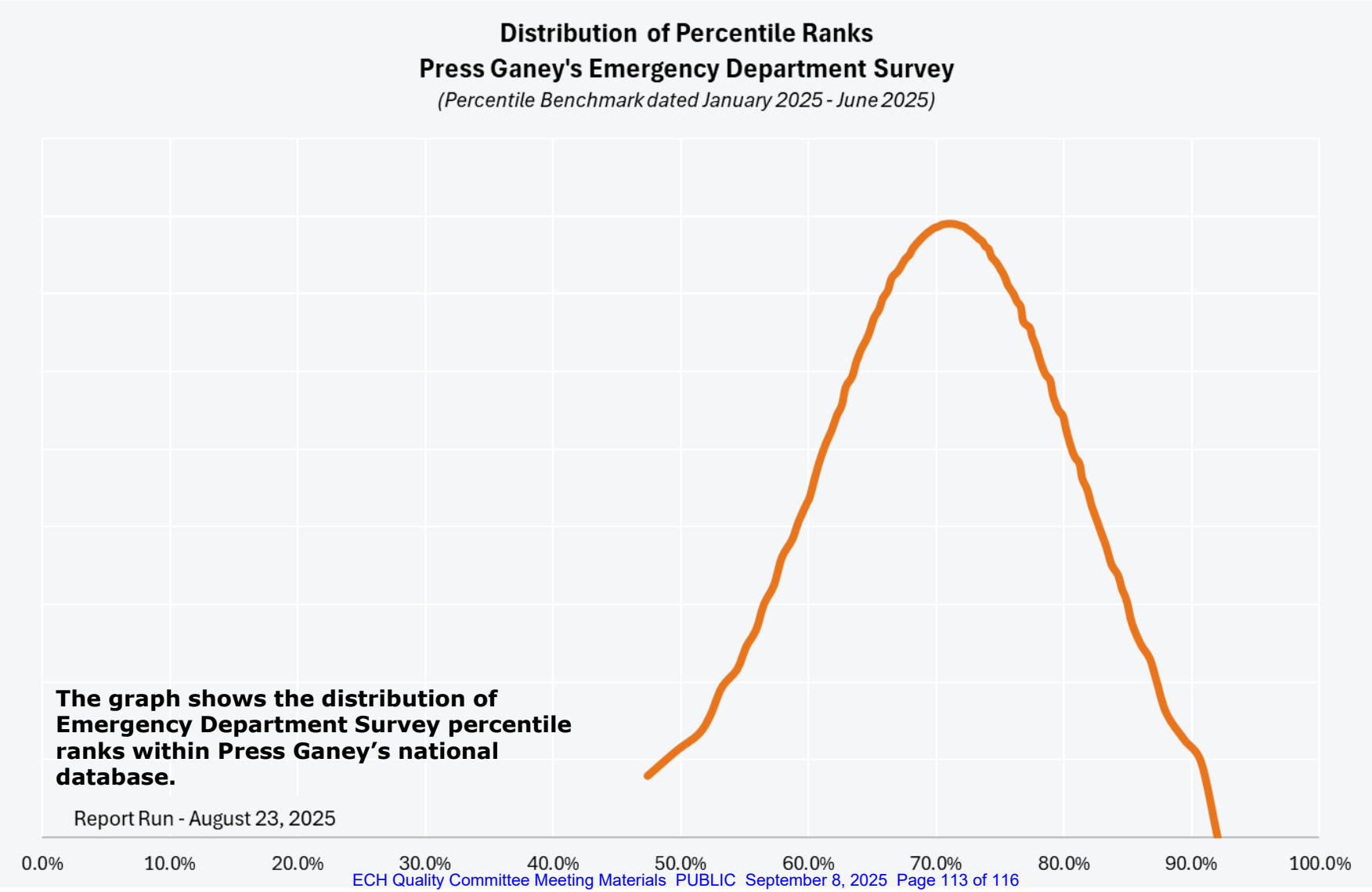
Patient Experience Update

Distribution of Percentile Ranks – Inpatient Survey



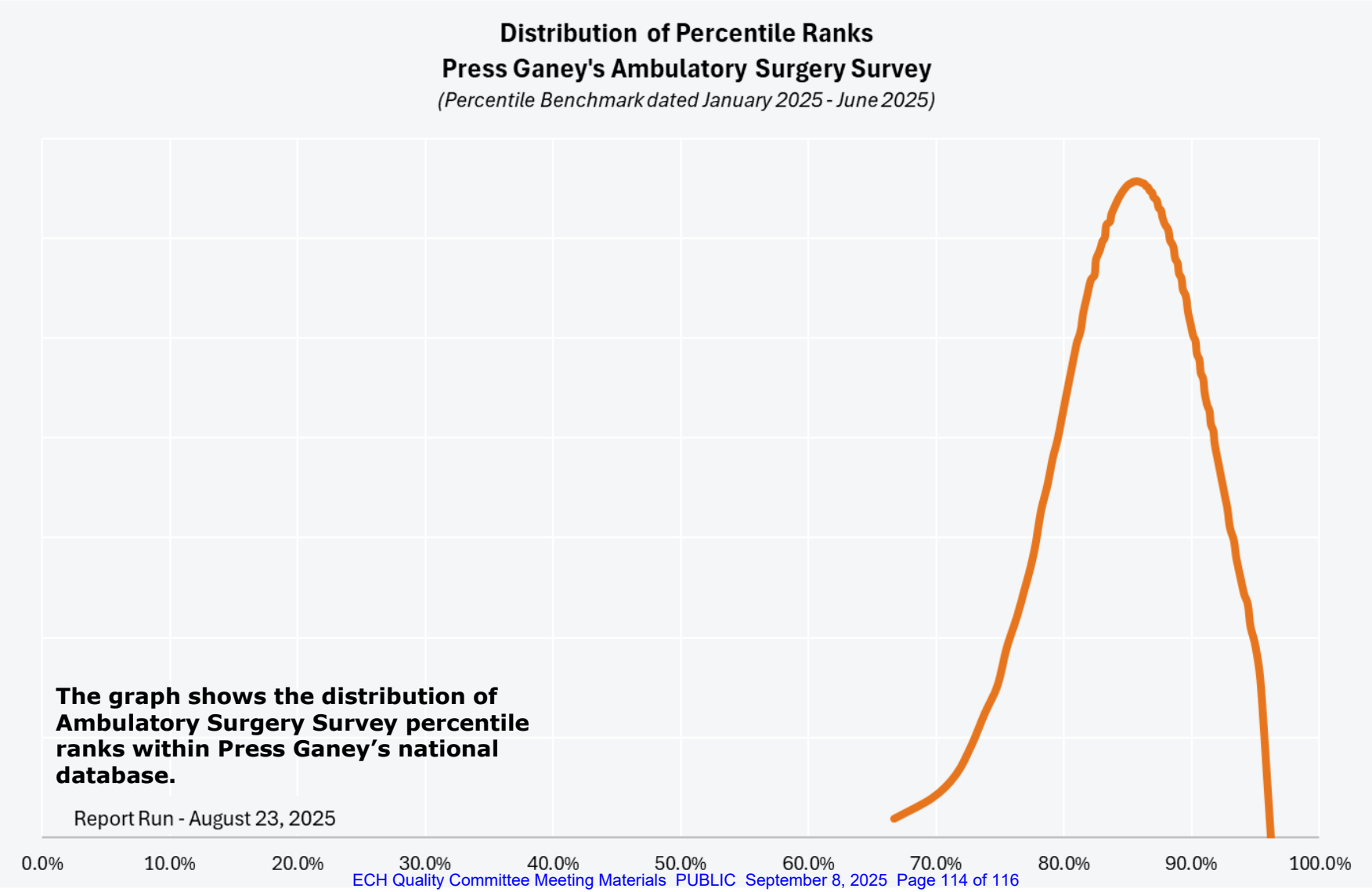
Patient Experience Update

Distribution of Percentile Ranks – Emergency Department Survey



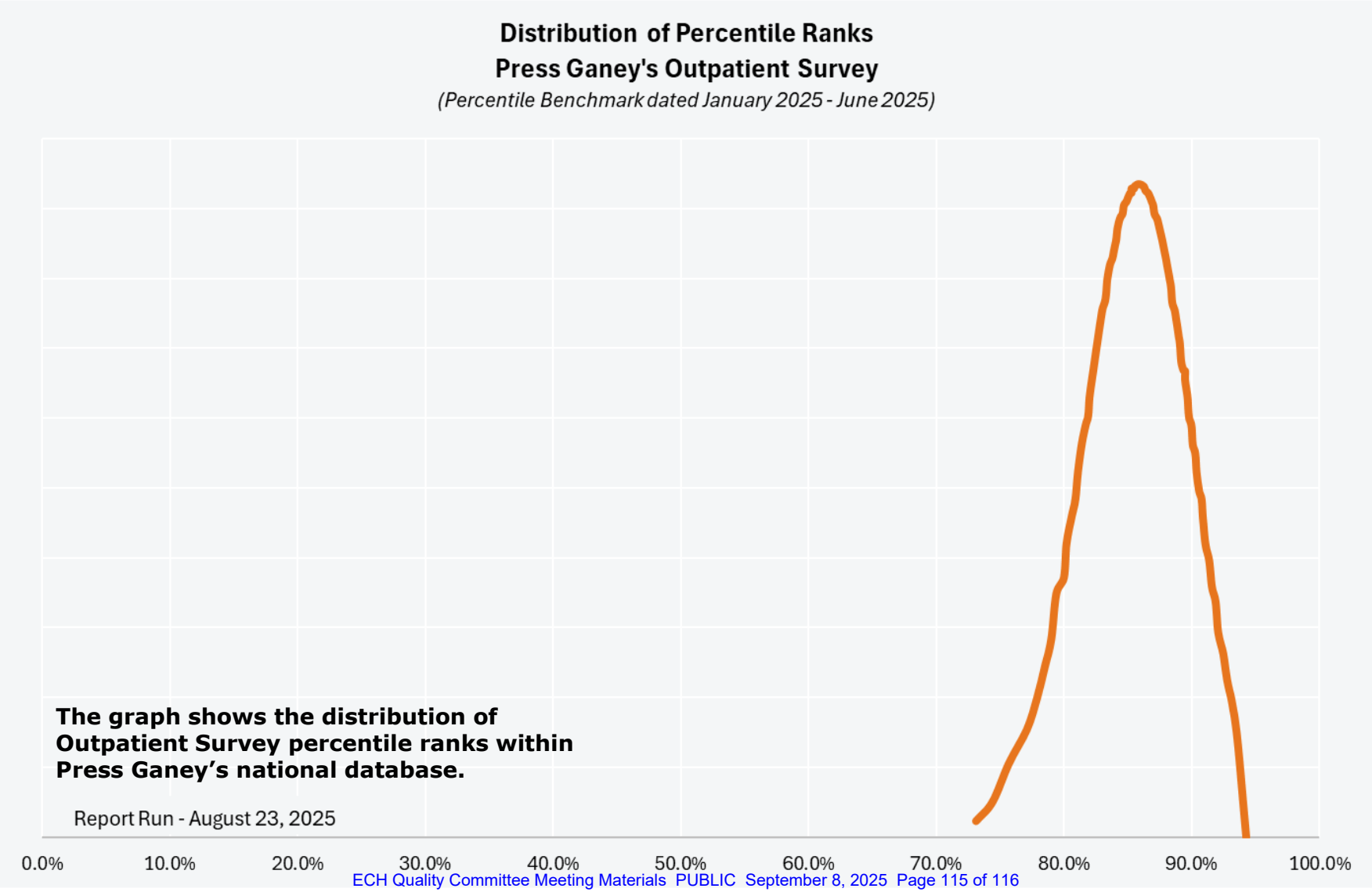
Patient Experience Update

Distribution of Percentile Ranks – Ambulatory Surgery Survey



Patient Experience Update

Distribution of Percentile Ranks – Outpatient Survey



Patient Experience Update

Distribution of Percentile Ranks – Oncology Survey