El Camino Health

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

Monday, November 3, 2025 – 5:30 pm

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

John Zoglin will be participating remotely via teleconference from 45 Kai Malina Parkway, Lāhainā, Maui, Hawai'i, 96761

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: 983 9579 3789 # 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.

TIME ESTIMATES: Except where noted as TIME CERTAIN, listed times are estimates only and are subject to change at any time, including while the meeting is in progress. The Committee reserves the right to use more or less time on any item, to change the order of items, and/or to continue items to another meeting. Particular items may be heard before or after the time estimated on the agenda. This may occur in order to best manage the time at a meeting.

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 MEMBER** a. Barbara Pelletreau	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 (09/08/2025) b. FY2026 Pacing Plan c. Receive CDI Dashboard	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:35 – 5:45**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	d. Receive Core Measures			
7.	**PATIENT STORY**	Ryan Lockwood, Vice President, Patient Experience	Information	**5:45 – 5:55**
8.	**SAFETY REPORT FOR THE ENVIRONMENT OF CARE**	Ken King, Chief Administrative Services Officer	**Motion Required**	**5:55 – 6:05**
9.	**Q1 FY26 STEEEP DASHBOARD REVIEW/ FY26 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, Chief Quality Officer	Discussion	**6:05 – 6:25**
10.	**VIZIENT CLINICAL DATABASE OVERVIEW**	Shreyas Mallur, MD, Chief Quality Officer	Information	**6:25 – 6:45**
11.	**EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT**	Jaideep Iyengar, MD, FAAOS Peter Goll, Chief Administrative Officer, ECHMN Kirstan Smith, BSN, CPHQ, Vice President, Quality Performance, ECHMN	Discussion	**6:45 – 7:05**
12.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:05 – 7:06**
13.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (09/03/2025) b. Quality Council Minutes (10/01/2025) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance Committee*	Carol Somersille, MD Quality Committee Chair	Information	**7:06– 7:11**
14.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (09/08/2025)** *Report involving Gov't Code Section 54957.2 for Closed Session Minutes.*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:11 – 7:15**
15.	**Q1 FY26 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	**7:15 – 7:25**
16.	**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**	**7:25 – 7:35**
17.	**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	**7:35 – 7:40**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
18.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:40 – 7:41**
19.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:41 – 7:42**
20.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:42 – 7:50**
21.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:50**

Next Meetings: 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, September 8, 2025
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD, Chair
Krutica Sharma, MD, Vice Chair
Pancho Chang
Shahram Gholami, MD (at 5:41 p.m.)
Erica Jiang (at 5:49 p.m.)
Jack Po, MD
Diane Schweitzer
John Zoglin

Members Absent
Barbara Pelletreau
Steven Xanthopoulos, MD

Staff Present
Mark Adams, MD, CMO
Shreyas Mallur, MD, CQO
Cheryl Reinking, DPN, RN CNO
Tracey Lewis Taylor, COO
Ryan Lockwood, VP, Patient Experience
Lyn Garrett, Senior Director, Quality
Peter Goll, CAO, ECHMN
Jaideep Iyengar, MD, ECHMN
Kirstan Smith, BSN, Director of Clinical Quality, ECHMN
Anne J. Yang, Executive Director, Governance Services
Gabriel Fernandez, Coordinator, Governance Services

**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:35 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Committee members Gholami, Jiang, Pelletreau, and Xanthopoulos were absent at the time of roll call. Dr. Gholami and Ms. Jiang joined at 5:41 p.m. and 5:49 p.m., respectively.	**Call to order at 5:35 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Chair Somersille asked if any Committee members were participating remotely. All present members participated in person.	
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. VERBAL INTRODUCTION OF NEW QUALITY	Chair Somersille welcomed the three new members of the Quality Committee. Ms. Schweitzer provided a summary of her professional experience in healthcare improvement and her collaboration with various	

COMMITTEE MEMBERS	organizations. Ms. Jiang was absent during introductions but joined the meeting later and introduced herself during agenda item 21. Ms. Pelletreau was unable to attend due to a prior travel commitment.	
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 (f) Receive Revised Committee Governance Policy. Ms. Schweitzer removed item (d) Recommend Quality Improvement and Patient Safety Plan (QIPS) for Hospital Board Approval f) Chair Somersille noted for the record that the item was for receipt only and that the Board had previously approved the item in June. Chair Somersille expressed concern regarding the FY 26 Revised El Camino Hospital Board Committee Governance Policy, specifically the provision allowing reassignment of existing community members to another Committee at the recommendation of the CEO, Board Chair, and Committee Chair. She stated her intention to recommend deleting this provision, citing alignment with governance best practices. d) Ms. Schweitzer requested further discussion regarding the Quality Improvement and Patient Safety Plan (QIPS). She inquired about the methodologies used for goal-setting within the plan. Staff responded by explaining that percentage decreases and patient-day calculations are utilized in the goal-setting process. **Motion**: To approve consent calendar items (a) Minutes of the Open Session, Minutes of the Quality Committee Meeting (06/02/2025). **Received**: (b) FY2026 Pacing Plan, (c) Progress against FY2026 Goals, and (e) Class Assignments for Community Members of the Quality Committee. **Movant**: Zoglin **Second**: Schweitzer **Ayes**: Somersille, Chang, Gholami, Po, Sharma, Scheweitzer, Zoglin **Noes**: None **Abstain**: None **Absent:** Jiang, Pelletreau, Xanthopoulos **Recused**: None **Motion**: To approve consent calendar items (d) Quality Improvement and Patient Safety Plan (QIPS) for Hospital Board Approval	***Consent Calendar Approved***

	Received: (f) Revised Committee Governance Policy **Movant**: Sharma **Second**: Po **Ayes**: Somersille, Chang, Gholami, Po, Sharma, Scheweitzer, Zoglin **Noes**: None **Abstain**: None **Absent:** Jiang, Pelletreau, Xanthopoulos **Recused**: None	
7. PATIENT STORY	Ms. Reinking presented two patient safety stories recognized with HeRO Awards for exemplary use of Universal Safety skills. The first highlighted the Maternal Child Health team's prompt response to a postpartum patient with malignant hyperthermia, resulting in a full recovery for both mother and infant. The second described a pathologist's identification of specimen contamination, which prevented a potential misdiagnosis.	
8. Q4 FY25 STEEEP DASHBOARD REVIEW/ FY26 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur provided an overview of the Q4 FY25 STEEEP Dashboard and previewed the FY26 Enterprise Quality Dashboard, highlighting performance across key safety and quality measures. Areas of improvement and ongoing challenges, such as infection rates and hand hygiene compliance, were discussed. The Committee reviewed planned changes for FY26, including earlier implementation of process improvements and upcoming transitions in radiology provider groups. Members discussed the complexity of radiology operations, including technology and staffing considerations. The launch of the inpatient hospice (GIP) program and its impact on mortality and length of stay metrics were noted. The Committee also reviewed new measures for equitable care, specifically compliance with state discharge requirements for unhoused patients. Committee members raised questions regarding mortality rate trends, radiology transitions, and dashboard accessibility. Dr. Mallur addressed these questions and confirmed continued monitoring and improvement efforts.	***ACTION:*** *The Committee requested an adjustment to the dashboard color coding for better visibility.*
9. EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT	Ms. Smith, Mr. Goll, and Dr. Iyengar shared the El Camino Health Medical Network's quality program report, including updates on the transition toward value-based care and the selection of quality measures aligned with	***ACTIONS:***

	both health plan requirements and Medicare's MIPS Value Pathways (MVPs). The report highlighted strong performance in specialty-specific quality metrics and ongoing efforts to support both primary and specialty care providers. Committee discussion focused on the rationale for selected quality measures and the challenges of implementing social determinants of health (SDOH) and homelessness screening in the outpatient setting due to resource limitations. Members also discussed opportunities and barriers to integrating hospital and outpatient social work resources, as well as the need for improved tracking of post-discharge follow-up visits, particularly for patients discharged from hospitals outside the El Camino system. Strategies for incorporating independent practice association (IPA) physicians into quality measurement were reviewed, including data integration challenges and the need for a phased approach. The Committee requested development of a plan to assess and improve IPA quality performance and discussed the importance of clear accountability for this work. Finally, there was interest expressed in exploring technology solutions, such as AI, to support patient outreach and close care gaps.	*The Committee requested the development of a plan to assess and improve the quality performance of IPA physicians, including clarification of accountability for this work.*
10. PATIENT EXPERIENCE REPORT	Mr. Lockwood shared the Patient Experience Report. Mr. Lockwood shared that El Camino Health achieved its target of maintaining the 80th percentile or higher for inpatient surveys, with both Los Gatos and Mountain View campuses performing well. The Medical Network maintained an 82.1% score, reflecting recent improvement. Management discussed the statistical significance of year-over-year changes in patient experience scores, noting that while small improvements may not be statistically significant, they are consistent with trends seen in top-performing hospitals and align with the organization's stretch goals. The Committee reviewed survey methodologies, including the potential use of real-time feedback tools, while acknowledging regulatory limitations imposed by CMS on survey content and administration. The limitations of current HCAHPS surveys were discussed, and the group considered the value of incorporating additional metrics such as Net Promoter Score (NPS) to supplement existing data. The Committee agreed to follow up in March to further explore alternative survey methodologies and their potential value, and to add NPS trend charts to long-term performance tracking.	***Actions:*** *Staff to provide a follow-up in March to further explore alternative survey methodologies and their potential value, and to add NPS trend charts to long-term performance tracking.*

11. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 6:52 p.m. **Movant**: **Second**: Po **Ayes**: Somersille, Chang, Gholami, Jiang, Po, Sharma, Scheweitzer, Zoglin **Noes**: None **Abstain**: None **Absent:** Pelletreau, Xanthopoulos **Recused**: None	***Recessed to Closed Session at 6:52 p.m.***
12. AGENDA ITEM 20: 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 June 2nd, 2025 meeting. Director Po left the meeting during the closed session at 7:40 p.m.	***Reconvened Open Session at 7:45 p.m.***
13. AGENDA ITEM 21: COMMITTEE ANNOUNCEMENTS	Ms. Jiang provided a brief introduction and background to the Committee.	
14. AGENDA ITEM 22: ADJOURNMENT	**Motion**: To adjourn at 7:47 p.m. **Movant**: Zoglin **Second**: Gholami **Ayes**: Somersille, Chang, Gholami, Jiang, Sharma, Scheweitzer, Zoglin **Noes**: None **Abstain**: None **Absent:** Pelletreau, Po, Xanthopoulos **Recused**: None	***Meeting adjourned at 7:47 p.m.***

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

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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

El Camino Health

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

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

To: Quality, Patient Care, and Patient Experience Committee
From: Cornel Delogramatic, MD, MBA, Director, Health Equity and Clinical Integrity
Date: November 3, 2025
Subject: Clinical Documentation Integrity Dashboard FY 2025 - 2026

Purpose: To provide a semi-annual update on the Clinical Documentation Integrity Department activity.

Summary:

1. Situation: From a clinical perspective, CDI ensures accurate descriptions of health conditions and creates electronic documents for every step of the patient's treatment and services that translates into quality outcomes (mortality score, readmission score, complication score, etc.), patient safety measures (PSI rate, HAC rate,) and utilization outcomes (expected LOS, denial rate, clean claim rate, RAF scores, CMI etc.).

2. Authority: The Quality Committee of the Board is responsible for oversight of the Clinical Documentation Integrity Department.

3. Background: The Clinical Documentation Integrity (CDI) department is critical to a hospital because it ensures that clinical documentation accurately tells the patient's story and that the records of each patient and their medical history are maintained for future use. CDI programs can aid in documenting diagnoses that are specific and consistent throughout the medical record, leading to accurate code assignment, better understanding of patient complexity, and improved safety and quality scores. Additionally, a well-trained clinical documentation integrity team will use consistent processes to ensure accurate claims, resulting in full reimbursement for rendered care services, reduced denials, and improved appeal processes for the organization.

4. Assessment: Each medical record is reviewed by a clinical documentation specialist (CDS) who identifies documentation deficiencies or opportunities and uses a communication tool named "clinical documentation query" to communicate with the physicians to correct the deficiencies or to validate the diagnoses/procedures clinically. The CDI team is also responsible for educating providers on documentation compliance requirements and newly emerging diagnostic guidelines, clinical classifications, and risk adjustment methodologies. Each query is stored within EMR as a part of the legal medical record.

   In this dashboard, higher metrics are better and are highlighted in green.

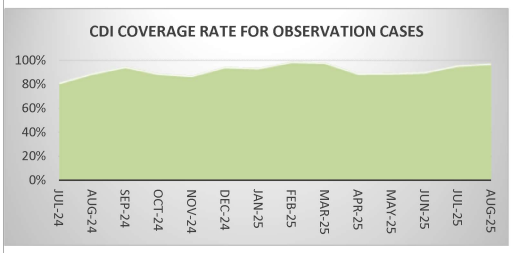
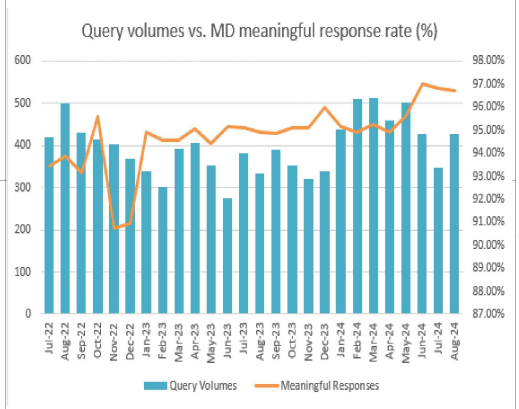
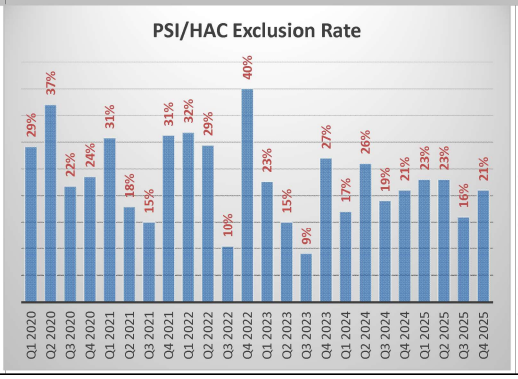
5. Outcomes:

   a. CDI review coverage rate – Inpatient population; (process measure)
   b. CDI review coverage rate – Outpatient population; (process measure)
   c. CDI query volumes and provider meaningful responses; (process and engagement measure)
   d. Patient Safety Indicator/Hospital Acquired Conditions exclusion rates

List of Attachments: CDI Dashboard FY24 – FY25.

El Camino Health

Clinical Documentation Integrity Dashboard (Monthly/ all adult, acute care, non-OB inpatient population)

As of Oct 17, 2024				Baseline	FY26 Goal	Trend	Comments
CDI Coverage		Performance		FY2025	FY2026 goal		
1	**All Payer CDI coverage rate** *Source: iCare CDI Productivity report*	**Sep 2025** 83%	**FYTD** 84%	75%	78%	CDI Coverage Rate FY 2018 79% 66% FY 2019 75% 67% FY 2020 86% 80% FY 2021 90% 79% FY 2022 92% 71% FY 2023 89% 68% FY 2024 92% 74% FY 2025 92% 75% FY 2026 93% 84%	The all-payer coverage highlights the CDI Team's effectiveness, with our 4.5 FTEs currently covering all adult non-OB patients across both campuses, amounting to approximately 1,300 to 1,500 patients per month.Adoption of AI solutions accelerated our productivity. We are committed to enhancing our productivity by continuing addopting new technologies and optimizing our processes throughout FY 2026.
2	**Observation CDI Coverage Rate** *Source: iCare CDI Productivity report*	**Sep 2025** 98%	**FYTD** 92%	92%	95%		Reviewing observations is crucial for various organizational functions, including hospital throughput, managing LOS, denials, etc. Engaging clinical documentation specialists in this process ensures that the medical record accurately reflects the medical necessity and that all comorbidities are properly coded and clinically validated.
Physician engagement		Performance		FY2025	FY 2026 goal		
3	**Query volumes** *Source: iCare CDI Query report*	**Sept 2025** **513**	**FYTD** **488**	440	490		This metric aims to evaluate physician engagement in our health system's CDI efforts by measuring the rate of meaningful responses relative to the total number of queries. Over the past four years, our CDI program has demonstrated significant improvement, with the response rate rising from 67% in FY 2019 to 95% year-to-date. This upward trend is largely driven by robust collaboration between CDI teams and physicians, as well as ongoing education on the value of high-quality clinical documentation for the organization.
4	**Meaningful Response Rate** *Source: iCare CDI Query report*	**Sep 2025** **96%**	**FYTD** **95%**	89%	92%		
CDI Quality Outcomes		Performance		FY2025	FY 2026 goal		
6	**PSI/HAC exclusion rate** *Source: CDI PSI/HAC Dashboard	**Q4 2025** **21%**	**FYTD Avg.** **23%**	21%	20%		CDI also plays a crucial role in enhancing the quality of care and ensuring accurate public reporting by reviewing cases involving PSIs and HACs. The team collaborates with physicians to identify any exclusion factors that may account for these safety events. Maintaining a high rate of exclusions for inaccurately documented complications not only improves patient care but also strengthens the public's perception of our institution. Long term, we strive to reduce the number of opportunities by strong education on the most common topics.

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: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: November 3, 2025
Subject: Fiscal Year 2025 Core Measure Dashboard

Purpose:

To update the Quality, Patient Care, and Patient Experience Committee on FY 2025 Core Measure Dashboard, Non-Hospital-based Inpatient Psychiatric Services (Non-HBIPS) and Hospital-based Inpatient Psychiatric Services (HBIPS).

Summary: As required under section 1890A(a)(6) of the Social Security Act, Centers for Medicare and Medicaid Services (CMS) assesses the quality and efficiency of care provided to patients through establishing quality standards and programs to improve health care for beneficiaries and all who receive care in the United States. Core measures are designed to be meaningful to patients, consumers, and physicians. CMS uses core measure performance to inform how we are graded in various quality initiatives, such as pay for reporting, value-based pay, and public reporting on Care Compare (https://www.medicare.gov/care-compare/), previously known as Hospital Compare.

Authority: The Quality, Patient Care, and Patient Experience Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on compliance with CMS measurements of clinical quality measures.

Background: There are no new revisions for FY 2025 by CMS or The Joint Commission (TJC) to the core measures. Some metrics are measured as eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS Promoting Interoperability (previously “Meaningful Use”) program. Sepsis (SEP-1) Core Measure is reported as its own dashboard. These measures reflect Inpatient Quality Reporting (IQR) Inpatient Psychiatric Quality Reporting (IPFQR) and some Outpatient Quality Reporting (OQR) Program Measures.

Assessment: CMS has two sets of Core Measures relevant to El Camino Health acute care: one covers acute hospitals (Non-HBIPS) and the second only applies to acute hospitals with inpatient behavioral health units (i.e. Mental Health and Addiction Services (MHAS), which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

A. Non-HBIPS Core Measures (Non**-** Hospital-based Inpatient Psychiatric Services**)**

1. **PC01- Elective Delivery (EED)** Prior to 39 weeks gestation- Percent of mothers with elective vaginal deliveries or elective cesarean births at >=37 and < 39 weeks gestation completed. This measure shows the percentage of pregnant individuals who had elective deliveries 1-2 weeks early (either vaginally or by C-section) whose early deliveries were not medically necessary. Higher numbers may indicate that hospitals aren't doing enough to discourage this unsafe practice. FY25 ECH Target = <1.6%, FY 2025 Performance: 0.4% (1/237) TJC rate is at <2%. We are currently in the sustainment phase with this measure.

2. **PC02- Cesarean Birth**- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. TJC benchmark is at < 25% while ECH’s internal

goal is 23.9%. FY 2025 Performance is 26.8% (594/2218). Of note, internal data from CMQCC shows our performance for July 2025 at 20.9%. OB Task Force is working to identify where we can make system improvements to reduce unnecessary NTSV. MCH leadership team has worked with independent OBs and OB groups to identify practice patterns and opportunities for improvement. The data shows steady progress.

We have an active NTSV prevention committee that is implementing countermeasures and reviewing all cases bi-weekly. Key countermeasures include:

- Quarterly unblinded data to OB providers, annual unblinded data to L&D RNs
- Bi-weekly case reviews with follow up/education/support for OBs as needed
- In CMQCC learning initiative: Promoting Vaginal Birth through an Equity Lens with monthly tasks and report outs. Some key CMQCC tasks below
  - Developed Perinatal Equity Dashboard, regularly review disparities/needs by race/ethnicity/economic background/language (e.g., developed S. Asian healthy birth class)
  - OB and RN education (Spinning Babies—RNs, OB Skills Days—OBs)
  - Offering Transcutaneous Nerve Electrostimulation (TENS)
  - Improved doula access/provide list to pts
  - Equity/bias assessments and surveys done, countermeasures in process (e.g., better education, more visibility into equity dashboard, addressing cultural/team needs)
- Implemented/implementing birth support equipment (e.g., new birthing balls) and tools (e.g., labor circuit position guide for RNs)

3. **PC05- Exclusive Breast Milk Feeding**- Newborns that were fed breast milk only since birth during the entire hospitalization. TJC is >50% (note the median CA rate per CMQCC for FY25 is 65.1%). FY 2025 Performance: enterprise-wide 79.4% (670/844) LG campus' rate is 85.5% while MV is 78.1%. Lactation team has done a spectacular job. Below are key interventions that have supported a significant improvement.

   - LG re-designated Baby Friendly in 2023 and far exceeds most hospitals (ranked 11th out of 155 hospitals)
   - MV completed all Baby Friendly required steps and had a site visit on 10/07/25-10/08/25. Survey went well. The report/decision will be issued in 6-8 weeks.
   - Our key interventions including enhancing lactation services, stratifying data by race/ethnicity and directly working to improve the disparity in data for patients of Asian descent, providing robust lactation training to staff and providers, improving educational materials and classes for patients, and offering banked breast milk to patients with normal newborns who are needing extra help has resulted in top quartile performance.
   - Introduced donor milk instead of formula for term well babies, as recommended by American Academy of Pediatrics (AAP)
   - Reopened MV OP lactation appointments
   - Expanded NICU lactation coverage from 4 days/week to 6 days/week.

4. **PC06- Unexpected Complications in Term Newborns**- This measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. TJC benchmark is <3%; FY 2025 Performance: enterprise-wide 2.5% (102/4077), LG is 3.8% (24/632), MV is 2.3% (78/3445) This measure is not publicly reported yet. The cases that failed the measures are forwarded to peer review for further assessment. All cases of severe unexpected complications are reviewed in detail and

changes implemented if opportunities are identified. MCH is tracking this closely as we try to lower the CS rate to ensure newborn safety is maintained. Each case is reviewed and presented at MCH leadership meetings. No significant increase in this metric in MV. No concerning trends. Note transports out due to lack of beds in LG has had some impact on this measure as well, although not significant.

5. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients**- Median time (in minutes) patients spent in the emergency department before leaving from the visit. ECH Target goal is 180 minutes or less; FY 2025 rate is ENT:157.6 minutes. Latest Care Compare - ECH 158 minutes, California average 207 minutes, and National average-194 minutes with reporting period Q42023-Q32024.

6. **OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke**- Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. ECH Target goal is 100%; FY 2025 performance is 81.8% (9/11). This data is being shared and presented to Stroke Committee. OP-23 results and outlier cases are also shared with the ED and Imaging for review. ED provider group were educated regarding use of the CT stroke order when indicated so that CT staff continue to prioritize those patients. This measure has a small denominator. Cases get excluded due to Last Known Well time unknown or >120 minutes, Left AMA and Expired in ED.

B. **HBIPS Core Measures (**Hospital-based Inpatient Psychiatric Services)

1. **IMM:** Influenza Immunization - Patients assessed and given influenza vaccination during flu season (the months of October through March).
FY 2025 rate is 94%. MHAS team is sustaining its daily review of epic emails notification alerting them of patients who need a vaccination.

2. **PC-TOB Perfect Care - Tobacco Use**- ECH TJC benchmark went up by a point from 15% to 16%. Everyone is struggling with this measure. FY 2025 rate is 20.6%. ECH is still working on improving this all or nothing measure. Patients are not receiving all components of practical counseling prior to discharge AND referral for outpatient tobacco cessation counseling not offered at D/C. Most of the fall outs are from Outpatient Tobacco Cessation Counseling not complete. Currently this is in the Social Worker (SW) workflow (since they complete the discharge appointments). An RFS for a BPA to alert the SW will be submitted.

3. **PC-SUB Perfect Care - Substance Abuse**- This measure shows the percentage of patients hospitalized in an inpatient psychiatric facility aged 18 years and older with alcohol or drug use disorder who, when discharged, received or refused medications to treat their alcohol or drug use OR who received or were offered a referral for addiction treatment. All CMS hospitals are at 61% FY 2025. ECH rate is 46.6%. MHAS team is engaging providers to better understand the measure and the workflow to increase compliance. Reviews of fallouts indicate that patients are pre-contemplative and decline treatment for alcohol or drug use disorder. Working on a change in Epic that the physician can select the reason during discharge to get a better understanding of the reason why patient declines. Most of the fall outs are due to Brief Intervention for alcohol not being completed. This is part of nursing workflow in the education section. MHAS leadership will bring this to the nursing huddles and explore if there are any Epic interventions that can promote compliance.

4. **TR-1:** Transition Record with Specified Elements Received by Discharged Patients**.** This measure shows the percentage of patients who were discharged from an inpatient psychiatric facility who received (or whose caregiver received) a transition record and with whom a complete transition record was discussed before they left the inpatient psychiatric unit or psychiatric hospital. All CMS hospitals are at 53%. FY 2025 rate is 72.5%. Primary reason for fallouts are:

    i. Advance Care Directives are not documented or there is no documented reason for not providing advanced care plan.
    Bring to nursing huddle to complete advanced care directive question and will consider adding Epic data field to state reason for not providing advanced care plan.
    ii. Reason for Admission – The data field where this is being extrapolated from is vague. We will change the wording in Epic to match the HBIPS verbiage.

5. **MET-1:** Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index, A1C or glucose test, Blood pressure, Lipid panel, Total cholesterol Low density lipoprotein, High density lipoprotein, Triglycerides. All CMS hospitals are at 93%. FY 2025 rate is 91.5%. Abstractors are instructed to capture labs in Care Everywhere per specification guideline.

6. **HBIPS-2:** Hours of Physical Restraint Use (per 1000 patient hours) lower is better. All CMS hospitals are at 0.0002; FY 2025 rate is 0.0005.

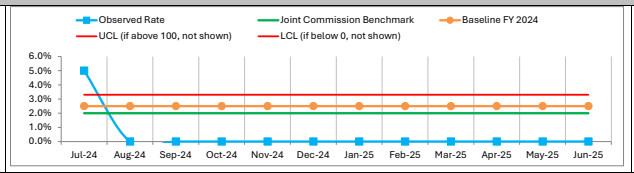
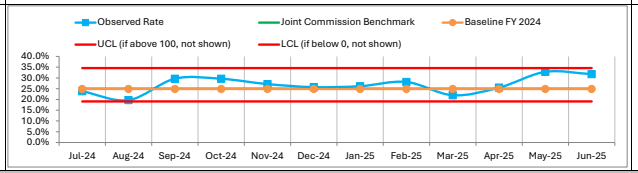
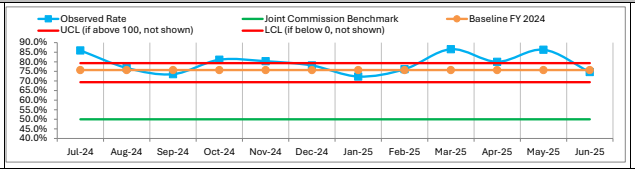
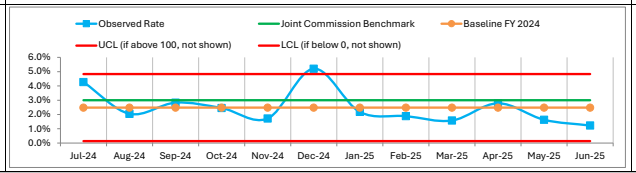
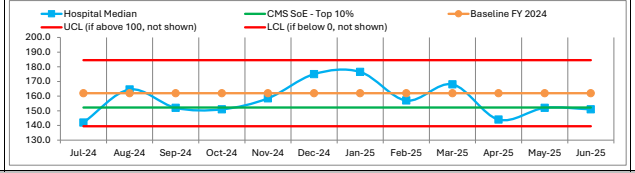
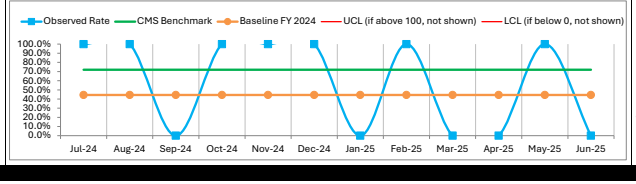
7. **HBIPS-3:** Hours of Seclusion Use (per 1000 patient hours) lower is better. All CMS hospitals are at 0.0002; FY 20245 rate is 0.0003.

List of Attachments:

1. Attachment 1: FY2025 Core Measure Report Non-HBIPS
2. Attachment 2: FY2025 Core Measure Report HBIPS

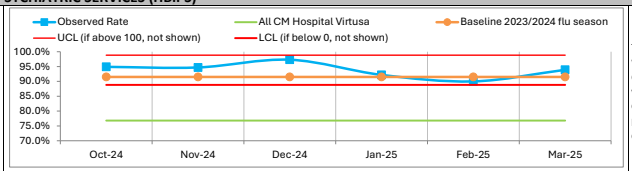
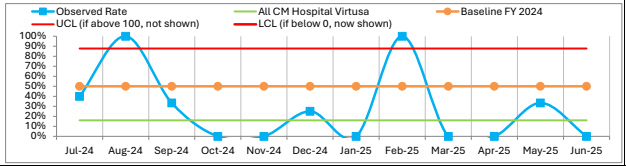
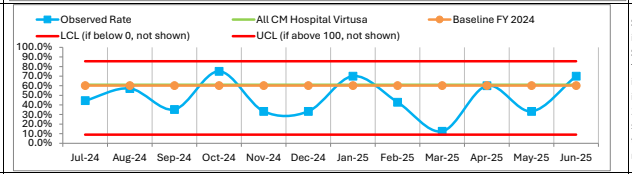
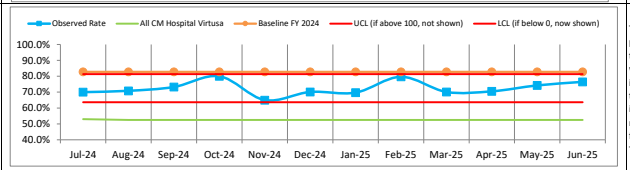
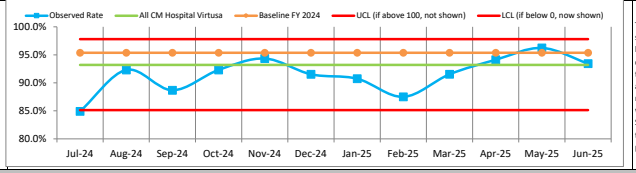
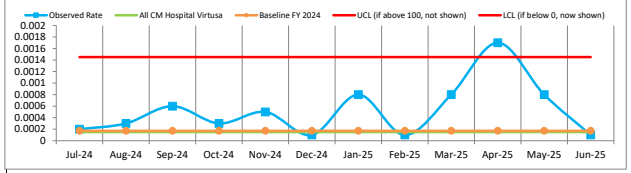
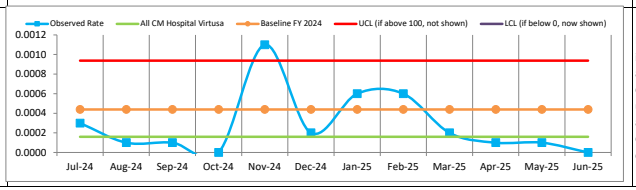
El Camino Health

FY 2025 Performance Core Measures Dashboard (Enterprise, unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2025 Performance	FY 2024 Baseline	Target	Trend Graph	2025-2026 Definition	Definition Owner	Work Group	Source
PERINATAL CARE MOTHER									
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) Data Source : Virtusa Latest Data Month: June 2025	ENT: 0.0% (0/18) MV: 0.0% (0/14) LG: 0.0% (0/4)	ENT: 0.4% (1/237) MV: 0.5% (1/194) LG: 0.0% (0/43)	ENT: 2.5% (7/280) MV: 2.2% (5/227) LG: 3.8% (2/52)	TJC < 2% ECH ≤1.6		Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to peer review coordinator	Virtusa CareDiscovery Quality Measures
PC-02 Cesarean Birth (lower = better) Data Source : Virtusa Latest Data Month: June 2025	ENT: 31.8% (54/170) MV: 31.8% (48/151) LG: 31.6% (6/19)	ENT: 26.8% (594/2218) MV: 27.6% (519/1881) LG: 22.3% (75/337)	ENT: 24.9% (536/2156) MV: 25.5% (478/1878) LG: 20.9% (58/278)	TJC < 25% Leapfrog ≤23.6% ECH ≤23.9%		Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Virtusa CareDiscovery Quality Measures
PERINATAL CARE BABIES									
PC-05 Exclusive Breast Milk Feeding Data Source : Virtusa Latest Data Month: June 2025	ENT: 74.6% (53/71) MV: 75.0% (48/64) LG: 71.4% (5/7)	ENT: 79.4% (670/844) MV: 78.1% (546/699) LG: 85.5% (124/145)	ENT: 75.7% (626/827) MV: 75.3% (536/712) LG: 78.3% (90/115)	TJC >50% CMQCC 65.1% ECH 74%		Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	TJC	Quarterly meeting/emails with L&D nursing leadership	Virtusa CareDiscovery Quality Measures
PC-06 Unexpected Complications in Term Newborns (lower = better) Data Source : Virtusa Latest Data Month: June 2025	ENT: 1.2% (4/326) MV: 1.4% (4/291) LG: 0.0% (0/35)	ENT: 2.5% (102/4077) MV: 2.3% (78/3445) LG: 3.8% (24/632)	ENT: 2.5% (99/3988) MV: 2.1% (71/3393) LG: 4.7% (28/595)	TJC < 3%		Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Virtusa CareDiscovery Quality Measures
ED THROUGHPUT									
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) Data Source : Virtusa Latest Data Month: June 2025	ENT: 151 Minutes	ENT: 157.6 Minutes	ENT: 162 Minutes	180 min ECH Goal		Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department	Hospital OQR Specifications Manual		Virtusa CareDiscovery Quality Measures
OUTPATIENT MEASURES									
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke Data Source : Virtusa Latest Data Month: June 2025	ENT: - no cases MV: - no cases LG: - no cases	ENT: 81.8% (9/11) MV: 80.0% (8/10) LG: 100.0% (1/1)	ENT: 44.4% (4/9) MV: 37.5% (3/8) LG: 100.0% (1/1)	100% (CMS Standard of Excellence - Top 10% of Hospitals)		Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)	Virtusa CareDiscovery Quality Measures

El Camino Health

Fiscal Year 2025 Performance - Core Measures (HBIPS) - Enterprise

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2025 Performance	FY 2024 Baseline	All CM Hospitals FY 2025 Benchmark	Trend Graph	2025-2026 Definition	Definition Owner	Work Group	Source
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)									
IMM-2 Influenza Immunization **FINALIZED** *Data Source: Virtusa* *Latest Data Month: March 2025* ***Data only captured during the flu season: Jan-Mar, Oct-Dec months*** (High is better)	93.9% (77/82)	94% (407/433) 2024/2025 Flu Season	91.7% (365/398) 2023/2024 Flu Season	77%		This prevention measure addresses acute care hospitalized inpatients age 6 months and older who were screened for seasonal influenza immunization status and were vaccinated prior to discharge if indicated. The numerator captures two activities: screening and the intervention of vaccine administration when indicated. As a result, patients who had documented contraindications to the vaccine, patients who were offered and declined the vaccine and patients who received the vaccine during the current year's influenza season but prior to the current hospitalization are captured as numerator events.	CMS/TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures
PC-TOB Perfect Care - Tobacco Use *Data Source: Virtusa* *Latest Data Month: June 2025*	33.3% (1/3)	20.6% (7/34)	50% (23/46)	16%		**TOB-3** Patients identified as tobacco product users who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge. **TOB-3a** Patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA-approved cessation medication upon discharge as well as those who were referred to outpatient counseling and had reason for not receiving a prescription for medication. The measure is reported as an overall rate which includes all patients to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge.	TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures
PC-SUB Perfect Care - Substance Abuse *Data Source: Virtusa* *Latest Data Month: June 2025*	70.0% (7/10)	46.6% (54/116)	60.2% (74/123)	61%		**SUB-2** Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. **SUB-2a** Patients who received the brief intervention during the hospital stay. The measure is reported as an overall rate which includes all patients to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.	TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures
TR-1 Transition Record with Specified Elements Received by Discharged Patients *Data Source: Virtusa* *Latest Data Month: June 2025*	76.5% (52/68)	72.5% (583/804)	82.8% (735/888)	53%		The Transition Record with Specified Elements Received by Discharged Patients measure assesses the percentage of patients, regardless of age, discharged from an IPF to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all the specified elements. If a patient is transferred to another inpatient facility and the discharging clinician documents in the patient record that the patient is clinically unstable, or the patient and/or caregiver is unable to comprehend the information at discharge, then the discharging facility is not required to discuss and provide the transition record to the patient and/or caregiver; however, all four elements must be discussed with the receiving facility to be included in the numerator for the Transition Record with Specified Elements Received by Discharged Patients measure.	CMS/TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures
MET-1 Screening for Metabolic Disorders *Data Source: Virtusa* *Latest Data Month: June 2025*	93.4% (57/61)	91.5% (617/674)	95.4% (597/626)	93%		The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	CMS/TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures
RESTRAINTS AND SECLUSIONS									
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower = better) *Data Source: Virtusa* *Latest Data Month: June 2025* *Event measures are calculated by event occurrence date	0.0001	0.0005	0.0002	0.0002		Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower = better) *Data Source: Virtusa* *Latest Data Month: June 2025* *Event measures are calculated by event occurrence date	0.0000	0.0003	0.0004	0.0002		Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	TJC	quarterly meeting/ email to BHS team	Virtusa Care Discovery Quality Measures

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: Ryan Lockwood, MBA, CPXP – Vice President of Patient Experience
Date: November 3, 2025
Subject: Patient Story – Heartfelt Gratitude for Compassionate Care

Purpose:

To share a patient and family story that highlights the extraordinary compassion, teamwork, and humanity demonstrated by our Los Gatos care team, reinforcing the tangible impact of El Camino Health's *WeCare* values and Relationship-Based Care approach.

Summary:

A patient recovering from hip replacement surgery at El Camino Health – Los Gatos and their family expressed deep gratitude for the coordinated, compassionate care they received throughout their stay. Their experience exemplifies how empathy, communication, and teamwork directly influence patient trust, recovery, and satisfaction.

The family's written letter commended multiple members of the care team for restoring hope after months of physical pain and emotional distress.

Situation: A patient recovering from hip replacement surgery at El Camino Health – Los Gatos and their family expressed deep gratitude for the coordinated, compassionate care they received throughout their stay. Their experience exemplifies how empathy, communication, and teamwork directly influence patient trust, recovery, and satisfaction.

The family's written letter commended multiple members of the care team for restoring hope after months of physical pain and emotional distress.

Authority: This patient story is presented to the Quality, Patient Care, and Patient Experience Committee as part of ongoing reporting on patient experience performance and cultural alignment.

Sharing real patient stories provides qualitative context to our quantitative data and demonstrates how the *WeCare* standards and Relationship-Based Care model are being lived out in daily practice.

Background: Following ten months of debilitating arthritis and uncertainty, the patient underwent hip replacement surgery at Los Gatos. The family shared that the experience—from admission through recovery—restored both physical and emotional well-being.

Special recognition was extended to:

- Ann Aquino and Debbie Torrey, for thoughtful coordination of room assignment and nursing care, ensuring a smooth and compassionate transition post-surgery.
- Gail Dammert, for ongoing guidance and connection to Kathi Lee, whose advocacy and emotional support profoundly impacted the family.
- Dr. Sagoo, whose flexibility in performing the surgery a week earlier than planned demonstrated exceptional responsiveness and compassion.
- Keen, Lorna, Antouh, and Mason, nurses who cared for the patient during recovery.
- Ali, the transporter, whose warmth and kindness provided comfort during moments of vulnerability.

Quality Committee Memo - Patient Story
November 3, 2025

The family described this care as a "perfect example of ECH's *WeCare* values in action."

Assessment: This story demonstrates:

- The effectiveness of cross-department collaboration and the importance of communication between nursing, surgical, and ancillary teams.
- The power of personalized, relationship-based care to transform patient and family experiences, even after prolonged suffering.
- The alignment between frontline actions and organizational culture, showing how compassion and teamwork advance ECH's mission to deliver exceptional, person-centered care.
- The positive correlation between staff engagement and patient gratitude, reinforcing ongoing PX initiatives such as *WeCare Wednesday* and the *It's Not Easy Being Green* recognition program.

This patient experience provides a qualitative validation of our improvement work and reinforces continued investment in culture, teamwork, and empathy training.

Outcomes:

- The patient is now walking again—slowly but steadily—with dignity and confidence restored.
- The family expressed that their faith in El Camino Health was reaffirmed, stating, *"You made a lasting difference in our loved one's life—and in ours."*
- The story highlights the measurable impact of Relationship-Based Care, nurse and staff engagement, and interdisciplinary collaboration on the healing process.
- It serves as a tangible example of how El Camino Health's *WeCare* values translate from policy into meaningful patient and family outcomes.

List of Attachments: Family member's letter that was emailed to an El Camino Health Leader.

El Camino Health

Hospital Campuses

2500 Grant Road
Mountain View, CA 94040
650-940-7000

815 Pollard Road
Los Gatos, CA 95032
408-378-6131

elcaminohealth.org

Memorandum

To: El Camino Health
From: *[Redacted]*
Date: October 7, 2025
Subject: Heartfelt Gratitude for Compassionate Care

On behalf of our entire family, we want to express our heartfelt gratitude for the exceptional care and compassion shown to [*our loved one*] during [*their*] recent recovery from hip replacement surgery.

A special thank you to Ann Aquino and Debbie Torrey for thoughtfully coordinating her room and nursing care. From the warm welcome in the post-op room to ensuring she was comfortable and introduced to her nurses, every detail reflected kindness and true compassion. After ten long months of pain and uncertainty, [*our loved one*] has finally felt seen, heard, and cared for — a perfect example of ECH's WeCare values in action.

We are also deeply grateful to Gail Dammert for her continued support and for connecting us with Kathi Lee, whose understanding, empathy, and advocacy changed the course of [*our loved one's*] recovery. Kathi truly saw the whole person behind the diagnosis and worked closely with Dr. Sagoo, who showed remarkable compassion by adjusting his schedule to perform [*our loved one's*] surgery just a week later. That moment brought our family hope and reminded us of the power of teamwork, empathy, and dedication.

Our sincere thanks also go to Keen, Lorna, Antouh, and Mason — the nurses who cared for [*our loved one's*] during [their] stay — and to Ali, the transporter whose simple kindness and friendly smile brought comfort at a time we felt invisible.

Our family has trusted El Camino Health for many years, but this experience was especially meaningful. Through one of the hardest times in our lives, your team restored [*our loved one's*] dignity, confidence, and hope. Today, [*they*]

are walking again — slowly but surely — and the light in [*their*] face says everything.

Thank you for the extraordinary compassion, professionalism, and humanity you bring to your work every day. You made a lasting difference in [*our loved one's*] life and in ours.

El Camino Health

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CAO
Date: November 3, 2025
Subject: FY-25 Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): The Safety Committee and the Emergency Management Committee of the Hospital recommend that the Board Quality Committee approve the Annual Report, Evaluation of the Environment of Care & Emergency Management for FY-25.

Summary:

Situation: The management of the environment of care, the safety program with all its elements and the emergency management plan produced mixed results in FY-25. Results include:

1. **Employee Safety:** The rate of OSHA Recordable Incidents increased 7.5% from FY-24. These rate increases from the prior year were due to an increased number of Patient Lift Transfer Injuries, and Bloodborne Pathogen Exposures. Note however that we remain below national and state rates for OSHA Recordable Injuries. Improvement strategies have been implemented to reduce the number of injuries.

2. **Security:** The number of OSHA reportable Workplace Violence incidents increased 33% from the prior year with a total of 60 WPV incidents in FY-25. The increase was due in large part to confused and dementia patients acting out along with an increase in events related to Behavioral Health patients. Code Grey incidents decreased 12% from the prior year with improvements largely due to the implementation of the CALM (Collaborative Aid Listening and Motivation) team implementation.

3. **Hazardous Materials:** There were no Reportable Hazardous Material Incidents or Wastewater Discharge violations. Additionally, the number of Recordable Hazardous Material Incidents decreased 33% from the prior year.

4. **Fire Safety:** There were no Fire Incidents at any El Camino Health facilities in FY-25.

5. **Medical Equipment:** The planned maintenance for high-risk medical equipment was maintained at 99.32% completion rates, equal to the prior year.

6. **Utilities: There** were four incidents of PG&E electrical power outages or voltage fluctuations during FY-25, two in Los Gatos and two in Mountain View. All emergency power systems functioned as designed and there were no negative outcomes.

7. **Emergency Management:** There were two incidents during FY-25 that prompted the activation of the Command Center and activation of the HICS (Hospital Incident Command System) protocols. Both were the result of power failures that were effectively managed without negative outcomes. Additionally, the organization participated in three Drills which provided valuable training and education for our emergency preparedness.

Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.

Annual Report – Evaluation of the Environment of Care and Emergency Management
November 3, 2025

Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement.

Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.

Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-25.

List of Attachments:

1. Full Report – FY-25 Evaluation of the Environment of Care & Emergency Management

El Camino Health

Fiscal Year 2025 Evaluation of the Environment of Care And Emergency Management

Prepared by:

Matt Scannell
Director, Safety and Security

Bryan Plett
Manager, Environmental Health and Safety

Created: 09/10/2025

Table of Contents

Program Overview

The Joint Commission standards provide the framework for the Safety Program for managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer (Ken King Chief Administrative Officer) develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing, Safety/Security and others

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on Safety Trends. The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for the Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2025. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer term.

Executive Summary

Safety Management

Performance

Performance indicators offer the opportunity to objectively assess key focus areas and identify potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-25. This includes data from both the Mountain View and Los Gatos campuses.

OSHA Recordable Injury & Illness

The total number of OSHA recordable incidents increased in FY 25 to **224**, compared to **208** in FY 24. Incident reporting also rose substantially, with **445 reports submitted** (up from 367 in FY 24, Figure 1). The ratio of total reports to OSHA recordable incidents was **1.99**, consistent with historical trends.

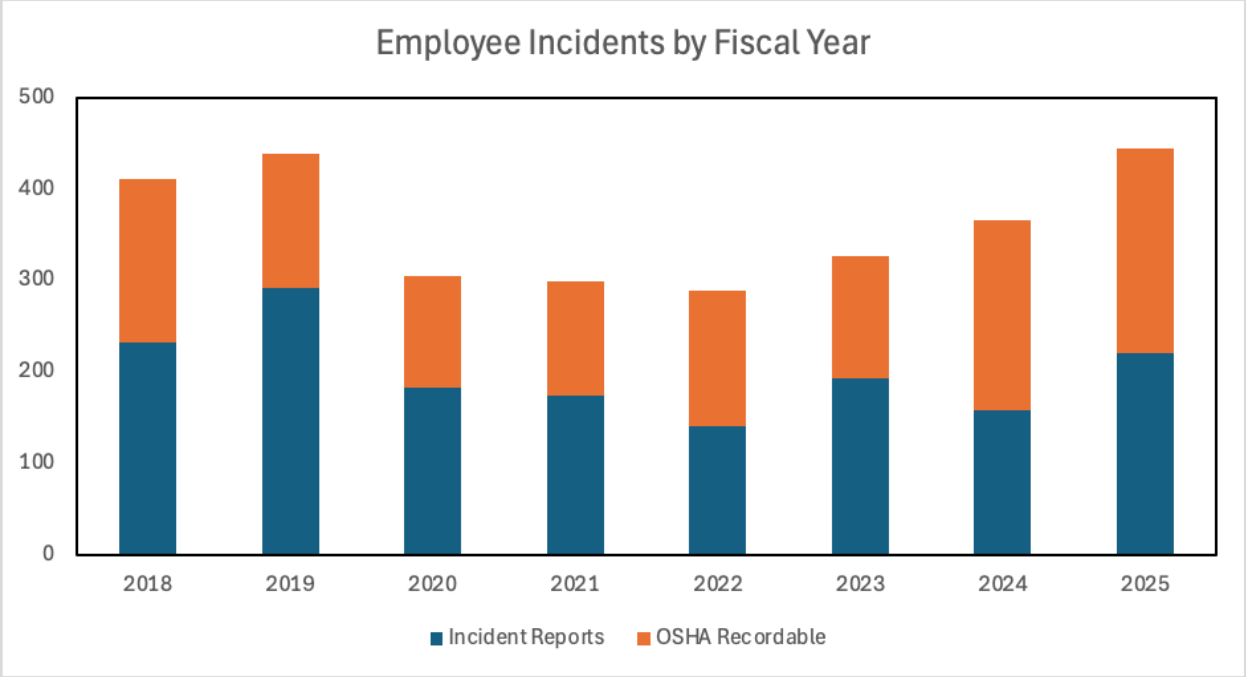


Figure 1. Employee incidents by fiscal year: total reports and OSHA recordable injuries.

The increase in reporting is attributed to the implementation of **Enterprise Health**, a new Employee Health electronic health record (EHR) launched July 1, 2024. The system provides a simplified digital experience for employees and managers, improving reporting and investigation workflows. Combined with greater awareness, prompt reporting, and heightened visibility through huddles and leadership emphasis, this shift reflects a return to pre-COVID-19 norms last observed in FY 2019 and earlier.

Two incidents were considered OSHA reportable during FY 25:

1. **September 2024:** An employee sustained a partial finger amputation when a cylinder hand truck collapsed under excessive load while crossing a doorway threshold. *Root cause*: equipment overload and failure. *Corrective actions*: replacement of all hand trucks with higher-capacity models, revised procedures with cylinder weight limits, and staff training.
2. December 2024: An employee sustained an ankle fracture following a syncopal episode and fall while exiting an office. *Root cause*: non-work-related medical condition. *Corrective actions*: none required beyond emergency response review and reinforcement of rapid response team protocols.

Effectiveness

Key indicators were identified to establish FY 25 goals, with opportunities to improve Safety Management within the Environment of Care.

FY 25 Goals

1) Reduce employee bloodborne pathogen exposures.

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce Bloodborne pathogen exposure OSHA recordable employee injuries 10% over FY24 baseline	EWHS /EH&S	47 (10% reduction from FY 24 baseline of 52) **Goal not met.** .

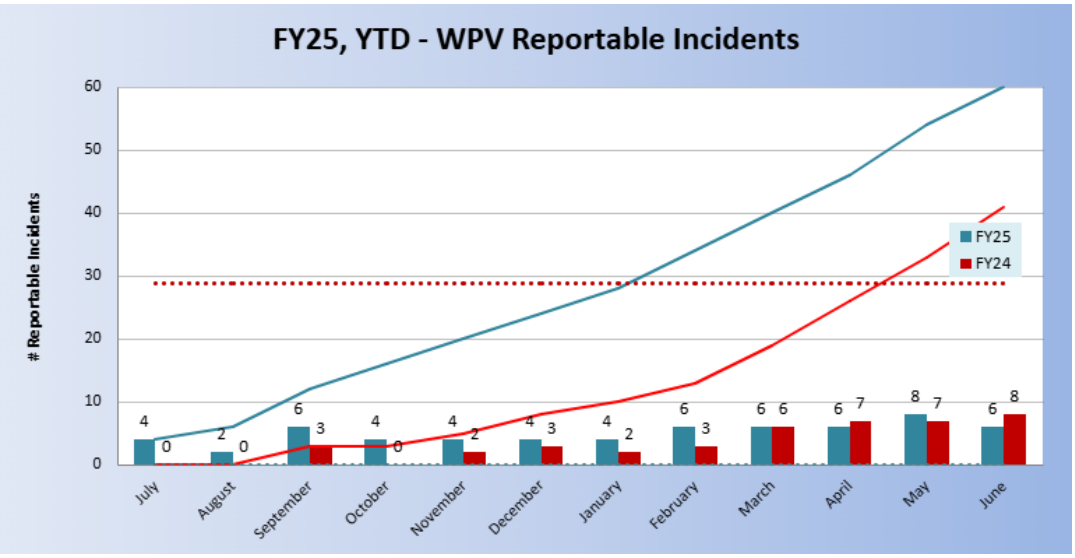
This goal was not met. Instead of the targeted reduction to 47, there were **58 OSHA-recordable BBPE injuries in FY 25**, representing an increase over baseline. EWHS continues efforts to ensure timely reporting, improve visibility, share lessons learned, and implement focused prevention strategies.

Security Management

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY25. The data includes activity from both campuses.

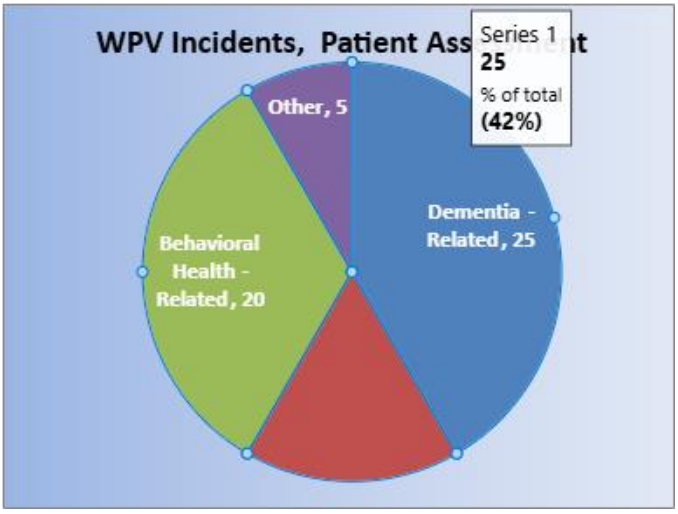
Review of the FY25 WPV incidents showed:

- There were 60 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 25. This is a 33 % increase from FY24.



- Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:

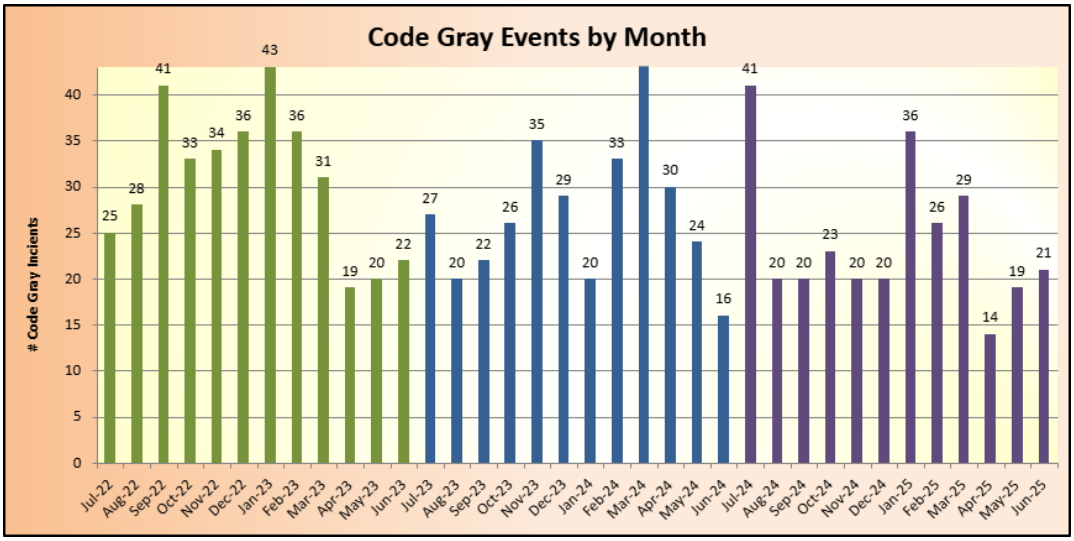
1. A significant increase in the number of WPV events related to dementia or delirium patients (Total =25).
2. A significant increase in the number of WPV events related to behavioral health patients (Total=20).



Note – A focus on managing our dementia related patient population and our behavioral health patient population will occur in FY 26.

Code Gray Responses:

Code Gray responses decreased (12%) in both MV and LG. The total number of incidents in FY25 was 289 compared to 327 in FY24. The decrease in code greys is largely due to the expansion of the CALM (Collaborative Aid through Listening and Motivation) team in M.V. and the expansion of the portable panic button program in Los Gatos in FY 25.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- **MV Emergency Dept. (ED) – 42%**
- **MV Medical Unit (4A)- 13%**
- **MV Medical Unit (3C) – 8%**

Responses are tracked through the Code Gray security shift report form and evaluated to help identify possible improvements to the process.

Effectiveness:

Key performance indicators were identified in FY25 to improve Security Management within the Environment of Care.

FY25 Goals

1. 5% reduction in number of reportable workplace violence incidents-There were 60 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 25. This is a 33 % increase from FY24. **This goal was not met.**

2. 10 % reduction in the number of Code Greys over FY 2024. In FY 25 there were a total of 289 code greys. This is a 12% reduction in the number of code greys over FY 24. **This goal was met.**

Hazardous Material Management

Performance

A. Hazardous Material Incidents

The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

Recordable Hazardous Material Incidents:

1) **7-10-24 Peridox 30 ml** – Inpatient Pharmacy, Mountain View - Overflow from controlled substances container after expired Peridox disinfectant was disposed of in the container. A knowledge Gap was identified and education for Pharmacy staff was provided for proper disposal at the point of origin. Education for staff to dispose of in appropriate RCRA containers. Signs placed near controlled substances bin for clarity for disposing material. Cleanup was handled safely, and no staff injuries were reported.
2) **10-10-24 Methotrexate ¼ cc spill – CT 3,** Mountain View – A Doctor spilled Methotrexate during a procedure with a patient. A knowledge Gap was identified with imaging staff on proper spill response. Completed spill response training to high-risk departments on10-25-24 is in Los Gatos and 11-1-24 in Mountain View. Cleanup was handled safely, and no staff injuries were reported.
3) **11-6-24 Fluorouracil 15-20 ml spill –** 4B Room 4208, Mountain View – While administering Fluorouracil to a patient the equipment disconnected from the patient causing the spill. An opportunity was identified to re-educate staff to ensure all connections are secure prior to administration of Fluorouracil. Education was provided for staff to double-check all connections prior to administration. Cleanup was handled safely, and no staff injuries were reported.
4) **12-4-24 Formalin 100 ml spill –** Willow OR 5, Mountain View – One formalin container was found tipped on its side which had caused the formalin to spill out into the secondary container basin. A knowledge Gap was identified with Willow Outpatient Surgery staff on spill response procedures. Spill response training with Willow OR staff was completed on 3-21-25. Cleanup was handled safely, and no staff injuries were reported.

Note- There was a 33% decrease in the number of recordable spills in FY 25 over FY 24. In FY 24 there were six recordable spills compared to 4 in FY 25. This was largely due to additional spill response training for high-risk departments.

- **In FY 25 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation, handling and spill response compliance:**
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors
  - Monthly Safety Rounds that include observation of waste segregation practices
  - Quarterly Surveys of medical waste/sharps by Stericycle and Clean harbors Compliance Coordinator with targeted education on nursing units addressed toward survey findings.
  - Confirmed contractual agreement with All Clean to assist with Code Orange Response process and procedures as needed.
  - Regular Hazardous Materials Work Group Meetings with the goal for discussion with high-risk hazardous materials and waste departments.
  - Reviewed and updated all Hazardous waste policies
  - Conducted Spill Response training with high-risk hazardous materials and waste departments on 10-25-24 is in Los Gatos and 11-1-24, 3-21-25 in Mountain View
  - Organization standardized chemo, formalin and universal spill kits to be used by high-risk hazardous materials and waste departments.
  - Conducted Unannounced solid waste assessments in Los Gatos 2-6-25 and in Mountain 2-7-25 in high-risk departments. All identified gaps found during the waste assessment are being addressed and training for those affected departments is being completed.

Effectiveness

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after exposure (15 minutes)
   - **Measurement of success** :> 95%. T**his goal was accomplished.**
2. Staff can describe the process of accessing a safety data sheet.
   - **Measurement of Success**: >95%. **This goal was accomplished**.

Fire Safety Management

Performance

A. Fire Incidents

There was no fire incidents in Mountain View or Los Gatos in FY25.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated as potential opportunities for improvement.

The total number of events in FY25 (41) was lower than FY24 (47). There were 40 events in Mountain View and 1 in Los Gatos. This decrease was mostly related to better oversight of construction activities at both campuses

C. Effectiveness

Based on opportunities for improvement identified in the FY24 annual EOC evaluation the FY 25 performance improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met= 93%
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met=92 %
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met=96 %

Note: We will choose all new indicators for FY25 due to staff performance in FY25.

Medical Equipment

Performance

A. Reports to the FDA –

There were **18** reports through the Medwatch[1] system in FY-25. There was no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet with compliance for the target of 95% completion within the month due in all areas.

- The Clinical Engineering department achieved an **89% maintenance completion rate** for FY25, reflecting a **4% decrease** compared to FY24. Despite this decline, **100% of devices were actively managed** through a structured communication process aimed at locating and servicing each asset. This managed approach improved the completion rate to **95%**.
- However, **4% of the total inventory (14,376 medical devices)** could not be located for scheduled maintenance, representing the primary barrier to achieving full completion.
- All high-risk, life safety equipment was maintained at a **97.90% completion rate**. Through a structured communication process designed to locate and service all devices, maintenance activities were **100% managed**. This proactive approach increased the overall completion rate to **99.32%**.
- Despite these improvements, certain devices—**external pacemakers, ventilators, and blood warmers**—remained challenging to locate consistently, preventing full completion of maintenance for those items.

C. Product Recalls Percentage Closed / Received

For FY-25, there were 532 recorded equipment recalls: 99% are completed and 100% managed

Effectiveness:

FY25 Performance Indicators

In FY 25 the performance improvement process focused on Asset Management and Asset Recalls.

- Enhance the efficiency and accuracy of our DICOM (Digital Imaging and Communications in Medicine) systems across the enterprise. By focusing on these areas, we aim to enhance the overall efficiency, accuracy, and compliance of our DICOM systems, ultimately improving patient care and operational

[1] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

effectiveness. Achieve 80% compliance and accuracy of all modalities (157) data sending, receiving and documented.

Results:

- This goal was successfully achieved with **100% validation by the Director or Imagining**. The initiative resulted in **80% compliance and accuracy** across all 157 imaging modalities, ensuring reliable data sending, receiving, and documentation. The improvements significantly strengthened enterprise-wide DICOM system performance and alignment with clinical and operational standards.
- Reduce open ECRI recall/alerts to 100% managed. Alerts being managed is defined by each alert/recall that has been addressed and closed. Any work orders left open are only due to the manufacture of corrective action plans that have not been developed or can execute to remediate the alert/recall.

Results:

- Goal successfully met. By the end of the fiscal year, the Clinical Engineering department had reduced open ECRI recalls/alerts to three, all of which were 100% managed. Each had corresponding open work orders for affected devices, with resolution pending manufacturer action plans.

Utility Systems

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-25.

A. Utility Reportable Incidents

There were four incidents in FY-25. All were electrical outages or voltage fluctuations.

- Los Gatos had a PG&E voltage fluctuation on January 5, 2025, at 1:25 a.m. to the Main Hospital recorded on our Building Management System. PG&E was notified, and they could not detect any outages/disturbances fluctuations and there was no patient safety impact related to this event. On March 12, 2025, there was a loss of electrical power to the Los Gatos Main Hospital due to a PG&E outage from 12:26 p.m. to 5 p.m. due to a squirrel blowing up a fuse requiring PG&E to shut down the circuit for repairs. The emergency generators ran and functioned as designed and there was no impact on patient safety.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on 11/19/24 & 3/12/25. There were system disruptions, hospital emergency generators ran and functioned properly.

B. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was 95%, meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

C. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

Effectiveness

Key indicators were targeted to establish goals. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**>90% Goal was not met 86%**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**>90 % Goal was met=92 %**

Note: Data is collected through fire drills and environment of care rounds.

Emergency Management

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant events are presented to the Central Safety Committee for review. For FY25, the following Emergency Management indicators were noted:

A. Activation of the Hospital Incident Command System (HICS)

There were two (2) recorded events and/or emergencies during FY25 requiring the activation of HICS and opening of the Hospital Command Center (HCC).

- 09/13/2024 – At approximately 1223 hours, El Camino Health Mountain View experienced a power outage due to a tree branch falling on a local power line. The generators activated as designed. HICS was activated and the Hospital Command Center was opened. This incident involved an elevator entrapment which was quickly resolved. All other outstanding issues were mitigated and the hospital returned to normal operations at approximately 1344 hours.
- 03/12/2025 – At approximately 1230 hours, El Camino Health Los Gatos experienced a power outage. HICS was activated and the Hospital Command Center was opened. Numerous issues were mitigated and the situation resolved at approximately 1700 hours.

B. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY25, this was met through separate planned exercises at both campuses (see below). The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

- 01/07/2025 – El Camino Health Enterprise hosted a Mass Casualty Incident Tabletop exercise. The scenario consisted of a large-scale community incident that involved 113 simulated patients transported to El Camino Health. The target objectives of the exercise were Communications (TJC EM.02.02.01), Safety and Security (TJC EM.02.02.05), Patient and Clinical Support Activities (TJC EM.02.02.07), and Command Management (TJC EM.01.01.01).

- 01/08/2025 – El Camino Health Office of Emergency Management facilitated a Code Pink (infant abduction) drill in the Mountain View Orchard Pavilion. The scenario involved an infant abduction originating from the Mother Baby Unit on the 3rd floor. The actor was intercepted by security on the first floor attempting to leave the building. The target objectives of the exercise were Communications (TJC EM.02.02.01), Safety and Security (TJC EM.02.02.05), and Staff Responsibility (TJC EM.02.02.07).

- 01/09/2025 – El Camino Health Office of Emergency Management facilitated a Code Pink (infant abduction) drill in the Los Gatos ECH Women's Hospital. The scenario involved an infant abduction originating from the Mother Baby Unit. The actor was intercepted by security attempting to leave the building. The target objectives of the exercise were Communications (TJC EM.02.02.01), Safety and Security (TJC EM.02.02.05), and Staff Responsibility (TJC EM.02.02.07).

C. Emergency Management Training

- New Hire and New Manager Orientation: Emergency management training was provided for all incoming new staff members.
- Safety Coordinator Meetings: Held both in-person and via Zoom, consisting of various aspects of emergency management-related training.
- CHA Disaster Preparedness Conference: The annual conference, hosted by the California Hospital Association in September, was well attended by El Camino Health representatives. This year's conference was held in September.
- 11/4/2024 – The El Camino Health Office of Emergency Management hosted Mary Massey, Vice President of Emergency Management, at the California Hospital Association to facilitate Hospital Command Center training for identified leaders. 29 El Camino Health leaders were certified in ICS 100, ICS 200, and ICS 700.

- There were minimal changes to the top five HVAs at both campuses in FY25 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	**(1) Earthquake**
(2) Mass Casualty	**(2) Mass Casualty**
(3) Utility Failure	**(3) Utility Failure**
(4) Patient Surge	**(4) Patient Surge**
(5) Unplanned Power Outage	**(5) Unplanned Power Outage**

D. Effectiveness

Key indicators were targeted to establish goals for FY25. The following goals presented opportunities to improve emergency management.

FY25 Goals

1. Establish and Maintain a Fully Stocked Mobile Command Center
   Objective: Ensure the hospital can sustain operations during facility disruptions by deploying a mobile, fully equipped command center.
   - **Measurement of Success**
   - Procure, stock, and maintain an operational mobile command center.
   - Draft and maintain an inventory checklist consisting of required critical supplies and keep stocked at all times.
   - **This *goal was accomplished.***
   - Mobile Command Center van was procured.
   - Van stocked with essential items electronics to maintain open lines of communication during incidents.

2. Strengthen Staff Readiness Through Comprehensive Emergency Training
   Objective: Improve hospital-wide emergency response capability by ensuring all relevant staff are trained and proficient in incident command procedures.
   - **Measurement of Success**
   - Train Incident Response Team members in the critical aspect of the Hospital Incident Command System.
   - Certify the Incident Response Team in ICS 100, ICS 200, and ICS 700.
   - **This *goal was accomplished.***
   - Partnered with Santa Clara County EMS to provide inter agency coordinated drills and exercises.
   - Hosted a class for the Incident Command Team resulting in the ICS 100, ICS 200, and ICS 700 certifications for 29 members.

FY 25 EOC Annual Evaluation

EC 1.0 - Safety Management

Work Group Chair: ***Michael Rea***

Scope

Safety Management is the responsibility of hospital leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

- Employee Wellness & Health Services
- Education Services
- Quality and Patient Safety
- Infection Prevention
- Security Management
- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

Performance

Performance indicators offer the opportunity to objectively assess key focus areas and identify potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-25. This includes data from both the Mountain View and Los Gatos campuses.

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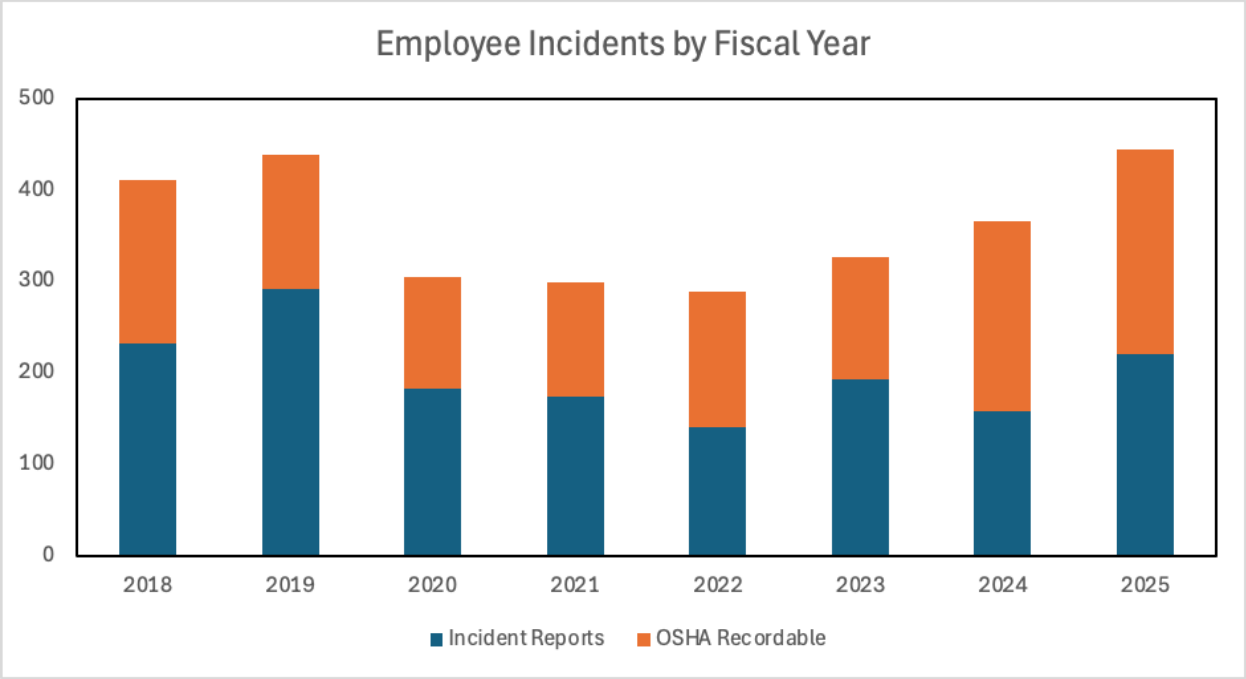

Figure 1. Employee incidents by fiscal year: total reports and OSHA recordable injuries.

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Two incidents were considered OSHA reportable during FY 25:

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4. December 2024: An employee sustained an ankle fracture following a syncopal episode and fall while exiting an office. *Root cause*: non-work-related medical condition. *Corrective actions*: none required beyond emergency response review and reinforcement of rapid response team protocols.

Safe Patient Handling and Mobility (SPHM)

SPHM injuries increased significantly in FY 25, with 58 reports (up from 42 in FY 24). Of these, 44 were OSHA recordable, nearly double the prior year, representing the highest volume since tracking began (Figure 2). Turning/pulling and patient fall prevention remained the leading categories.

The increase reflects not only a true rise in incidents but also changes in injury coding practices and case review processes, which improved classification accuracy and ensured events previously undercounted were now consistently captured as OSHA recordable.

EWHS expanded worksite evaluations and will continue targeted interventions with high-risk departments. Additional measures to strengthen SPHM education and proactive injury prevention strategies are under development.

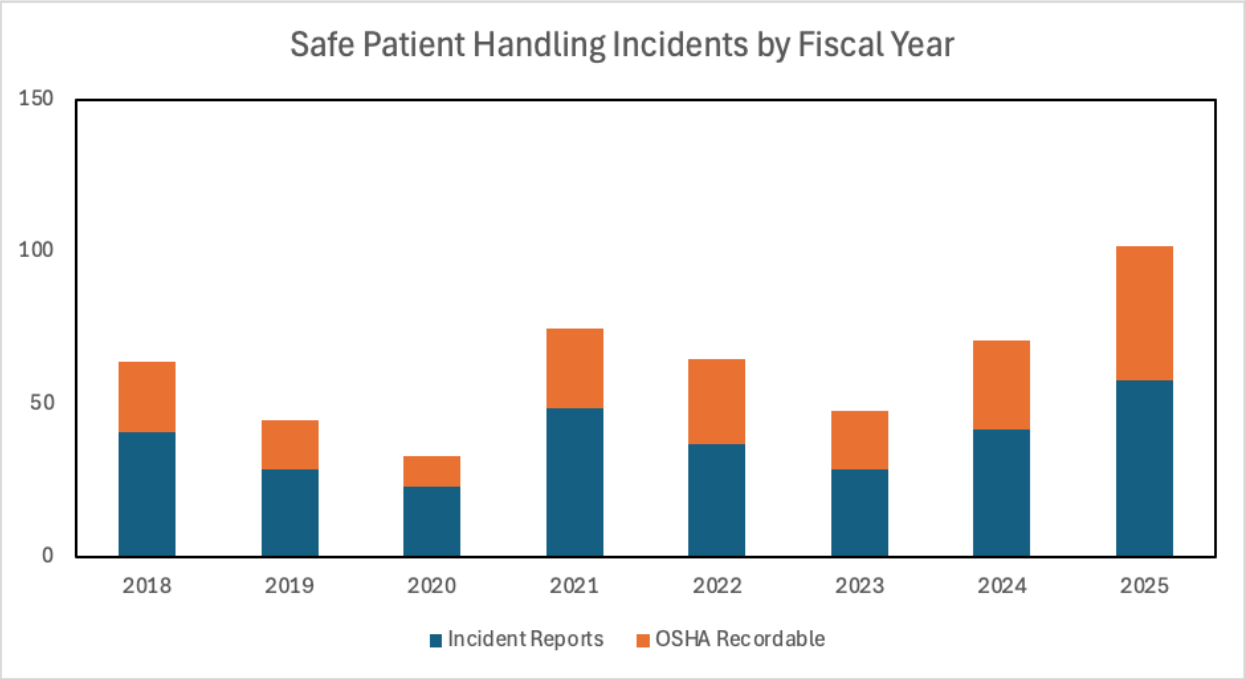


Figure 2. Employee SPHM Incidents by fiscal year of incident reports and OSHA Recordable injuries.

Bloodborne Pathogen Exposures (BBPE)

FY 25 saw **58 BBPE incidents**, including **43 percutaneous injuries** and **15 mucous membrane exposures**, compared to 52 total exposures in FY 24 (Figure 3). The increase was primarily driven by sharps-related injuries.

Improvement strategies include targeted education in high-incidence units, continued emphasis on safe sharps handling, and collaboration with Supply Chain to expand availability of protective eyewear to prevent splash exposures to the eyes.

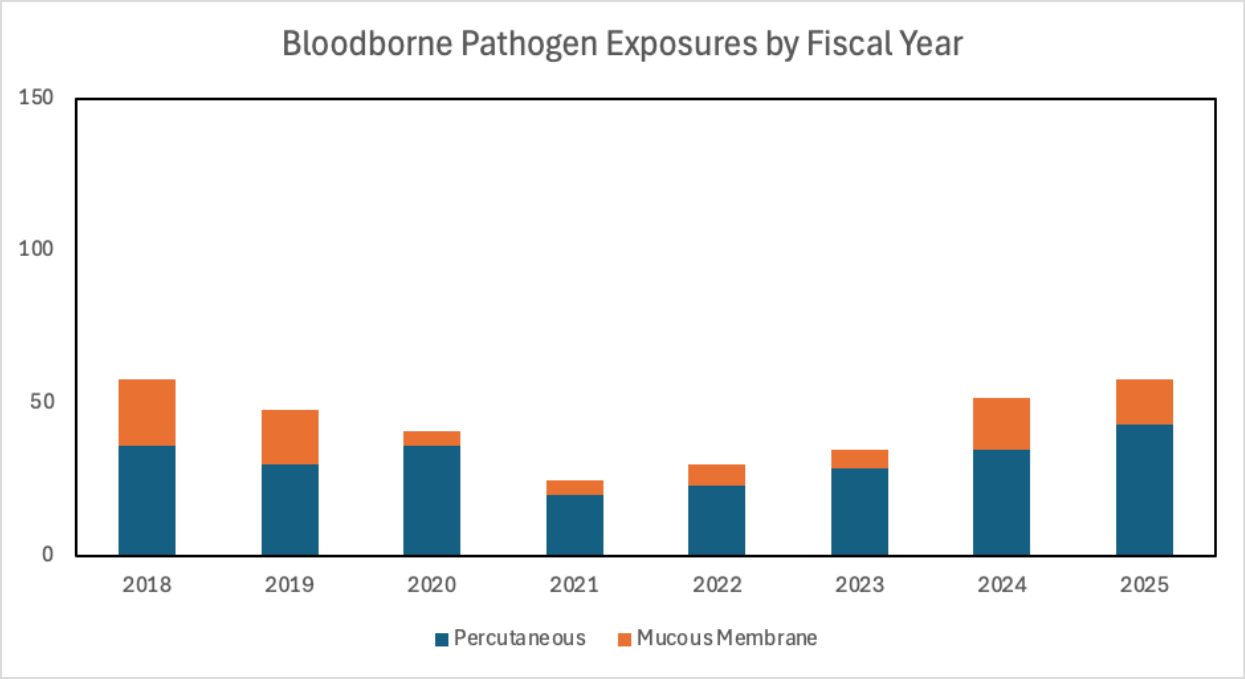


Figure 3. Employee OSHA Recordable BBPE by fiscal year of percutaneous sharp injuries and mucous membrane exposures.

Infectious Disease Exposures

There were no OSHA recordable occupational infectious disease exposures in FY 25. One tuberculosis conversion was identified through routine post-exposure surveillance, with all follow-up managed in accordance with regulatory and infection prevention standards.

Environmental and Chemical Exposures

There were 27 reported environmental and chemical exposures, of which 5 were OSHA recordable. Fourteen exposures were linked to petrochemical roofing projects; none met OSHA recordable criteria. The remaining cases primarily involved formalin or other laboratory reagents.

Slips, Trips, and Falls (STF)

Slips, trips, and falls increased to 59 incidents in FY 25, compared to 43 in FY 24. Of these, 31 were OSHA recordable (Figure 4). This reverses the prior downward trend and highlights the need for renewed focus on floor contaminants and staged equipment, as well as bodily reaction (unexplained loss of balance without an identifiable environmental hazard) as leading causes.

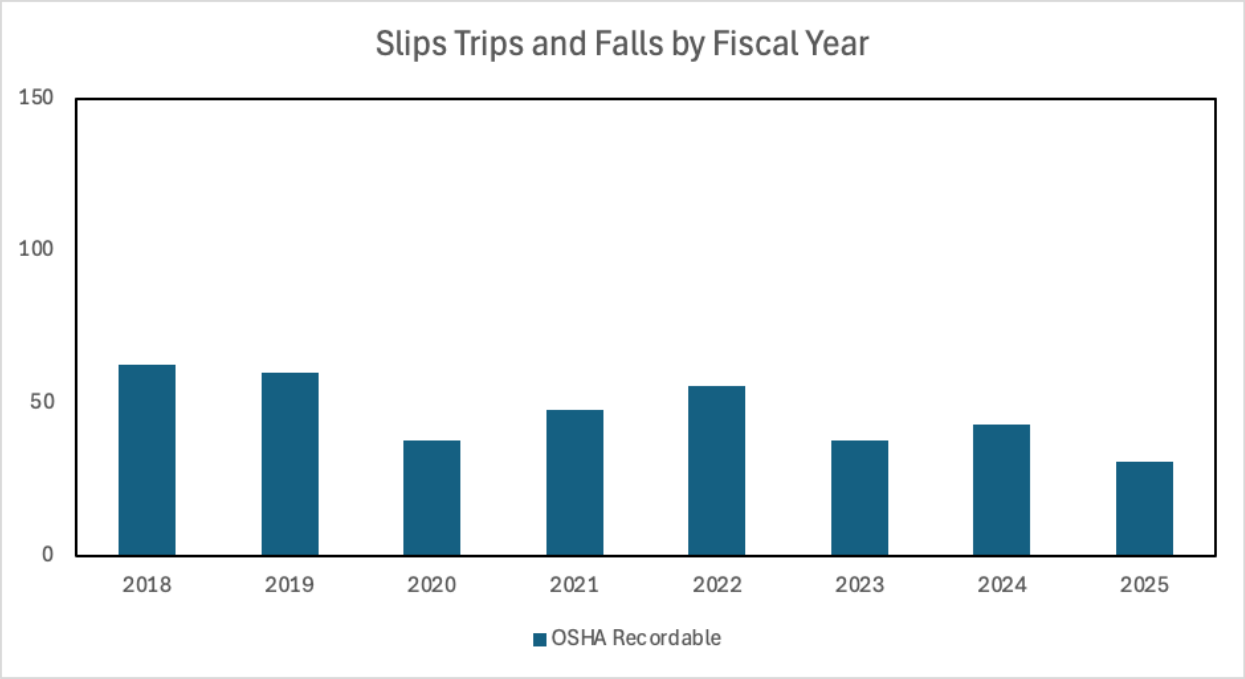


Figure 4. Employee OSHA Recordable Slips, Trips, and Falls by fiscal year.

Workplace Violence (WPV)

Workplace violence reports remained elevated in FY 25, with **53 incidents reported to EWHS** and **14 OSHA recordable injury cases**. Of these, **seven OSHA recordable injuries were related to SPHM activities**. The persistence of WPV underscores the importance of continued staff training, de-escalation strategies, and close coordination with Security and Nursing leadership.

Safety Training Indicators

Ensuring staff receive the necessary training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-based training is required for all employees. All new employees complete orientation upon hire, and annual regulatory review courses are provided as online modules covering fire safety, evacuation, hazardous materials, and other safety topics.

- New employee orientation: 100% (Target: 100%)
- Annual Regulatory Clinical Review: 86% (Target: 95%)
- Annual Regulatory Non-Clinical Review: 93% (Target: 95%)

Effectiveness

Key indicators were identified to establish FY 25 goals, with opportunities to improve Safety Management within the Environment of Care.

FY 25 Goals

2) Reduce employee bloodborne pathogen exposures.

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce Bloodborne pathogen exposure OSHA recordable employee injuries 10% over FY24 baseline	EWHS /EH&S	47 (10% reduction from FY 24 baseline of 52) **Goal not met.** .

This goal was not met. Instead of the targeted reduction to 47, there were **58 OSHA-recordable BBPE injuries in FY 25**, representing an increase over baseline. EWHS continues efforts to ensure timely reporting, improve visibility, share lessons learned, and implement focused prevention strategies.

EC 2.0 - Security Management

Work Group Chair: ***Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

The Workplace Violence Prevention Plan is required by Cal-OSHA (Section 3342 of Title 8 of the California Code of Regulations). This plan is specifically for healthcare workers. The WPVP program at El Camino Health is overseen by the Workplace Violence Prevention Committee. There are four required elements to the plan:

1. Written Plan: The plan is reviewed and updated annually.
2. Response: The plan includes a comprehensive violent incident investigation process.
3. Training: The hospital has developed two levels of training.
    - **AVADE** – Computer based training module assigned annually to most staff.
    - **CPI Prevention Frist-** Computer based nonviolent crisis intervention training with a mental health emphasis.
    - **Nonviolent Crisis Intervention (NCI) training** – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
        - Behavioral Health
        - Emergency Department
        - Security
        - Assistant Hospital Managers (Hospital Supervisors)
        - Select staff on the inpatient nursing floors*.

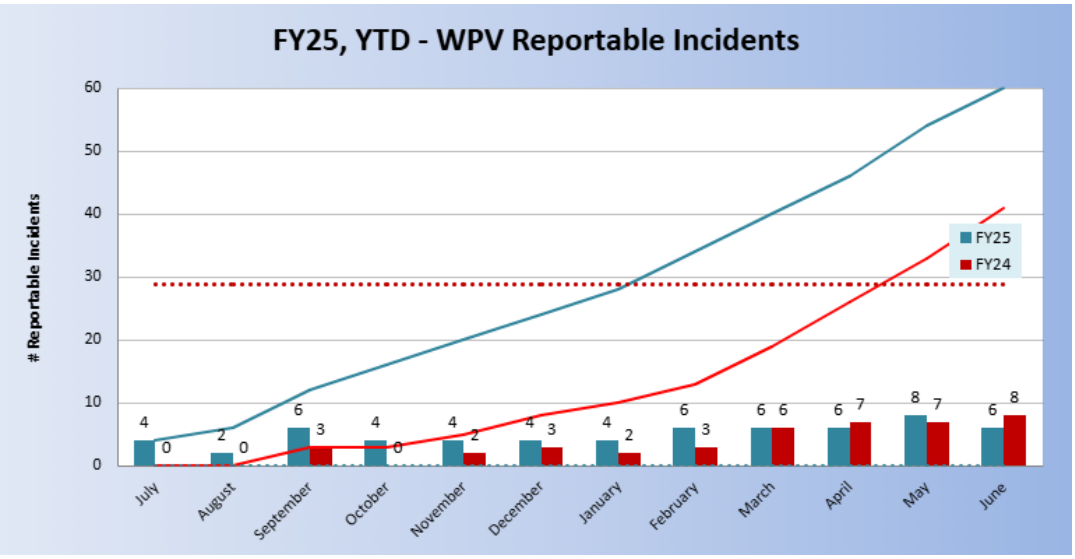
      ***Note- In FY 25 select staff on the inpatient nursing floors were included in the NCI training to support the implementation of the CALM team.**
4. Reporting: An ongoing WPV reporting team ensures reporting is completed as required.
    - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
    - In FY25, 60 incidents were reported to the CAL-OSHA WPV website compared to 45 in FY 24. There were no major WPV related injuries reported to the CAL-OSHA district office.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY25. The data includes activity from both campuses.

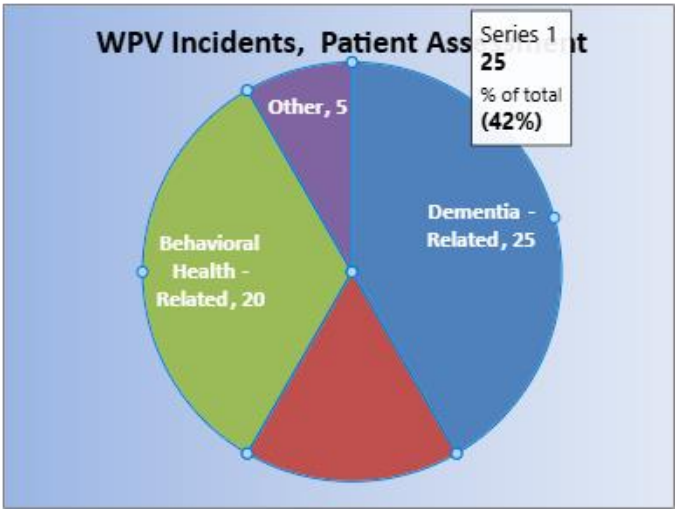
Review of the FY25 WPV incidents showed:

- There were 60 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 25. This is a 33 % increase from FY24.



- Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:

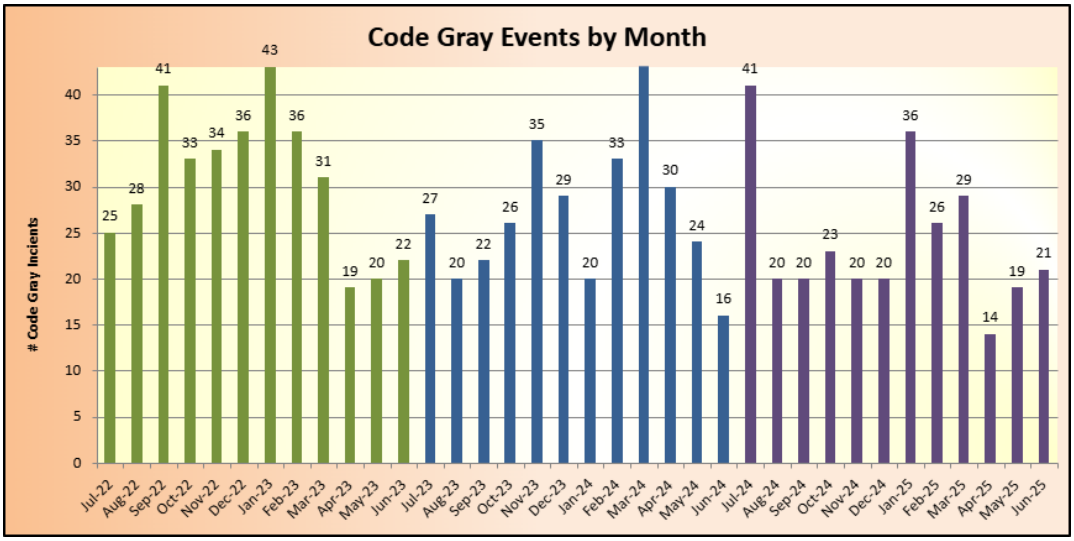
1. A significant increase in the number of WPV events related to dementia or delirium patients (Total =25).
2. A significant increase in the number of WPV events related to behavioral health patients (Total=20).



Note – A focus on managing our dementia related patient population and our behavioral health patient population will occur in FY 26.

Code Gray Responses:

Code Gray responses decreased (12%) in both MV and LG. The total number of incidents in FY25 was 289 compared to 327 in FY24. The decrease in code greys is largely due to the expansion of the CALM (Collaborative Aid through Listening and Motivation) team in M.V. and the expansion of the portable panic button program in Los Gatos in FY 25.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- **MV Emergency Dept. (ED) – 42%**
- **MV Medical Unit (4A)- 13%**
- **MV Medical Unit (3C) – 8%**

Responses are tracked through the Code Gray security shift report form and evaluated to help identify possible improvements to the process.

A. Security Incidents

There was a total of 596 reported security related incidents for FY25 requiring a security response. This is a slight increase from FY24 of 563.

B. Bulletins, Alerts & Presentations

Security Services issued seven personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 7,200 chain-of-custody transactions involving patient's belongings in FY 25. This was a significant increase over FY 24 due to a higher patient census in our behavioral health unit and the inpatient hospital units.

D. Fire Drills / Fire Watches

Security Officers conducted 105 fire drills, and 12 fire watches in FY25. There was a 50 % Increase in the number of fire watches in FY 25 due to ongoing construction related activities at both campuses.

E. ID Badges

Security Badging Services issued approximately 3,800 El Camino Health badges in FY 25, which was an increase of approximately 350 Photo ID Badges (mostly related to students and the expansion of the health network. This provides access and barcoding technology to staff, physicians, auxiliary, contractors, and students. Additionally, in FY 25 approximately 410 temporary badges were issued to staff who forgot, or temporality lost their badges.

F. Investigations & Audits

Security Services performed 180 investigations and audits including, but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

G. Lost and Found

Security Officers performed 780 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

H. Inspections

Security Services performed a total of 85,300 inspections (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks. This as an increase

over FY 24 due to the additions of eyewash stations, fire extinguishers panic buttons and delayed egress doors.

I. Loitering

Security Officers responded to 357 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: The increase in FY 25 can be attributed to one patient/individual having multiple incidents who required time and assistance leaving hospital property.

J. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 120 vehicle-related services including jump-starts, door unlocks and tows. 1,560 parking citations and warnings were issued to vehicles on the Mountain View and Los Gatos campuses. There was a significant increase in parking warning notices for employees parking in our adjacent neighborhoods at both campuses.

K. Police Activity

Law enforcement agencies were on-site 132 times in response to requests for assistance, urgent calls and for investigative activities. This is a slight decrease from FY 24 of 141.

Effectiveness:

Key performance indicators were identified in FY25 to improve Security Management within the Environment of Care.

FY25 Goals

1. 5% reduction in number of reportable workplace violence incidents-There were 60 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 25. This is a 33 % increase from FY24. **This goal was not met.**

2. 10 % reduction in the number of Code Greys over FY 2024. In FY 25 there were a total of 289 code greys. This is a 12% reduction in the number of code greys over FY 24. **This goal was met.**

EC 3.0 - Hazardous Materials & Waste Management

Work Group Chair: ***Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Health. The work group chair serves as the central contact point for the reporting and documentation for the work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

B. Hazardous Material Incidents

The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

Recordable Hazardous Material Incidents:

5) **7-10-24 Peridox 30 ml** – Inpatient Pharmacy, Mountain View - Overflow from controlled substances container after expired Peridox disinfectant was disposed of in the container. A knowledge Gap was identified and education for Pharmacy staff was provided for proper disposal at the point of origin. Education for staff to dispose of in appropriate RCRA containers. Signs placed near controlled substances bin for clarity for disposing material. Cleanup was handled safely, and no staff injuries were reported.

6) **10-10-24 Methotrexate ¼ cc spill – CT 3,** Mountain View – A Doctor spilled Methotrexate during a procedure with a patient. A knowledge Gap was identified with imaging staff on proper spill response. Completed spill response training to high-risk departments on10-25-24 is in Los Gatos and 11-1-24 in Mountain View. Cleanup was handled safely, and no staff injuries were reported.

7) **11-6-24 Fluorouracil 15-20 ml spill –** 4B Room 4208, Mountain View – While administering Fluorouracil to a patient the equipment disconnected from the patient causing the spill. An opportunity was identified to re-educate staff to ensure all connections are secure prior to administration of Fluorouracil. Education was provided for staff to double-check all connections prior to administration. Cleanup was handled safely, and no staff injuries were reported.

8) **12-4-24 Formalin 100 ml spill –** Willow OR 5, Mountain View – One formalin container was found tipped on its side which had caused the formalin to spill out into the secondary container basin. A knowledge Gap was identified with Willow Outpatient Surgery staff on spill response procedures. Spill response training with Willow OR staff was completed on 3-21-25. Cleanup was handled safely, and no staff injuries were reported.

Note- There was a 33% decrease in the number of recordable spills in FY 25 over FY 24. In FY 24 there were six recordable spills compared to 4 in FY 25. This was largely due to additional spill response training for high-risk departments.

- **Reportable Hazardous Material Incidents** – There were no reportable spills in FY 25.

C. Waste Water Discharge Violations:

- There were no wastewater discharge violations in FY 25.

D. Monitoring and Inspections

- **Hazardous Waste Inspections** – There were no external hazardous materials or waste inspections in FY 25.
- **Santa Clara County Annual Medical Waste Inspections** – There were no medical waste inspections in FY 25.
    - **In FY 25 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation, handling and spill response compliance:**
    - Annual Waste Management education for staff
    - Daily rounds by EVS supervisors
    - Monthly Safety Rounds that include observation of waste segregation practices
    - Quarterly Surveys of medical waste/sharps by Stericycle and Clean harbors Compliance Coordinator with targeted education on nursing units addressed toward survey findings.
    - Confirmed contractual agreement with All Clean to assist with Code Orange Response process and procedures as needed.
    - Regular **Hazardous Materials Work Group** Meetings with the goal for discussion with high-risk hazardous materials and waste departments.
    - Reviewed and updated all Hazardous waste policies
    - Conducted Spill Response training with high-risk hazardous materials and waste departments on **10-25-24 is in Los Gatos and 11-1-24, 3-21-25 in Mountain View**
    - Organization standardized chemo, formalin and universal spill kits to be used by high-risk hazardous materials and waste departments.
    - Conducted Unannounced solid waste assessments in Los Gatos 2-6-25 and in Mountain 2-7-25 in high-risk departments. All identified gaps found during the waste assessment are being addressed and training for those affected departments is being completed.

E. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly at the Central Safety Committee.

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, staff from all areas

represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[2] training course.

Key indicators were targeted to establish goals for FY-25. The following goals presented opportunities to improve hazardous materials & waste management.

FY-25 Goals:

3. Staff knowledge on the length of time you should wash your eyes at an eye wash station after exposure (15 minutes)
    - Measurement of success :> 95%. **This goal was accomplished.**
4. Staff can describe the process of accessing a safety data sheet.
    - Measurement of Success: >95%. This goal was accomplished.

Note- New goals for FY 26 will be created due to the goals being met in FY 25.

EC 4.0 – Fire Life Safety Management

Work Group Chair: John Folk

Scope

The Fire Life Safety Management Plan is designed to assure appropriate, effective response to a fire emergency that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY25.

D. Fire Incidents

There was no fire incidents in Mountain View or Los Gatos in FY25.

E. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated as potential opportunities for improvement.

The total number of events in FY25 (41) was lower than FY24 (47). There were 40 events in Mountain View and 1 in Los Gatos. This decrease was mostly related to better oversight of construction activities at both campuses

[2] HAZWOPER: Hazardous Waste Operations and Emergency Response

C. Fire Drills Completed / Scheduled

All required fire drills were completed in FY25. All opportunities for improvement are corrected on the spot, through facility work orders or with further education by the dept. Manager.

F. Effectiveness

Based on opportunities for improvement identified in the FY24 annual EOC evaluation the FY 45 performance improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met= 93%
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met=92 %
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met=96 %

Note: We will choose all new indicators for FY25 due to staff performance in FY25.

EC 5.0 - Medical Equipment Management

Work Group Chair: ***Jeff Hayes***

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-25.

D. Reports to the FDA –

There were **18** reports through the Medwatch[3] system in FY-25. There was no patient deaths associated with any of the reports.

E. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet with compliance for the target of 95% completion within the month due in all areas.

- The Clinical Engineering department achieved an **89% maintenance completion rate** for FY25, reflecting a **4% decrease** compared to FY24. Despite this decline, **100% of devices were actively managed** through a structured communication process aimed at locating and servicing each asset. This managed approach improved the completion rate to **95%**.
- However, **4% of the total inventory (14,376 medical devices)** could not be located for scheduled maintenance, representing the primary barrier to achieving full completion.
- All high-risk, life safety equipment was maintained at a **97.90% completion rate**. Through a structured communication process designed to locate and service all devices, maintenance activities were **100% managed**. This proactive approach increased the overall completion rate to **99.32%**.

[3] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

- Despite these improvements, certain devices—**external pacemakers, ventilators, and blood warmers**—remained challenging to locate consistently, preventing full completion of maintenance for those items.

F. Product Recalls Percentage Closed / Received

For FY-25, there were 532 recorded equipment recalls: 99% are completed and 100% managed

Effectiveness:

FY25 Performance Indicators

In FY 25 the performance improvement process focused on Asset Management and Asset Recalls.

- Enhance the efficiency and accuracy of our DICOM (Digital Imaging and Communications in Medicine) systems across the enterprise. By focusing on these areas, we aim to enhance the overall efficiency, accuracy, and compliance of our DICOM systems, ultimately improving patient care and operational effectiveness. Achieve 80% compliance and accuracy of all modalities (157) data sending, receiving and documented.

Results:

- This goal was successfully achieved with **100% validation by the Director or Imagining**. The initiative resulted in **80% compliance and accuracy** across all 157 imaging modalities, ensuring reliable data sending, receiving, and documentation. The improvements significantly strengthened enterprise-wide DICOM system performance and alignment with clinical and operational standards.
- Reduce open ECRI recall/alerts to 100% managed. Alerts being managed is defined by each alert/recall that has been addressed and closed. Any work orders left open are only due to the manufacture of corrective action plans that have not been developed or can execute to remediate the alert/recall.

Results:

- Goal successfully met. By the end of the fiscal year, the Clinical Engineering department had reduced open ECRI recalls/alerts to three, all of which were 100% managed. Each had corresponding open work orders for affected devices, with resolution pending manufacturer action plans.

EC 6.0 - Utilities Management

Work Group Chair: John Thompson

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-25.

D. Utility Reportable Incidents

There were four incidents in FY-25. All were electrical outages or voltage fluctuations.

- Los Gatos had a PG&E voltage fluctuation on January 5, 2025, at 1:25 a.m. to the Main Hospital recorded on our Building Management System. PG&E was notified, and they could not detect any outages/disturbances fluctuations and there was no patient safety impact related to this event. On March 12, 2025, there was a loss of electrical power to the Los Gatos Main Hospital due to a PG&E outage from 12:26 p.m. to 5 p.m. due to a squirrel blowing up a fuse requiring PG&E to shut down the circuit for repairs. The emergency generators ran and functioned as designed and there was no impact on patient safety.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on 11/19/24 & 3/12/25. There were system disruptions, hospital emergency generators ran and functioned properly.

E. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was 95%, meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

F. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

Effectiveness

Key indicators were targeted to establish goals. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**>90% Goal was not met 86%**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**>90 % Goal was met=92 %**

Note: Data is collected through fire drills and environment of care rounds.

EC 7.0 – Emergency Management

Work Group Chair: Bryan Plett

Scope

El Camino Health's Emergency Operations Plan (EOP) addresses all non-fire-related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee is responsible for ensuring an effective response to these emergencies. The hospital collaborates with state and local emergency management organizations to coordinate community planning and response efforts. Although Emergency Management is a distinct chapter under The Joint Commission, annual reporting is integrated with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant events are presented to the Central Safety Committee for review. For FY25, the following Emergency Management indicators were noted:

E. Activation of the Hospital Incident Command System (HICS)

There were two (2) recorded events and/or emergencies during FY25 requiring the activation of HICS and opening of the Hospital Command Center (HCC).

- 09/13/2024 – At approximately 1223 hours, El Camino Health Mountain View experienced a power outage due to a tree branch falling on a local power line. The generators activated as designed. HICS was activated and the Hospital Command Center was opened. This incident involved an elevator entrapment which was quickly resolved. All other outstanding issues were mitigated and the hospital returned to normal operations at approximately 1344 hours.

- 03/12/2025 – At approximately 1230 hours, El Camino Health Los Gatos experienced a power outage. HICS was activated and the Hospital Command Center was opened. Numerous issues were mitigated and the situation resolved at approximately 1700 hours.

F. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY25, this was met through separate planned exercises at both campuses (see below). The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

- 01/07/2025 – El Camino Health Enterprise hosted a Mass Casualty Incident Tabletop exercise. The scenario consisted of a large-scale community incident that involved 113 simulated patients transported to El Camino Health. The target objectives of the exercise were Communications (TJC EM.02.02.01), Safety and Security (TJC EM.02.02.05), Patient and Clinical Support Activities (TJC EM.02.02.07), and Command Management (TJC EM.01.01.01).

- 01/08/2025 – El Camino Health Office of Emergency Management facilitated a Code Pink (infant abduction) drill in the Mountain View Orchard Pavilion. The scenario involved an infant abduction originating from the Mother Baby Unit on the 3rd floor. The actor was intercepted by security on the first floor attempting to leave the building. The target objectives of the exercise were Communications (TJC EM.02.02.01), Safety and Security (TJC EM.02.02.05), and Staff Responsibility (TJC EM.02.02.07).

- 01/09/2025 – El Camino Health Office of Emergency Management facilitated a Code Pink (infant abduction) drill in the Los Gatos ECH Women's Hospital. The scenario involved an infant abduction originating from the Mother Baby Unit. The actor was intercepted by security attempting to leave the building. The target objectives of the exercise were Communications (TJC EM.02.02.01), Safety and Security (TJC EM.02.02.05), and Staff Responsibility (TJC EM.02.02.07).

G. Emergency Management Training

- New Hire and New Manager Orientation: Emergency management training was provided for all incoming new staff members.
- Safety Coordinator Meetings: Held both in-person and via Zoom, consisting of various aspects of emergency management-related training.
- CHA Disaster Preparedness Conference: The annual conference, hosted by the California Hospital Association in September, was well attended by El Camino Health representatives. This year's conference was held in September.
- 11/4/2024 – The El Camino Health Office of Emergency Management hosted Mary Massey, Vice President of Emergency Management, at the California Hospital Association to facilitate Hospital Command Center training for identified leaders. 29 El Camino Health leaders were certified in ICS 100, ICS 200, and ICS 700.

H. Community Involvement

El Camino Hospital remains actively involved in the Santa Clara County Hospital Emergency Preparedness Program (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). El Camino Health currently hosts the SCCHEPP meeting at the Mountain View campus and the meeting is chaired by El Camino Health Manager of Emergency Management. The SCCHEPP group meets monthly with representatives from all county hospitals and EMS to develop a collaborative emergency response and disaster plan. Additionally, the group organizes county-wide disaster exercises in which the hospital actively participates.

The EPHC extends similar emergency preparedness initiatives to all healthcare facilities in the county, including clinics and skilled-nursing facilities. The group meets quarterly to share information and provide training.

The Hospital conducts an annual Hazard Vulnerability Assessment (HVA) to evaluate the risk of various emergency situations. Separate HVAs are performed for the Los Gatos and Mountain View campuses to account for site-specific differences. Efforts are then directed towards mitigating the highest risks identified for the fiscal year.

- There were minimal changes to the top five HVAs at both campuses in FY25 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(6) Earthquake	**(6) Earthquake**
(7) Mass Casualty	**(7) Mass Casualty**
(8) Utility Failure	**(8) Utility Failure**
(9) Patient Surge	**(9) Patient Surge**
(10) Unplanned Power Outage	**(10) Unplanned Power Outage**

I. Effectiveness

Key indicators were targeted to establish goals for FY25. The following goals presented opportunities to improve emergency management.

FY25 Goals

3. Establish and Maintain a Fully Stocked Mobile Command Center
   Objective: Ensure the hospital can sustain operations during facility disruptions by deploying a mobile, fully equipped command center.
   - **Measurement of Success**
   - Procure, stock, and maintain an operational mobile command center.
   - Draft and maintain an inventory checklist consisting of required critical supplies and keep stocked at all times.
   - **This *goal was accomplished.***
   - Mobile Command Center van was procured.
   - Van stocked with essential items electronics to maintain open lines of communication during incidents.

4. Strengthen Staff Readiness Through Comprehensive Emergency Training
   Objective: Improve hospital-wide emergency response capability by ensuring all relevant staff are trained and proficient in incident command procedures.
   - **Measurement of Success**
   - Train Incident Response Team members in the critical aspect of the Hospital Incident Command System.
   - Certify the Incident Response Team in ICS 100, ICS 200, and ICS 700.
   - **This *goal was accomplished.***
   - Partnered with Santa Clara County EMS to provide inter agency coordinated drills and exercises.
   - Hosted a class for the Incident Command Team resulting in the ICS 100, ICS 200, and ICS 700 certifications for 29 members.

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: November 3, 2025
Subject: Enterprise Quality, Safety, and Experience and STEEEP Dashboards through September 2025

Purpose:

To provide the Quality, Patient Care, and Patient Experience Committee with an update on quality, safety, and patient experience performance through September 2025 (unless otherwise noted). This memo summarizes results from both the STEEEP and Enterprise Quality Dashboards for FY 26 YTD.

Summary:

The FY 26 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:

A. Safe Care

1. **C. Difficile Infection:** There have been 5(1.66 cases per month) (Goal: </= 27 infections FY 2026 or less than 2.25 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 are on track for this measure. 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.)

2. **Catheter Associated Urinary Tract Infection (CAUTI):** There have been 1 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).

3. **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)

4. **Surgical Site Infection**. The number of cases/month of surgical site infections for FY 26 (8) 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)

5. **Hand Hygiene Combined Compliance rate:** Performance for YTD FY2026 is favorable (84.5%) 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)

6. **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 (70.9%) 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. Management has decided to change the vendor for radiology services. The new radiology group is expected to start on January 1 2026. (Timeline for improvement: Realistically, we anticipate improvement in the Turnaround times by Q3 2026)

C. Effective

1. **30 Day Readmission Observed Rate:** Performance YTD through August of 26 (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 two months of data, the latest month shows a decrease in the readmission rate. However, we are confident we will continue to maintain our FY 25 trend)

2. **Risk Adjusted Mortality Index.** Performance YTD FY26 (1.18) 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 month (0.99) has been positive for this index.)

3. **Sepsis Mortality Index.** Performance through FY2026 (1.29) 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 live since September 2026. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation.)

4. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. FY26 performance through July of 2025 (20.9%) is favorable 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 is one month of data. 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 FY26 is (0.99) is favorable to 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 three 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 are on track to meet this target; however, this metric, along with the readmission rate, will continue to be closely monitored to ensure sustained performance).

2. **Median Time from ED Arrival to ED Departure (Enterprise).** Performance YTD FY26 (154 minutes) is favorable to the target of < 159 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 26 performance YTD is (88.6%) is favorable to target of 70%. 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. (Timeline for improvement: We are on track to meet this target)

2. **Homeless Planning Discharge Compliance Rate:** New measure for FY26. FY 26 YTD is (71%) is unfavorable to target of 77%. This measure was chosen because of new CMS regulations on monitoring our efforts on homeless discharge compliance rates. (Timeline for improvement: This is a new measure. We will monitor this and improvement efforts include hardwiring tools in the EMR to capture and document the compliance rate).

F. Patient Centered:

1. **FY26 Performance Highlights** (July 2025 through September 2025's performance)

Domain	National Percentile	California Percentile	Bay Area Percentile
Inpatient (HCAHPS)	**83rd**	**75th**	**82nd**
Medical Network (ECHMN)	**44th**	**56th**	**38th**

El Camino Health continues to advance its strategic goal of achieving and sustaining patient experience performance at or above the 80th percentile for HCAHPS, while demonstrating significant improvement within the Medical Network, which is now performing above its FY26 national target (29th percentile). As of September 2025, the Medical Network reached the 55th percentile nationally, reflecting steady progress and the impact of focused improvement initiatives across our clinics and urgent cares.

Across the enterprise, inpatient results are trending positively at 83.9% year-to-date, exceeding the annual target of 83.4%, with strong performance in Maternal Child Health, Oncology, and Emergency Departments. The Medical Network is also showing strong momentum, achieving 85.9% year-to-date, above its target of 83.2%, and reflecting continued progress toward systemwide consistency.

To strengthen alignment and systemwide ownership, the Patient Experience Action Team (PEAT) officially launched on September 29, 2025, establishing a multidisciplinary governance structure that integrates acute care, ambulatory, and medical network leaders.

PEAT serves as the central mechanism for identifying performance drivers, defining best practices, and sustaining improvements through a closed-loop feedback process.

2. **Fiscal Year 2026 Patient Experience Focus Areas**
    - **Patient Experience Action Team (PEAT):** Multi-disciplinary oversight body deployed on September 29, 2025.
    - **PX Playbook**: Standardized guide for leaders and staff (in progress; deployment Q3 FY26).
    - **Patient & Family Advisory Groups**: Re-established to amplify patient voice (in progress; deployment Q3 FY26).
    - **Refresher Training**: WeCare and service-recovery refresher for all employees (in progress; deployment Q3 FY26).
    - **PX Reporting**: Development of comprehensive, system-level dashboards and reports (in progress; deployment Q3 FY26).
    - **Physician Partnership Program**: Deepening provider engagement in patient experience improvement (in progress; deployment Q4 FY26).

Attachments:

1. Enterprise Quality Dashboard through September of 2026
2. STEEEP Dashboard through September 2026

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

Month to Board Quality Committee : Nov 2025

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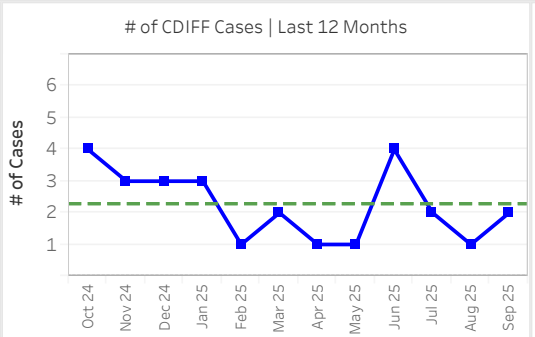
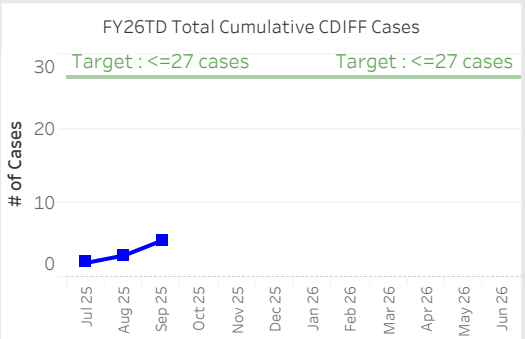
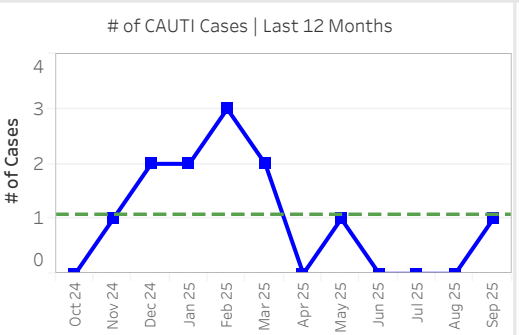
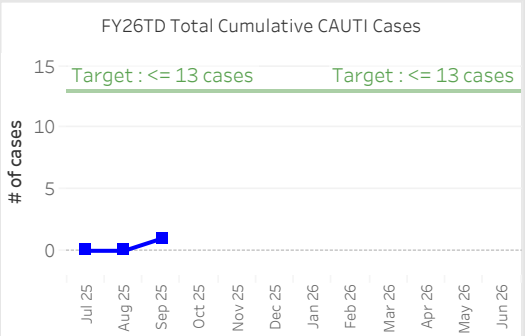
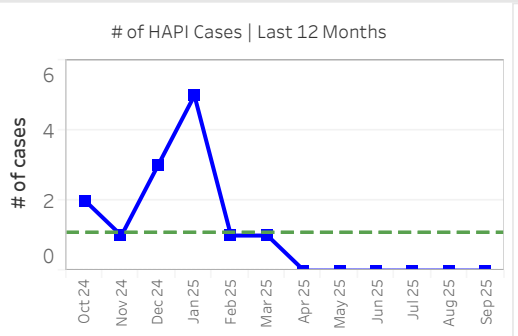
Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases Latest Month : September 2025	2 cases	Total FY26 5 cases 1.67 cases/mo	Total FY25 28 cases 2.33 cases/mo	Total FY26 Target <= 27 cases 2.25 cases/mo	BETTER	# of CDIFF Cases | Last 12 Months BETTER
*Organizational Goal Catheter Associated Urinary Tract Infection (CAUTI) cases Latest Month : September 2025	1 cases	Total FY26 1 case 0.33 cases/mo	Total FY25 14 cases 1.17 cases/mo	Total FY26 Target <= 13 cases 1.08 cases/mo	BETTER	# of CAUTI Cases | Last 12 Months BETTER
*Organizational Goal Hospital Acquired Pressure Injury (HAPI) cases Latest Month : September 2025	0 cases	Total FY26 0 case 0.00 cases/mo	Total FY25 14 cases 1.17 cases/mo	Total FY26 Target <= 13 cases 1.08 cases/mo	BETTER	# of HAPI Cases | Last 12 Months BETTER

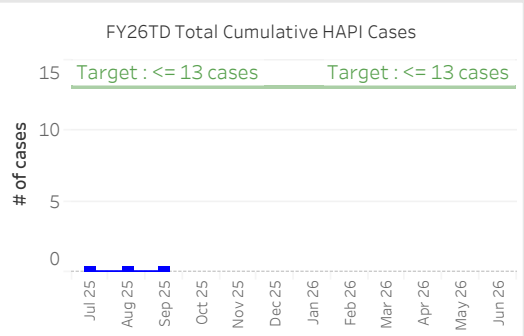












Quality Department | Note : updated as of October 14, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

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

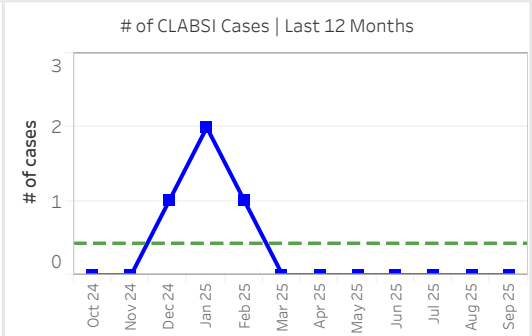
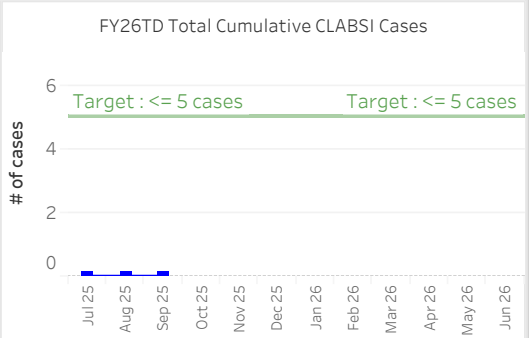
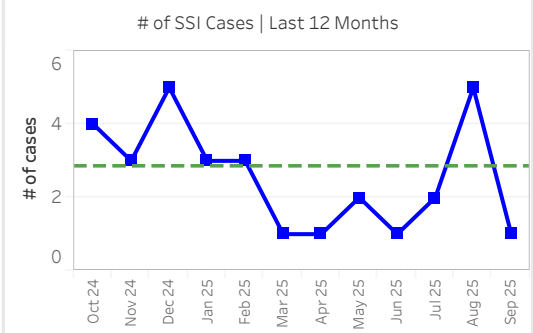
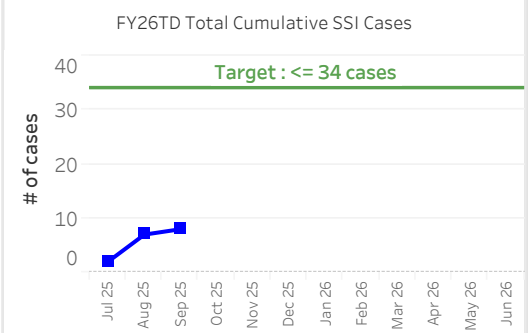
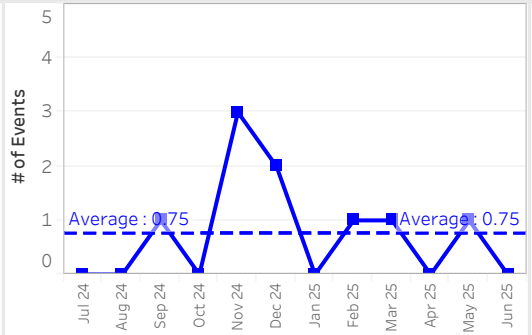
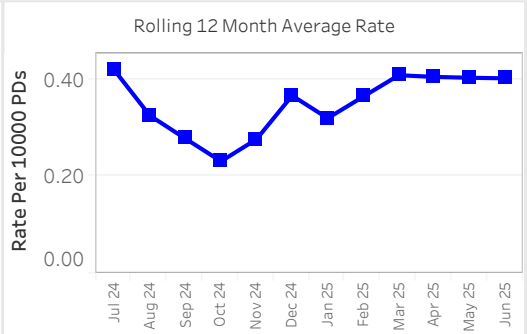
Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal Clostridium Difficile Infections (C-Diff) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
*Organizational Goal Catheter Associated 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	Stage 3 & 4 & Unstageable HAPIs	**Epic Report** (ECH Pressure Injuries - By Department (RWSQL) with manual chart reviews

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

Month to Board Quality Committee : Nov 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 : Sept 2025	0 cases	0.00 cases/mo	Total FY25 4 cases 0.33 cases/mo	Total FY26 Target <= 5 cases 0.42 cases/mo		
Surgical Site Infections (SSI) cases Latest Month : Sept 2025	1 cases	2.67 cases/mo	Total FY25 38 cases 3.17 cases/mo	Total FY26 Target <= 34 cases 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		

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

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

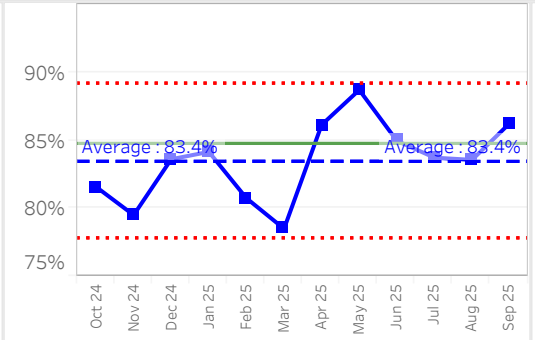
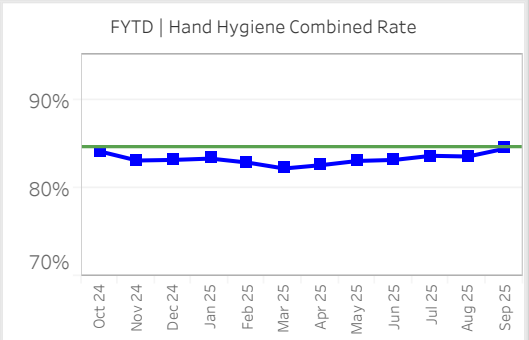
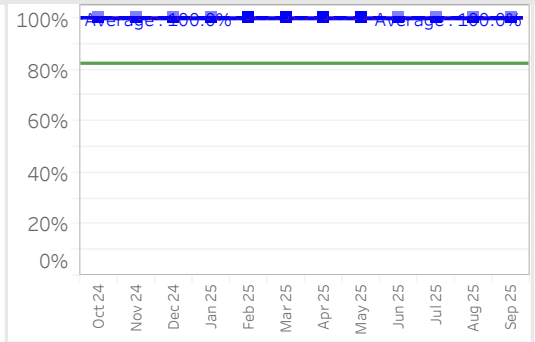
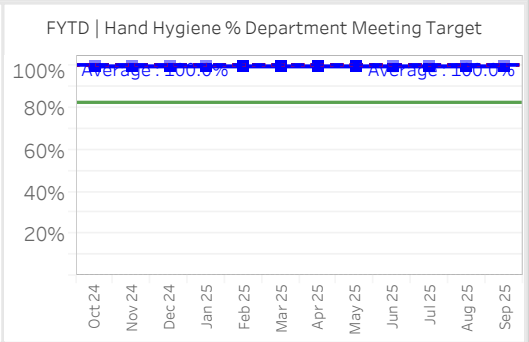
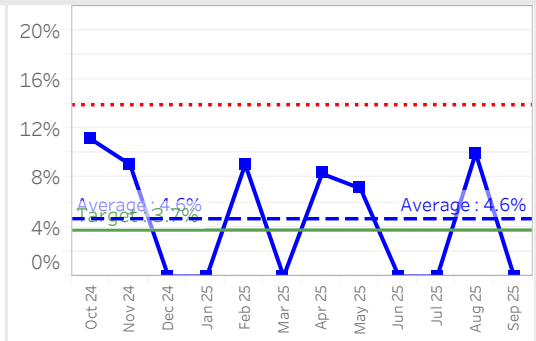
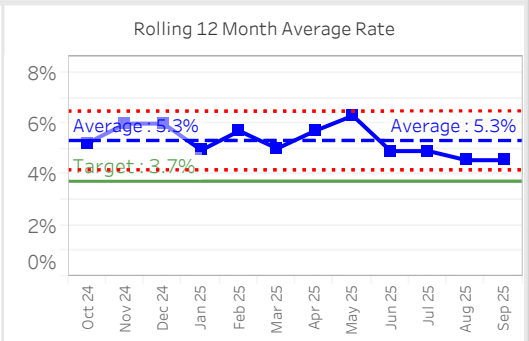
Measure	Definition Owner	Metric Definition	Data Source
Central Line Associated Blood Stream Infection (CLABSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Surgical Site Infections (SSI) cases	C. Nalesnik	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

Sept 2025 (unless other specified)

Month to Board Quality Committee : Nov 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 : Sept 2025	86.2% (9209 / 10679)	84.5% (26282 / 31094)	83.2% (171444 / 205958)	>=84% (1% improve of FY25)		
Hand Hygiene % of Departments Meeting Target Latest Month : Sept 2025	100.0% (25 / 25)	100.0% (75 / 75)	100.0% (300 / 300)	80% of units		
Complications - Inpatient Hip & Knee Observed Rate (within 90 days of procedure) Latest Month : Sept 2025	0.0% (0 / 5)	4.8% (1 / 21)	4.8% (6 / 126)	<= 4.3% (10% reduction of FY25)		

Quality Department | Note : updated as of October 14, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 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 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

Sept 2025 (unless other specified)

Month to Board Quality Committee : Oct 2025

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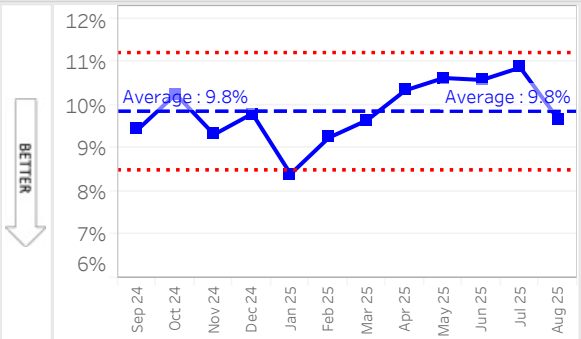
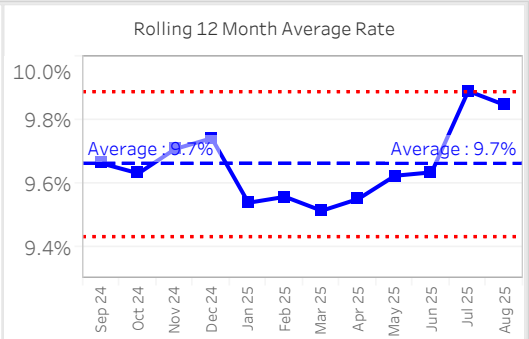
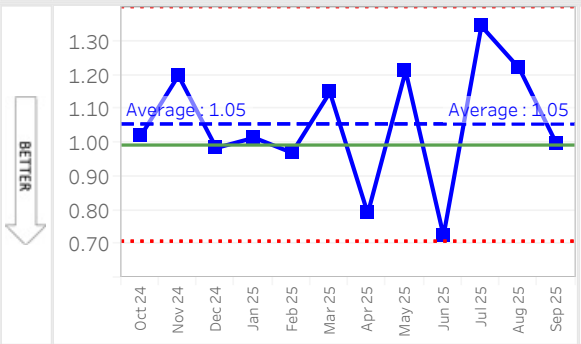
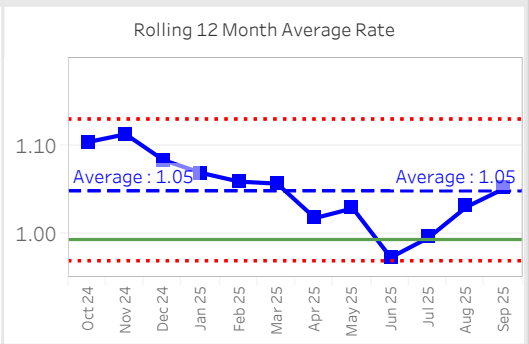
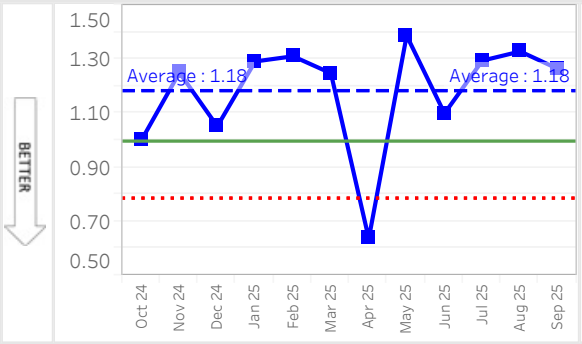
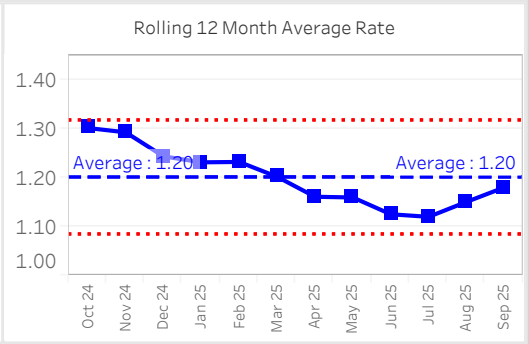
Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
30-Day Readmission Observed Rate Vizient Risk Model Latest Month : August 2025	9.7% (125 / 1294)	10.3% (272 / 2647)	9.6% (1568 / 16268)	<= 9.8%		
Mortality Index Observed / Expected Vizient Risk Model Latest Month : September 2025	0.99 (2.24% / 2.26%)	1.18 (2.38% / 2.01%)	0.98 (2.22% / 2.28%)	<= 0.97		
Sepsis Mortality Index Observed / Expected Vizient Risk Model Latest Month : September 2025	1.26 (12.14% / 9.61%)	1.29 (12.33% / 9.52%)	1.07 (10.63% / 9.98%)	<= 1.00		

Quality Department | Note : updated as of October 14, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

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

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

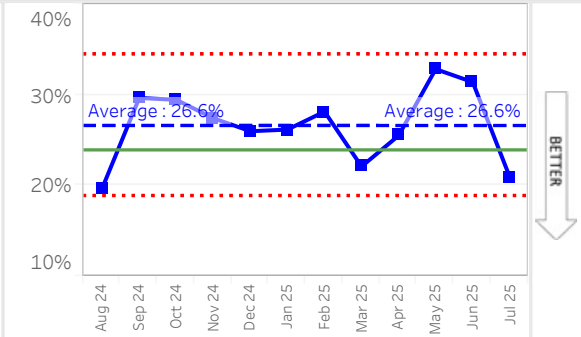
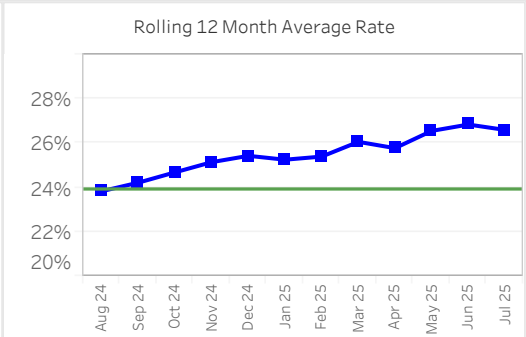
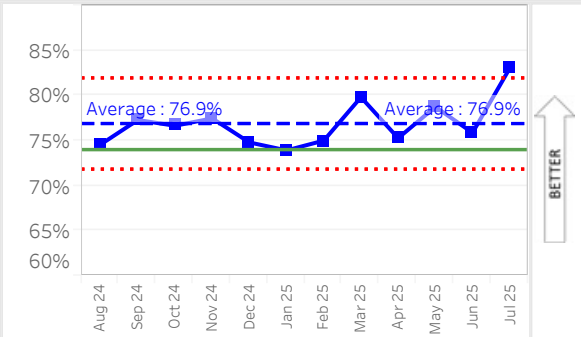
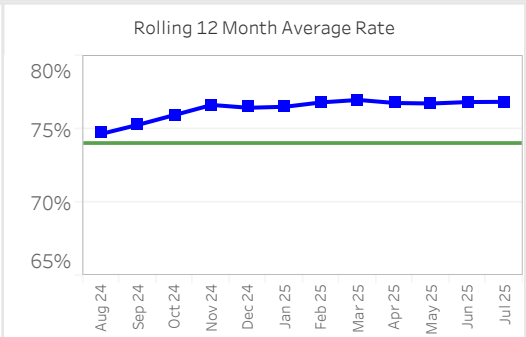
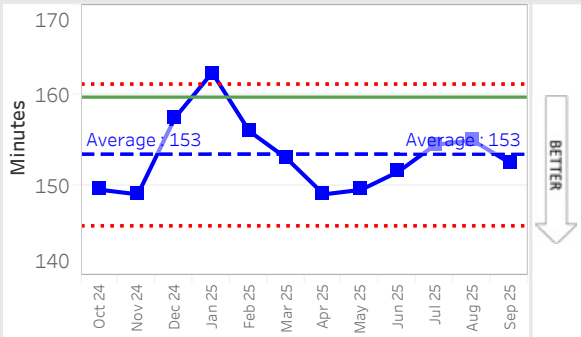
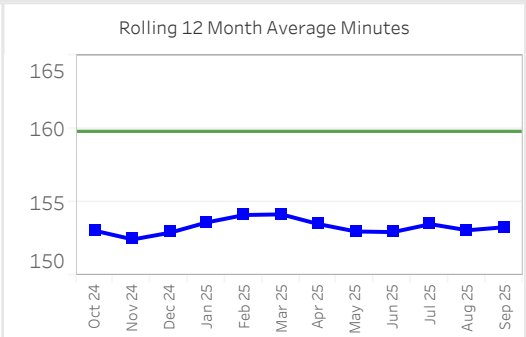
El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

Month to Board Quality Committee : Nov 2025

page 5/6

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 21.6% (37 / 171)	MV : 21.6% (37 / 171)	MV : 27.6% (516 / 1870)	23.9% (FY26 ENT Target)		
	LG : 16.0% (4 / 25)	LG : 16.0% (4 / 25)	LG : 19.4% (62 / 320)			
Latest Month : July 2025	ENT : 20.9% (41 / 196)	ENT : 20.9% (41 / 196)	ENT : 26.4% (578 / 2190)			
PC-05 : Exclusive Breast Milk Feeding	MV : 82.0% (269 / 328)	MV : 82.0% (269 / 328)	MV : 58.1% (1998 / 3437)	74.0% (FY26 ENT & MV Target) 84.0% (FY26 LG Target)		
	LG : 89.1% (49 / 55)	LG : 89.1% (49 / 55)	LG : 68.4% (428 / 626)			
Latest Month : July 2025	ENT : 83.0% (318 / 383)	ENT : 83.0% (318 / 383)	ENT : 59.7% (2426 / 4063)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	MV : 167 mins	MV : 168 mins	MV : 169 mins	FY26 Goals = MV ED = 178 min LG ED = 140 min ENT = 159 min		
	LG : 138 mins	LG : 140 mins	LG : 137 mins			
Latest Month : September 2025	ENT : 153 mins	ENT : 154 mins	ENT : 153 mins			

Quality Department | Note : updated as of October 14, 2025

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

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

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**

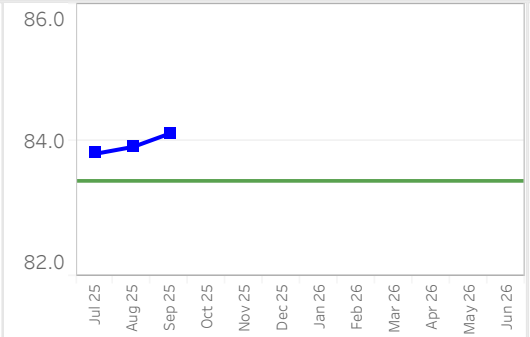
El Camino Health

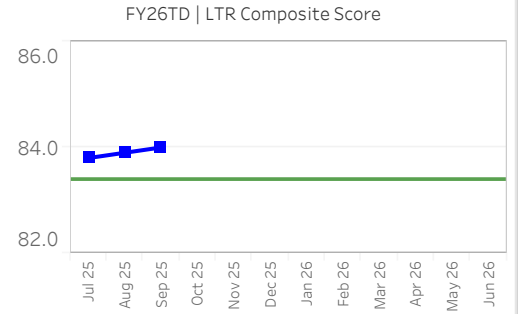
FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

Month to Board Quality Committee : Nov 2025

Measure	FY26 Performance		Baseline FY25 Actual	FY26 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
LTR Composite Score Latest Month : September 2025	83.9	84.0	83.4	>= 83.4	BETTER	BETTER





Quality Department | Note : updated as of October 14, 2025

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FY26 Enterprise Quality, Safety and Experience Dashboard

Sept 2025 (unless other specified)

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

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 Health Quality Board: FYTD26 STEEEP

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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	5	28	**5**		<= 27 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	3	7	1	1	14	**1**		<=13 cases	Lower is Better
HAPI (Stage 3, 4 & Unstageable)	6	7	0	0	14	**0**		<= 13 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	8	38	**8**		<=34 cases	Lower is Better
Hand Hygiene Audit Compliance (Leapfrog measure)	81.5%	80.9%	86.6%	84.5%	83.2%	**84.5%**		>=84%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	69.4%	77.7%	76.9%	70.9%	73.9%	**70.9%**		>=84.0%	Higher is Better
Effective									
30-Day Readmission Rate (Based on Vizient Risk Model)	9.8%	9.1%	10.5%	10.3%	9.6%	**10.3%**		<=9.8%	Lower is Better
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.06	1.04	0.91	1.18	0.98	**1.18**		<= 0.97	Lower is Better
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.10	1.28	1.04	1.30	1.07	**1.29**		<= 1.00	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	27.5%	25.4%	29.8%	20.9%	26.8%	**20.9%**		<=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	**0.99**		<=1.00	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	152	154	153	154	152	**154**		<=159 min	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate	21.0%	82.6%	87.8%	88.6%	41.3%	**88.6%**		>=70%	Higher is Better
Homeless Planning Discharge Compliance Rate	73.5%	76.5%	75.1%	71.0%	73.6%	**71.0%**		>=77.0%	Higher is Better
Patient-Centered									
LTR Composite Score Press Ganey				84.0	83.4	**84.0**		>=83.4	Higher is Better

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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
Date: November 3, 2025
Subject: Elevating Quality at El Camino Health: Harnessing Vizient CDB for National Benchmarking

Purpose:

To inform the Board Quality, Patient Care, and Patient Experience Committee about the adoption and strategic use of the Vizient Clinical Data Base (CDB) for quality benchmarking, performance improvement, and national ranking.

Summary:

Vizient CDB is a comprehensive benchmarking tool leveraging clinical outcomes and resource utilization data from over 1,300 hospitals nationwide. It enables El Camino Health (ECH) to compare key quality metrics, including mortality, readmissions, safety, patient experience, and efficiency (length of stay) against peer organizations in real time, overcoming the limitations of outdated public data.

Key Features:

- **Timely Data:** Access to comparative data within weeks of submission (vs. 2+ years lag in public datasets).
- **Risk Adjustment:** Ensures fair comparisons by accounting for patient complexity, demographics, and case mix.
- **Comprehensive Metrics:** Six domains: safety, mortality, effectiveness, patient-centeredness, efficiency, and variation in care.
- **Annual Scorecard:** Released each September (July–June data); quarterly calculators track ongoing performance and predict annual results.
- **Actionable Insights:** Identifies clinical practice variation and highlights opportunities for targeted improvement.

Attachments:

1. Vizient Clinical Data Base Presentation

Vizient Clinical Data Base (CDB)

Elevating Quality at El Camino Health: Harnessing Vizient CDB for National Benchmarking

Shreyas Mallur M.D, MBA – Chief Quality Officer (CQO)

Steven Sun – Dir of Quality Analytics

Lyn Garrett – Senior Quality Director

11/03/2025

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Vizient Clinical Data Base (CDB)

MEMBER HOSPITALS	Over 1,300 Hospitals in Database
	• 126 Hospitals in CA
	• Notable Local Hospitals
	  ○ Sutter Health
	  ▪ Mills-Peninsula, CPMC, Eden, Alta Bates Summit, Santa Cruz Maternity, plus other 20 other Sutter Affiliates throughout Northern CA
	  ○ Stanford
	  ○ UCSF + all other UC Hospitals
	  ○ SF General/Zuckerberg

BENCHMARK	• **Transparent Benchmarking** (view performance by hospital names) • Customizable comparison (example Bay Area Hospitals)
NETWORK / COLLABORATION	Networking and collaboration module are included as a package • Network and connect with other member networks to facilitate performance improvement (**PI Collaborative**)
RISK ADJUSTED METHODOLOGY	Transparent Risk-adjusted methodology

What is Vizient CDB?

- Leverages clinical outcomes data and resource utilization data

- Provide transparent and comprehensive comparative analysis
  - Enable members to **benchmark** against peer organizations and track performance trends
  - identify **clinical practice variation** and highlight **opportunities for improvement**

- Compare key metrics:
  - **Mortality, Readmissions, Safety, Patient Experience, and Efficiency (LOS)**

- Employs Risk Adjustment models for comparisons with “similar” facilities
  - Academic Medical Centers
  - Complex Care Medical Centers
  - Community Hospitals

Quality and Accountability 2025 cohort criteria

Comprehensive academic medical centers

Perform annually:

- ≥ 125 combined neurosurgery and cardiothoracic surgery cases
- ≥ 25 solid organ transplants

and either:

- ≥ 600 trauma cases
- ≥ 1,500 acute transfers in from another acute care facility

Large, specialized complex care medical centers

Perform annually:

- ≥ 75 combined cardiothoracic and neurosurgery cases

and either:

- ≥ 25 solid organ transplants
- ≥ 600 trauma cases
- ≥ 1,500 acute transfers in from another acute facility

Complex care medical centers

- Do not meet criteria for previous two cohorts
- Perform 25-75 combined neurosurgery and cardiothoracic surgery cases annually

Mountain View or Enterprise (Combined LG & MV)

Community medical centers

- Do not meet criteria for previous three cohorts
- ≥ 450 inpatient surgical cases annually
- Excludes critical access and specialty hospitals

Los Gatos – Community Hospitals

Small community hospitals

- < 450 inpatient surgical cases annually
- Excludes critical access and specialty hospitals

Critical access hospitals

- Meet Medicare Conditions of Participation (42 CFR 485 subpart F)
- No more than 25 inpatient beds
- Average annual length of stay 96 hours

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Vizient Hospital Ranking Quality and Accountability (Q&A) Scorecard

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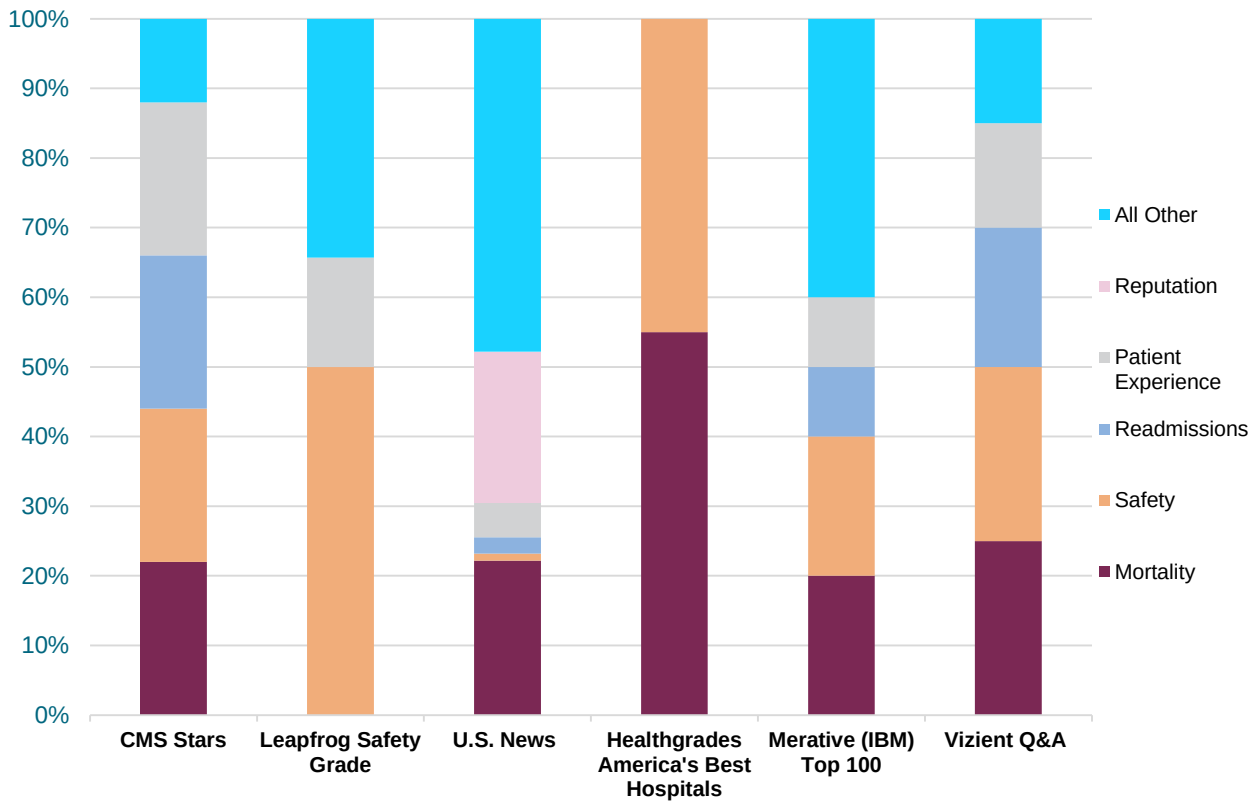
National Rankings



Data Lag	2-5 years	2-4 years	3-5 years	1-3 years	1-3 years	90 days

Vizient Q&A Study	External Ranking Organizations
Designed to inform hospital staff and leaders about their institution	Designed to inform public or healthcare consumers
Offers transparent access to the data at the patient level with detailed risk model information down to the specific factors considered, significance level, and expected values for individual encounters	Offers only aggregate data without detailed explanation of how values were derived, often risk adjustment is done at an aggregate level or for very broad groups
Obtains complete data from hospital members covering all patients	Often only considers Medicare or CMS reported cases
Examines the most recent data available, with quarterly calculators showing trends over time	At least one, often several years, behind current state
Able to link patient level outcomes data to procedures, drugs, and cost data	Does not consider patient level data or non-outcome related data

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Why Use Vizient?

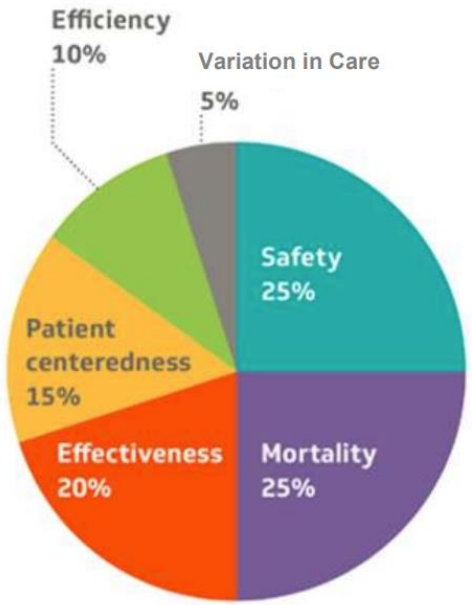
CMS				Other External Reporting Entities			
HAC Reduction Program	Hosp. Read. Reduct. Program (HRRP)	Value Based Purchasing	5 - Star	Top 100 Hospital (Premier / PINCAI)	LeapFrog	Healthgrade	U.S. Newsweek Top Hospitals
HAI - Prior Calendar Year's Performance. PSI 90 - Prior 18 month performance	FY2024 performance based on Jul 2019 - Jun 2022, exclude Q1 and Q2 of 2020 (COVID)	Mortality Metrics - 3 Years ending in June of Prior Year THA/TKA Comp. - 3 Years ending in March of Prior Year All Others - Prior Calendar Year's Performance	Many metrics; data periods range from three years (Cohort Based Metrics) to prior Calendar Year.	MEDPAR FFY 2016-2021, CMS Hospital Compare 2017-2021, Medicare Cost Report 2017-2021	2023 Voluntary Hospital Survey (CPOE, BCMA, IPS, Measurement, Nursing Staff). - HCAHPS (FY2022) - CMS HAC/PSI Indicators (FY2020 to 2022) - HAI (CY2022)	MEDPAR DATA from CMS for years 2020 and 2022: Mortality Based Procedures & Conditions, and In-Hospital Complications-Based Procedures & Conditions	CMS MedPAR Mortality (FY2018 to FY2020) HAI (FY2020) Readmission (2018 to FY2020) HCAHPS (FY2020) CMS Hospital Compare Timely and Effective Care (FY2020)

- **Publicly available data are outdated; most external reports use CMS MEDPAR data from 2022**(most recent available data for public consumption)
- **ECH - two hospitals system (limitation in internal benchmarking due to a smaller sample size)**
  - Vizient allows comparison with over 1,300 hospitals (and growing)
  - Enables patient-level benchmarking by diagnosis, service line, and other attributes
- **Vizient comparative data is available immediately after monthly submission**
  - Example: We have data for other hospitals up to October 2025

Quality and Accountability Mock Dashboard

- Ranks similar hospitals (cohorts) in six domains: safety, mortality, effectiveness, patient-centeredness, efficiency and variation in care
- Annual scorecard is released in September (discharge time frame: July-June).
- Calculators are released to show trends.

Figure 4c: Complex Care cohort domain weighting used for organizational score



Safety 25%
- PSIs: 3, 6, 9, 11, 13
- NHSN: CLABSI, CAUTI, SSI-COLO, SSI-HYST, CDI
- THK complication
- Hypoglycemia in insulin use
- Warfarin elevated INR

Mortality 25%

Mortality O/E ratios for 12 individually scored service lines

Effectiveness 20%

12 individually scored service lines for:
- 30-day all-cause readmission rate
- Excess days rate per 100 admissions

Returns to ED or inpatient after ambulatory procedures for 4 procedure groups

Lab based measures for sepsis lactate and blood transfusion

Patient centeredness 15%

HCAHPS: **12** questions/**8** categories

Efficiency 10%

14 individually scored service lines for:
- LOS O/E ratio (excluding LOS outliers)
- Direct Cost O/E ratio (excluding LOS outliers)

Variation in Care 5%

Differences in gender, race and socioeconomic status in lab measures inpatient performance for Sepsis, CHF, NSTEMI, and obstetric populations on process & outcome measures

Abbreviations: CAUTI = catheter-associated urinary tract infection; CDI = *Clostridium difficile* infection; CHF = congestive heart failure; CLABSI = central line-associated bloodstream infection; COLO = colon surgery; ED = emergency department; HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems; HYST = hysterectomy; LOS = length of stay; O/E = observed-to-expected ratio; NHSN: National Healthcare Safety Network; NSTEMI = non-ST elevation myocardial infarction; PSI = patient safety indicator; SSI = surgical site infection; THK = total hip or knee replacement.

Setting Targets: A Guide

vizient.

Drawing on the experience of clinical leaders and Vizient's expertise, this guide will assist your health system in developing a target-setting methodology that incorporates:

- Historical Performance
- Benchmarks
- Ease of Use
- Different Journeys
- Buy-in

Methodology

%tile Rank vs Q&A Cohort	Target	Distinguished
> **Top Decile**	1% reduction of *baseline* value	Additional 2.5% reduction from target value
Between **Top Decile** & **Top Quartile**	Top decile value or 2% reduction of *baseline* (whichever is greater)	Additional 2.5% reduction from target value
Between **Top Quartile** & **Median**	Top quartile value or 3% reduction of *baseline* (whichever is greater)	Additional 2.5% reduction from target value
Between **Median** & **Bottom Quartile**	Median value or 4% reduction of *baseline* (whichever is greater)	Additional 2.5% reduction from target value
< **Bottom Quartile**	Quartile value or 5% reduction of *baseline* (whichever is greater)	Additional 2.5% reduction from target value

(% reduction from baseline should be adjusted based on ECH organizational goal)

REFLECTION

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Why Risk Adjust?

Example in comparing Hospital A vs. Hospital B

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Assessing Quality of Care

- Hospital A has 1.6% mortality rate.

"We put the utmost emphasis on quality of care, and this rate reflects the excellent care our staff provides."

- Hospital B has a 2.5% mortality rate.

"Due to our location and facilities, the patients arriving at our hospital are sicker than average. This prevents us from attaining stellar mortality rates despite providing excellent care."

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Risk-Adjustment: hospital to hospital

Hospital A
Annual Inpatient discharges = 16,000
Suburban Location
High Socioeconomic Status
Patients with few co-morbidities
General/Routine Clinical Conditions & Procedures

% Obs. Deaths = **1.6%** or 262 deaths

% Exp. Deaths = 1.4% or 230 deaths

Hospital B
Annual Inpatient discharges = 56,000
Urban Location
Low Socioeconomic Status
Patients have multi-co-morbidities
Urgent/Emergency Conditions

% Obs. Deaths = **2.5%** or 1,400 deaths

% Exp. Deaths = 2.7% or 1,495 deaths

Observed Value ÷ **Expected Value** = **Index (O/E Ratio)**

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Risk-Adjustment: Hospital to Hospital

Hospital A
Annual Inpatient discharges = 16,000
Suburban Location
High Socioeconomic Status
Patients with few co-morbidities
General/Routine Clinical Conditions & Procedures

% Obs. Deaths = **1.6%** or 262 deaths

% Exp. Deaths = 1.4% or 230 deaths

Mortality Index*= **1.14**

Performing Worse

Hospital B
Annual Inpatient discharges = 56,000
Urban Location
Low Socioeconomic Status
Patients have multi-co-morbidities
Urgent/Emergency Conditions

% Obs. Deaths = **2.5%** or 1,400 deaths

% Exp. Deaths = 2.7% or 1,495 deaths

Mortality Index* = **0.94**

Performing Better

*Observed / Expected = Index Value

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Interpreting O/E Ratio (Index)

O/E Ratio < 1

- Observed is less than expected
- Lower costs than expected
- Fewer deaths than expected
- Shorter LOS than expected
- Desirable outcome

O/E Ratio = 1

- Observed is equal to expected

O/E Ratio > 1

- Observed is greater than expected
- Higher costs than expected
- More deaths than expected
- Longer LOS than expected
- Opportunities for improvement

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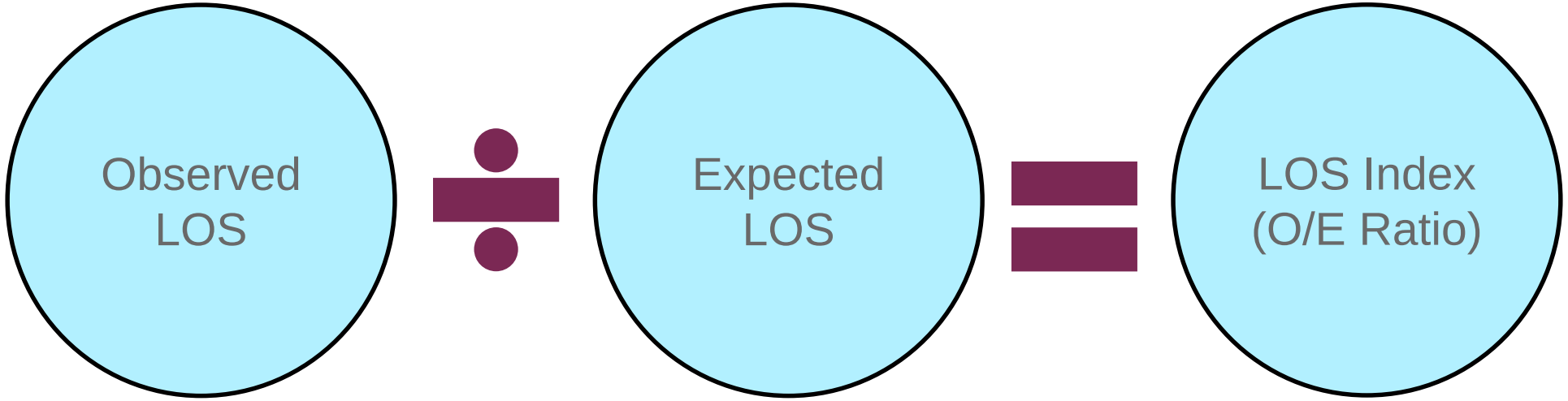
Observed / Expected (O/E) LOS Ratio



- O/E ratio of 1.0 indicates performing as expected
- Goal should be to achieve a lower LOS index (< 1.0)

Improving Risk Adjusted LOS Ratio – *<u>Two</u> Potential Avenues*

Avenue 1:	↓	Observed	• **Clinical Practice** • **Patient Selection**
Avenue 2:	↑	Expected	• **Coding & Documentation** • **Model Comparisons**

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Risk adjusted methodology

- **Based on MS DRGs, procedures and demographics, Vizient risk adjusts 4 outcomes:**
- **Mortality**
- **LOS**
- **Cost**
- **Readmissions** ***(To be release in Nov 2024 in Vizient CDB app)***

- **Stated in Observed/Expected index (O/E ratio)**
- **Less than 1.0 = Better than Expected**
- **Greater than 1.0 = Worse than Expected**

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Questions?

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EL CAMINO HEALTH BOARD OF DIRECTORS
QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE 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: November 3, 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:

Our 2025 Quality Program is strategically designed to maintain excellence in fee-for-service care while preparing for value-based models, in alignment with health plan priorities and Medicare requirements. As Medicare transitions from traditional MIPS to MIPS Value Pathways (MVPs), with a proposed phase-out of traditional MIPS by 2029, we are proactively updating our quality infrastructure.

Currently, our Quality Program and its associated measures are in a period of transition. Our long-term objective is to align specialists with metrics that are most relevant to their specific areas, ideally within the appropriate MVP. However, since CMS has not yet released MVPs for all specialties, we are using a hybrid reporting model this year, which will continue in future program years. The quality measures selected for our network were chosen based on their alignment with health plan priorities, clinical importance, and to support regulatory compliance. Each measure was mapped to MVPs, with many applicable across multiple pathways, highlighting their applicability across different specialties.

For the 2024 performance year, we successfully submitted three MVPs and achieved higher scores in each compared to our previous results with traditional MIPS. This improvement highlights the effectiveness of MVP reporting and supports our continued transition to this new framework. CMS finalized 2024 MVP scores were released in September 2025, which are presented now due to the delayed CMS reporting timeline.

To showcase the exceptional performance of our network, data sourced directly from the QPP CMS website indicates the following achievements:

- Our nephrologist, submitted under the Kidney Health MVP, achieved a score 46.5% above the national average.
- Providers participating in the Value in Primary Care MVP scored 31.1% higher than the national average.
- Providers submitted under the Focusing on Women's Health MVP outperformed the national average by 23.3%.

These results reflect the dedication and excellence of our network providers.

ECHMN Quarterly Quality Report to Quality Committee
November 3, 2025

In 2025, we are positioned to submit at least five MVPs, enabling more specialists to report on measures that are most relevant to their areas of practice.

The Network's quality measures are reset each year to match health plan and Medicare tracking standards, aiming for sustained achievement by the end of the year. The data shown in the slides reflects the calendar year for the 11 shared network goals. Although specialists are increasingly engaged in quality initiatives, the measures are mainly focused on PCP practices. Performance dashboards are used to monitor the contributions of specialist and urgent care providers, who continue to play a key role in supporting overall system quality objectives.

As of October 13, 2025, the network is currently meeting 8 out of 11 established quality goals for the current calendar year. The remaining 3 measures are demonstrating positive progress and are within 2% of their respective targets. To further support improvement in these areas, targeted interventions, such as a focused chart abstraction and patient outreach are actively being implemented. It is important to note that this progress has been made during a period of transition to the MIPS attribution model in CY2025, replacing the previous provider attribution approach. This change has resulted in an expanded patient population under evaluation. Despite this challenge, the network's standardized quality processes have contributed to sustained performance improvements across measures, underscoring the effectiveness of our ongoing quality initiatives.

In summary, our network's Quality Program is navigating a significant period of transition, marked by the adoption of a hybrid reporting model and the gradual implementation of MVPs tailored to specialist practice areas. Despite the evolving regulatory landscape and the challenges posed by the shift to the MIPS attribution model, our network has demonstrated measurable progress, currently achieving 8 out of 11 quality goals and making substantial gains on the remaining measures. The successful submission and improved performance of MVPs in 2024, along with plans to expand MVP participation in 2025, underscore the effectiveness of our current strategies and our commitment to continuous improvement. Through ongoing alignment with health plan priorities, targeted interventions, and robust performance monitoring, we remain focused on advancing quality outcomes for all providers and patients within our network.

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
Kirstan Smith BSN, RN, CNN, CPHQ, Vice President of Quality Performance
Peter Goll, CAO

November 3, 2025

El Camino Health Medical Network

Agenda

- ECHMN Traditional MIPS vs. MVP Performance
  - MIPS vs. MVP Scores (2023–2024)
  - MVP Quality Score vs. National Average
  - Value in Primary Care MVP 2025 YTD Performance
- 2025 ECHMN YTD Performance
  - Quality Measure Performance
  - CY 2024 Attribution Model vs. 2025 MIPS Panel Comparison
  - Performance and Action Items
- Appendix

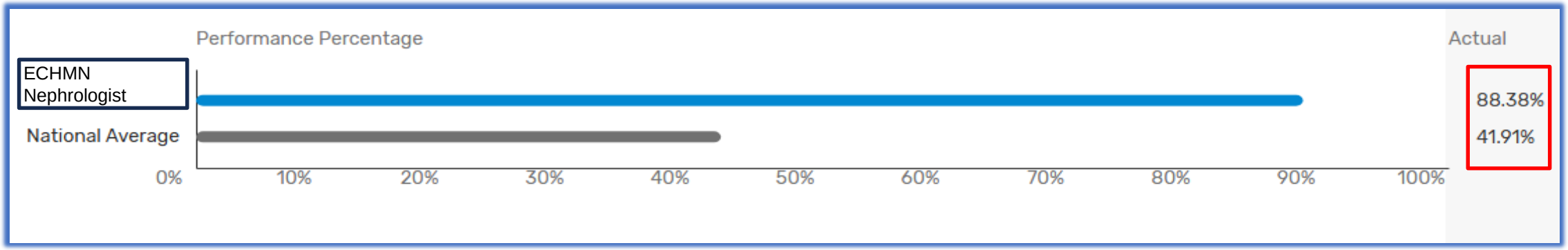
ECHMN Traditional MIPS vs. MVP Performance

2023 & 2024 Traditional MIPS Score vs. 2024 MVP Score

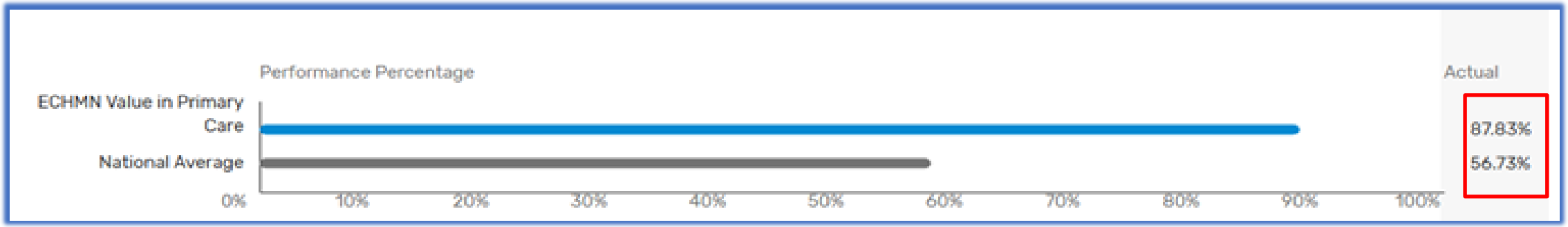
MVP Submission Type	Total Score	Improvement from 2023
2023 Traditional MIPS	83.56	--
2024 Traditional MIPS	85.47	1.91
2024 MVP Reporting		
Women's Health (Breast Cancer Screening, Cervical Cancer Screening, HIV Screening, Appropriate Use of DXA Scans)	86.77	3.21
Primary Care (A1c Greater than 9%, Controlling High Blood Pressure, Screening for Depression, HIV Screening)	89.25	5.69
Kidney Health (A1c Greater than 9%, Controlling High Blood Pressure, Documentation of Current Medications, *Kidney Health Evaluation measure was suppressed)	93.78	10.22

- ECHMN improved over 2023 in both traditional MIPS and MVPs. In 2024, all MVP subgroups scored higher than traditional MIPS. The table above displays CMS finalized 2024 MVP scores, released in September 2025, which are presented now due to the delayed CMS reporting timeline.

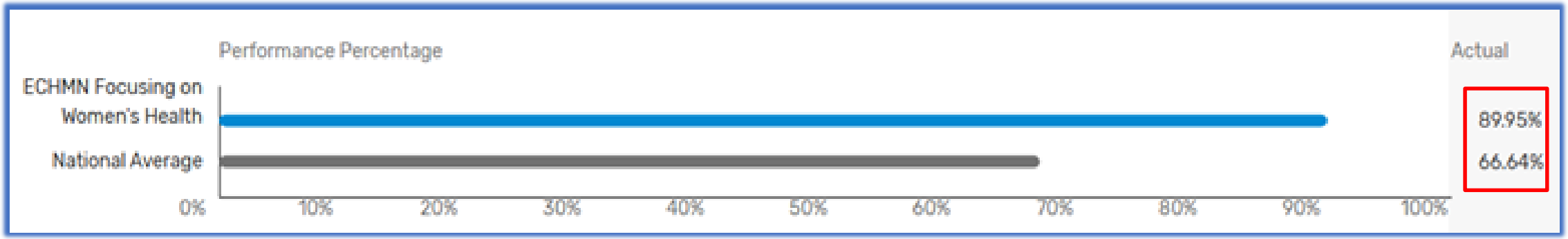
MVP Quality Score vs. National Average



+46.5%



+31.1%



+23.3%

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The data was obtained from the CMS QPP website.

Value in Primary Care MVP 2025 YTD Performance

The Quality Department is actively monitoring performance to ensure the continued success of the MVPs in 2025.

MVP:	Value in Primary Care
Specialty:	PCPs, Urgent Care Providers, and all other providers not currently assigned to an MVP

CMS ID	Measure	YTD Performance	Network Goal	YTD Percentile	Total Points	Decile 7	Decile 8	Decile 9	Decile 10
122	Diabetes: A1c Greater than 9%	16.7%	13%	Decile 9	9	27.54 - 23.03	23.02 - 18.50	18.49 - 13.47	<= 13.46
165	Controlling High Blood Pressure	78.5%	77%	Decile 8	8	71.94 - 75.30	75.31 - 79.30	79.31 - 84.73	>= 84.74
2	Screening for Depression	92.7%	90%	Decile 9	9	58.11 - 71.38	71.39 - 84.22	84.23 - 94.98	>= 94.99
348	HIV Screening	34.1%	N/A	Decile 9	9	20.00 - 24.99	25.00 - 31.36	31.37 - 40.26	>= 40.27

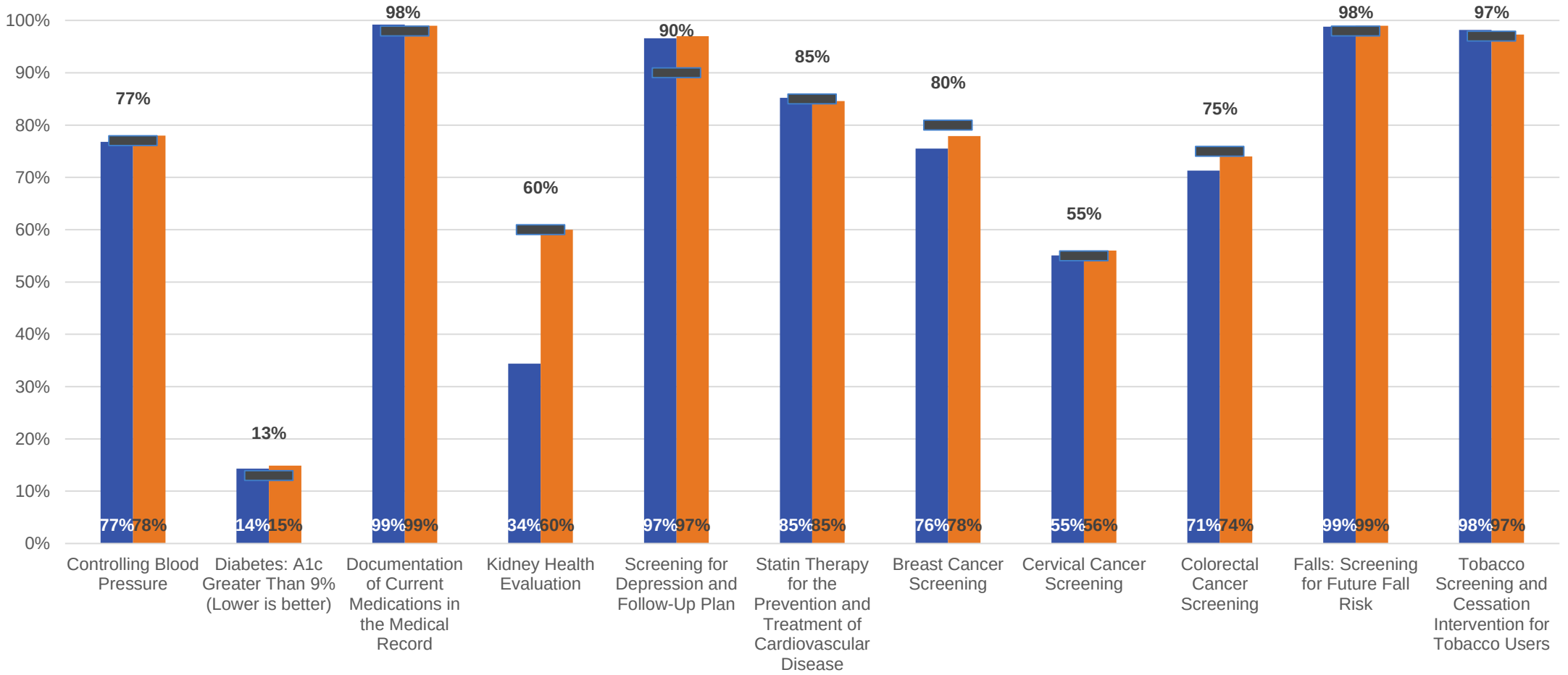
Grand Total Points on top 4 measures	35/40 = 87.5%

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 October 13, 2025, the network is meeting 8 out of 11 goals year-to-date, up from 5 of 11 in September.
- The remaining 3 measures are showing positive trends and are less than 2% from established targets.

YTD ECHMN Primary Overall Performance (YTD thru 10/13/25)



Current Performance: 8 of 11 Measures Currently Meeting

*While measures are currently being met, final results will not be determined until December 31st.

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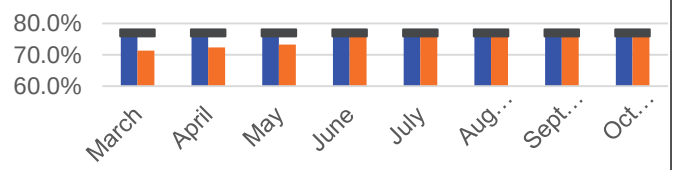
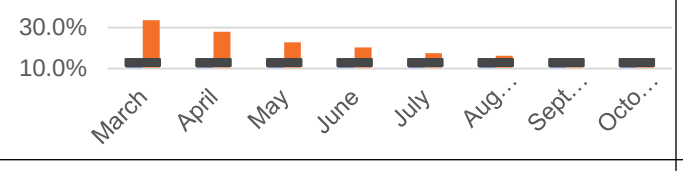
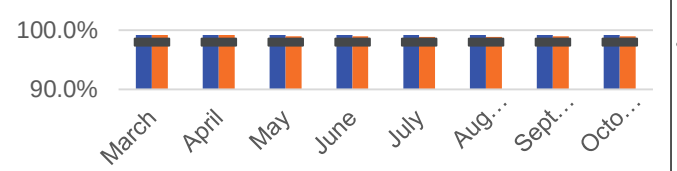
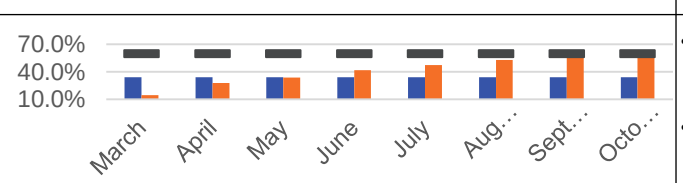
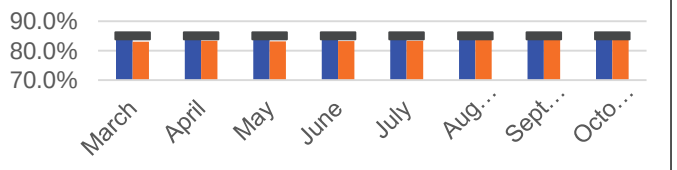
Quality Metric Performance (YTD thru 10/13/25)

Measures Met	8
Total Measures	11

Measure	YE 2024	Goal	October YTD	Pts To Goal	% Increase*	YTD Trend	Action Plan
Controlling Blood Pressure	77%	77%	78%	Meeting	0.7%		• "MyChart Home Blood Pressure Self-Report Campaign will be launched at the beginning of Q4. • MA outreach to patients
Glycemic Status Assessment (Lower is better)	14%	13%	15%	56	-3.0%		• 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%	98%	99%	Meeting	0.1%		• 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%	60%	60%	Meeting	12.1%		• 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	97%	90%	97%	Meeting	0.4%		• Identify outliers and provide training to providers and staff.
Statin Therapy- Patients w/ ASCVD	85%	85%	85%	Meeting	1.1%		• Provide out of target report to providers. • Verify the accuracy of mapping and ensure exclusions and exceptions are being appropriately captured.

*increase since previous meeting

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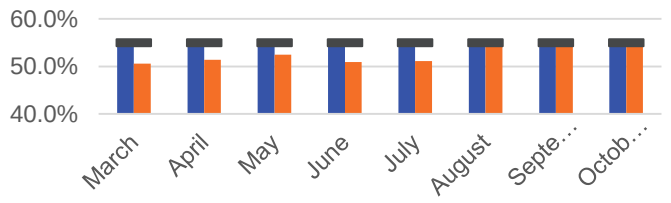
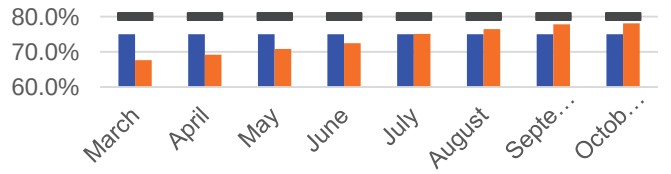
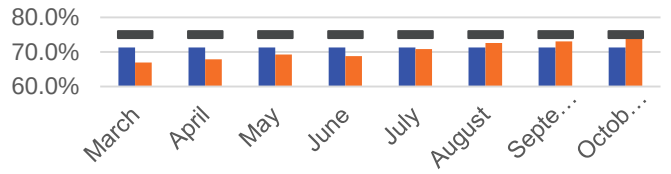
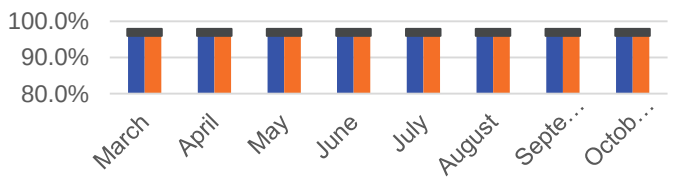
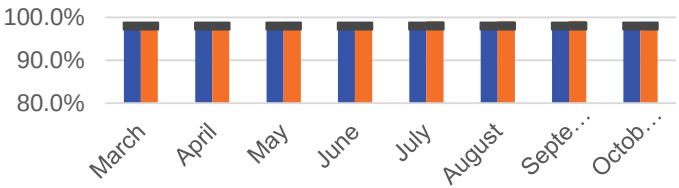
Quality Metric Performance (YTD thru 10/13/25)

Measures Met	8
Total Measures	11

Measure	YE 2024	Goal	October YTD	Pts To Goal	% Increase*	YTD Trend	Action Plan
Cervical Cancer Screening	55%	55%	56%	Meeting	4.5%		• Provide out of target report to providers. • Review proper measure capture in Epic.
Breast Cancer Screening	76%	80%	78%	116	3.0%		• Chart abstraction is currently underway. • BCS outlier lists were distributed to all primary care providers and clinic leadership for outreach. • Review proper measure capture in Epic
Colorectal Cancer Screening	71%	75%	74%	150	3.2%		• Chart abstraction is currently underway. • Provide out of target report to providers. • Review proper measure capture in Epic
Tobacco Screening and Cessation Intervention	98%	97%	97%	Meeting	0.5%		• Identify outliers and provide training to providers and staff.
Falls: Screening for Future Fall Risk	99%	98%	99%	Meeting	-0.1%		• Identify outliers and provide training to providers and staff.

*increase since previous meeting

CY 2024 Attribution Model vs. 2025 MIPS Panel Comparison

This table illustrates how switching to the MIPS attribution model has expanded the patient population included in quality reporting and how standardized quality processes have led to ongoing performance improvements.

Measures	CY 24 Attribution Model Panel Size	CY 25 YTD Panel Size	Difference
Breast Cancer Screening	5,057	6,059	+1,002
Colorectal Cancer Screening	11,023	14,365	+3,342
Statin Therapy (ASCVD)	3,852	4,867	+1,015
Screening for Depression and Follow-Up Plan	18,197	30,637	+12,440
Screening for Future Fall Risk	8,805	10,185	+1,380
Diabetes – Glycemic Status Assessment <9%	3,228	3,641	+413
Controlling Blood Pressure	7,421	9,060	+1,639
Cervical Cancer Screening	6,196	9,326	+3,130

*Data limitations prevented inclusion of some measures. CY 25 YTD panel size as of 10/6/25.

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.

Quality Measure Comparison Across 21 MVPs

ECHMN Quality Measures	Is this measure a high Priority for Health Plans	How many 2025 MVPs does this measure fall under (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	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

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%