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

Monday, May 4, 2026 – 5:30 pm

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

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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 Committee member is participating in the meeting via teleconference.

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:30 pm**
3.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Committee on any matter within the subject matter jurisdiction of the Committee 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 Committee 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**
4.	**CONSENT CALENDAR ITEMS** a. Approve Minutes of the Open Session of the Quality Committee Meeting (03/02/2026) b. FY2026 Pacing Plan c. Core Measures d. Recommend for Board Approval Revised FY2026 Patient Safety Plan	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**5:30 – 5:35**
5.	**VERBAL COMMITTEE EXPERTISE REPORT**	Steven Xanthopoulos, MD, Quality Committee Member Shahram Gholami, MD, Quality Committee Member	Information	**5:35 – 5:45**
6.	**PATIENT STORY**	Ryan Lockwood, Vice President, Patient Experience	Information	**5:45 – 5:55**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
7.	**EL CAMINO HEALTH MEDICAL NETWORK QUALITY REPORT**	Alan Muster, MD, MBA, MHA, FCCP, President, ECHMN Jaideep Iyengar, MD, FAAOS Peter Goll, Chief Administrative Officer, ECHMN Kirstan Smith, BSN, CPHQ, Vice President, Quality Performance, ECHMN	Discussion	**5:55 – 6:15**
8.	**Q3 FY2026 STEEEP DASHBOARD REVIEW / FY2026 ENTERPRISE QUALITY DASHBOARD**	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**6:15 – 6:35**
9.	**RECOMMEND FY2027 COMMITTEE PLANNING ITEMS FOR APPROVAL** a. Committee Dates b. Committee Goals c. Pacing Plan	Shreyas Mallur, MD, MBA, Chief Quality Officer	**Motion Required**	**6:35 – 6:55**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**6:55 – 6:55**
11.	**QUALITY COUNCIL MINUTES** a. Quality Council Minutes (03/04/2026) b. Quality Council Minutes (04/01/2026) *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Carol Somersille, MD Quality Committee Chair	Information	**6:55 – 7:01**
12.	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL QUALITY COMMITTEE (03/02/2026)** *Report involving Gov't Code Section 54957.2 for closed session minutes*	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:01 – 7:06**
13.	**REVIEW FY2027 ENTERPRISE QUALITY AND PATIENT EXPERIENCE-RELATED ANNUAL ORGANIZATIONAL PERFORMANCE INCENTIVE METRICS AND GOAL-SETTING METHODOLOGIES** *Health and Safety Code Section 32106(b) and Gov't Code Section 54957.6 for a report and discussion involving healthcare facility trade secrets, and a report and discussion on personnel matters*	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**7:06 – 7:21**
14.	**Q3 FY2026 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, MBA, Chief Quality Officer	Discussion	**7:21 – 7:26**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
15.	**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**	**7:26 – 7:31**
16.	**VERBAL SERIOUS SAFETY EVENT REPORT** *Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff Quality Assurance committee*	Shreyas Mallur, MD, MBA, Chief Quality Officer	Discussion	**7:31 – 7:36**
17.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:36 – 7:36**
18.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:36 – 7:37**
19.	**RECOMMEND FOR APPROVAL FY2027 ENTERPRISE QUALITY AND PATIENT EXPERIENCE-RELATED ANNUAL ORGANIZATIONAL PERFORMANCE INCENTIVE METRICS AND GOAL-SETTING METHODOLOGIES**	Shreyas Mallur, MD, MBA, Chief Quality Officer	**Motion Required**	**7:37 – 7:42**
20.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:42 – 7:45**
21.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	**Motion Required**	**7:45**

Next Meetings: June 1, 2026

Minutes of the Open Session of the
Quality, Patient Care, and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, March 2, 2026
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Staff Present
Carol Somersille, MD, Chair **Krutica Sharma, MD**, Vice Chair **Pancho Chang** **Shahram Gholami, MD** *(at 5:42 pm)* **Erica Jiang** **Barbara Pelletreau** **Jack Po, MD** **Diane Schweitzer** **Steven Xanthopoulos, MD** **John Zoglin**	***via teleconference*	**Dan Woods,** CEO **Mark Adams, MD,** CMO **Shreyas Mallur, MD,** CQO **Tracey Lewis Taylor,** COO ** **Cheryl Reinking**, DPN, RN, CNO **Deb Muro,** CIO ** **Lyn Garrett,** Senior Director, Quality **Ryan Lockwood,** VP, Patient Experience **AJ Reall**, VP, Strategy **Anne Yang,** Executive Director, Governance Services **Tracy Fowler,** Director, Governance Services** **Gabriel Fernandez,** Coordinator, Governance Services

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:30 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Committee member Gholami was absent at the time of roll call.	**Call to order at 5:30 p.m.**
2. 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.	
3. PUBLIC COMMUNICATION	There were no comments from members of the public.	
4. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Dr. Sharma removed Item a) Minutes of the Open Session of the Quality Committee Meeting (02/02/2026). Dr. Sharma requested a clerical revision to correct the minutes, which incorrectly indicated that Ms. Jiang attended the IHI Forum. Dr. Somersille requested that additional information be included for agenda item 8 of the Open Session Minutes to include that "the Committee requested that future patient experience presentations be more robust with actionable content."	***Consent Calendar Approved***

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	Motion: To approve consent calendar items with the requested revisions to item a. **Movant**: Sharma **Second**: Jiang **Ayes**: Somersille, Chang, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** Gholami **Recused**: None	
5. VERBAL COMMITTEE MEMBER EXPERTISE REPORT	Director Jack Po provided a Committee Expertise Report on advancements in artificial intelligence (AI) within healthcare. He disclosed his role as Founder and CEO of AnsibleHealth and noted that AnsibleHealth collaborates with Anthropic on AI development and deployment. Director Po clarified that the presentation was educational and vendor-neutral, citing real-world examples, such as the Sentinel system, to illustrate AI's broad capabilities, clinical impacts, and future potential in healthcare. Director Po summarized recent developments in large language models and their applications in medical documentation, information retrieval, and case review processes. He highlighted the emergence of AI agents capable of executing tasks by integrating multiple tools, noting their significant potential in clinical settings. The committee discussed concerns about AI hallucination and bias, with Director Po explaining that newer models exhibit lower hallucination rates, though some vendors may use older models for cost efficiency. He shared challenges related to interoperability across electronic health record (EHR) systems and infrastructure to connect to national healthcare exchanges. The committee inquired about measurable financial and clinical impacts of AI adoption. The committee concluded by discussing the balance between technological advancement and public trust, noting that patients prioritize improved care and convenience, though privacy concerns remain.	
6. PATIENT SAFETY STORY	Ms. Reinking presented a patient safety story illustrating patient experience, quality outcomes, and opportunities for learning and improvement in clinical care. The case involved the collection of venous blood samples, where incorrect labeling was identified. The laboratory team detected the labeling discrepancy and followed the established escalation procedure in accordance with QVV protocols, preventing a near miss.	

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7. PATIENT EXPERIENCE REPORT	Mr. Lockwood presented the Patient Experience Report, summarizing updates on patient experience survey methodology and performance across multiple service lines for the current fiscal year. Mr. Lockwood shared progress toward established targets, noting strong performance in inpatient and maternal-child health areas, with the emergency department and select outpatient services identified as areas for further improvement. The report highlighted ongoing efforts to standardize patient experience measurement, implement consistent expectations across departments, and enhance feedback strategies. The committee discussed the importance of balancing survey scores with meaningful improvements in patient care, as well as integrating real-time feedback and reducing variation in patient experiences. Additional topics included clarifying terminology, evaluating sample sizes, and considering benchmarking within the Bay Area market while maintaining privacy compliance. The committee emphasized the value of continuous improvement and the incorporation of patient feedback into quality initiatives.	
8. FY 2026 ENTERPRISE QUALITY DASHBOARD	Dr. Mallur presented the FY 2026 Enterprise Quality Dashboard, offering a summary of organizational performance across core quality measures. The committee reviewed trends and areas for further progress, including ongoing efforts to address surgical site infections. Committee members discussed data interpretation, benchmarking practices, and alignment with quality objectives, underscoring the commitment to continuous improvement in patient care.	
9. REVIEW FY 2027 COMMITTEE PLANNING ITEMS	The committee reviewed the FY 2027 Committee Planning items. There was a request to revise the meeting schedule to update the May 2027 meeting date to May 3, 2027. Committee members discussed potential changes to the annual meeting calendar, including reducing the number of meetings from seven to six per year by removing either the December or the February meeting. The proposed committee goals were also reviewed, with the committee emphasizing the development of more outcome-oriented objectives.	***Action:*** *Staff to revise the proposed FY2027 May meeting date to May 3, 2027.*

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10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session at 7:06 p.m. **Movant**: Po **Second**: Sharma **Ayes**: Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** None **Recused**: None	***Recessed to Closed Session at 7:06 p.m.***
11. AGENDA ITEM 17: 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 February 2, 2026, meeting.	***Reconvened Open Session at 7:44 p.m.***
12. AGENDA ITEM 18: COMMITTEE ANNOUNCEMENTS	The Committee discussed plans to participate in the 2026 IHI Forum in Phoenix. Chair Somersille encouraged members to submit ideas for presentation topics, including health equity and the integration of quality measures. Members were asked to share their thoughts with Dr. Mallur and the management team for further development.	
13. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:48 p.m. **Movant**: Chang **Second**: Po **Ayes**: Somersille, Chang, Gholami, Jiang, Pelletreau, Po, Schweitzer, Sharma, Xanthopoulos, Zoglin **Noes**: None **Abstain**: None **Absent:** None **Recused**: None	***Meeting Adjourned at 7:48 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

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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)

06/19/2025

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

To: ECH Quality Committee
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: May 4, 2026
Subject: Calendar Year 2025 Core Measure Dashboard

Purpose:

To update the Quality, Patient Care, and Patient Experience Committee on CY 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.

1. 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.
2. Background: There are no new revisions for CY 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. These measures reflect Inpatient Quality Reporting (IQR) Inpatient Psychiatric Quality Reporting (IPFQR) and some Outpatient Quality Reporting (OQR) Program Measures.
3. 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)

i. **PC01- Early Elective Delivery (EED)** Percent of elective vaginal/C-section deliveries at >=37 and <39 weeks without medical indication. Target <1.6%; CY 2025: 2.8% (7/254). TJC benchmark <2%; Leapfrog <5%. Sustainment underway.

- All non-medically indicated <39-week inductions/C-sections require MCH Medical Director approval before scheduling.
- Scheduling and forms have been standardized across both campuses.
- When TJC Table 11-07 exclusions don’t apply, physicians document individualized risk/benefit (e.g., severe anxiety, musculoskeletal pain, MFM recommendation).

ii. **PC02- Cesarean Birth**- Nulliparous, term, singleton, vertex C-section rate. TJC benchmark <25%; ECH goal <23.9%; CY 2025: 26.9% (597/2216). OB Task Force continues case review and system/practice improvements; progress is steady. Key actions:

- Quarterly unblinded data to OBs; annual unblinded data to L&D RNs.
- Bi-weekly case reviews with follow-up education/support as needed.
- California Maternal Quality Care Collaborative (CMQCC) initiative “Promoting Vaginal Birth through an Equity Lens” with monthly tasks/report-outs.
- Perinatal Equity Dashboard to monitor disparities (race/ethnicity, language, economic factors) and tailor supports.
- OB/RN education (e.g., Spinning Babies for RNs; OB Skills Days).
- Offering Transcutaneous Nerve Electrostimulation (TENS).
- Improved doula access and sharing of resources list with patients.
- Equity/bias assessments completed; countermeasures in progress (education, visibility, team supports).
- Birth-support equipment/tools added (e.g., birthing balls, labor circuit position guides).

iii. **PC05- Exclusive Breast Milk Feeding** - Newborns fed breast milk only during hospitalization. TJC benchmark >50%. CY 2025: 81.2% enterprise (685/844); LG 86.3%, MV 80.3%. Key drivers:

- LG re-designated Baby-Friendly in 2023 (ranked 11th of 155).
- MV completed Baby-Friendly designation 2025.
- Expanded lactation services/training, improved patient education, tracked equity gaps (incl. Asian patients), and offered banked breast milk—supporting top-quartile performance.
- Introduced donor milk in place of formula for term well babies (AAP-aligned).

iv. **PC06- Unexpected Complications in Term Newborns** - Tracks moderate–severe adverse outcomes in otherwise healthy term newborns. TJC benchmark <3%. CY 2025: 2.0% enterprise (81/4092); LG 3.0% (17/575); MV 1.8% (63/3516). Fallouts go to peer review; severe cases reviewed and improvements implemented. Trending down year over year.

v. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients** - Median ED length of stay (minutes) for discharged patients. Target ≤180 minutes; CY 2025: 160 minutes. CA avg 211; US avg 203 (Q2 2024–Q1 2025).

vi. **OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke -** Percent of ED stroke-symptom patients with brain scan results within 45 minutes. Target 100%; CY 2025: 46.2% (6/13). Reviewed with Stroke Committee; outliers shared with ED/Imaging and providers re-educated on CT stroke ordering. Small denominator; common exclusions include unknown/>120-minute last-known-well, left AMA, and expired in ED.

vii. **SEP-1 Severe Sepsis and Septic Shock Management Bundle** - Measures timely completion of key sepsis bundle elements (lactate, cultures, antibiotics, fluids, reassessment/vasopressors, repeat lactate). Target >75%. CY 2025: 82.6% enterprise (370/448); LG 76.5% (65/85); MV 84.0% (305/363).

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

i. **IMM: Influenza Immunization -** Flu-season (Oct–Mar) assessment and vaccination. 2025/2026 season (Oct–Dec to date): 95%. MHAS sustains daily Epic alert review to identify patients needing vaccination.

ii. **PC-TOB Perfect Care - Tobacco Use -** Measures medication/referral offered (or refused) for alcohol/drug use disorder at discharge. CMS ~61% (CY 2025); ECH 50%. Many fallouts reflect patients declining treatment and incomplete brief intervention documentation. Team is engaging providers and exploring Epic updates to capture declination reasons and prompt completion.

iii. **PC-SUB Perfect Care - Substance Abuse** - Measures medication/referral offered (or refused) for alcohol/drug use disorder at discharge. CMS ~61% (CY 2025); ECH 50%. Many fallouts reflect patients declining treatment and incomplete brief intervention documentation. Team is engaging providers and exploring Epic updates to capture decline reasons and prompt completion.

iv. **TR-1: Transition Record with Specified Elements Received by Discharged Patients.** Percent of discharged patients (or caregivers) who received and reviewed a complete transition record before leaving. CMS ~53%; CY 2025: 75.8%. Main fallout drivers include missing advance-care directive documentation/reason and earlier ambiguity in the "reason for admission" data field (now updated in Epic).

v. **MET-1: Screening for Metabolic Disorders -** Comprehensive screening (BMI, glucose/A1C, BP, lipid panel). CMS ~93%; CY 2025: 90.6%. Abstractors capture qualifying labs from Care Everywhere per specifications.

vi. **HBIPS-2: Hours of Physical Restraint Use** (per 1000 patient hours) lower is better. All CMS hospitals are at 0.0004; CY 2025 rate is 0.0004.

vii. **HBIPS-3: Hours of Seclusion Use** (per 1000 patient hours) lower is better. All CMS hospitals are at 0.0002; CY 2025 rate is 0.0002.

<u>List of Attachments</u>:

1. Attachment 1: CY2025 Core Measure Report Non-HBIPS
2. Attachment 2: CY2025 Core Measure Report HBIPS

El Camino Health

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

KEY PERFORMANCE INDICATORS & METRICS	CY 2025 Performance	CY 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	ENT: 2.8% (7/254) MV: 2.4% (5/207) LG: 4.3% (2/47)	ENT: 1.2% (3/255) MV: 1.0% (2/205) LG: 2.0% (1/49)	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	ENT: 26.9% (597/2216) MV: 28.0% (534/1909) LG: 20.5% (63/307)	ENT: 25.4% (550/2167) MV: 26.1% (481/1845) LG: 21.4% (69/322)	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	ENT: 81.2% (685/844) MV: 80.3% (578/720) LG: 86.3% (107/124)	ENT: 80.0% (663/829) MV: 78.9% (539/683) LG: 84.9% (124/146)	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	ENT: 2.0% (81/4092) MV: 1.8% (63/3516) LG: 3.0% (17/575)	ENT: 3.0% (119/4004) MV: 2.7% (90/3343) LG: 4.4% (29/661)	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	ENT: 160 Minutes	ENT: 157 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	ENT: 46.2% (6/13) MV: 75.0% (3/4) LG: 25.0% (2/8)	ENT: 78.6% (11/14) MV: 75.0% (9/12) LG: 100.0% (2/2)	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
SEPSIS								
SEP-1 Severe Sepsis and Septic Shock: Management Bundle Data Source : Virtusa	ENT: 82.6% (370/448) MV: 84.0% (305/363) LG: 76.5% (65/85)	ENT: 75.3% (143/190) MV: 74.8% (116/155) LG: 77.1% (27/35)	ECH Goal >75%		This measure focuses on adults 18 years and older with a diagnosis of severe sepsis or septic shock. Consistent with Surviving Sepsis Campaign guidelines, it assesses measurement of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement.	Hospital IQR Specifications Manual	Daily oversight by the Sepsis Team	Virtusa CareDiscovery Quality Measures

El Camino Health

CY 2025 Performance - Core Measures (HBIPS) - Enterprise

KEY PERFORMANCE INDICATORS & METRICS	CY 2025 Performance	CY 2024 Baseline	All CM Hospitals CY 2025 Benchmark	Trend Graph	2025-2026 Definition	Definition Owner	Work Group	Source
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)								
IMM-2 Influenza Immunization *Data Source: Virtusa* ***Data only captured during the flu season: Jan-Mar, Oct-Dec months*** (High is better)	95% (178/187) 2025/2026 Flu Season (Oct-Dec)	94% (407/433) 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*	16.67% 5/30	31.43% 11/35	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*	50% 45/90	47.9% 57/119	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*	75.8% 689/909	75.7% 635/839	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*	90.6% 590/651	92.8% 628/677	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* *Event measures are calculated by event occurrence date	0.0004	0.0002	0.0004		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* *Event measures are calculated by event occurrence date	0.0002	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

Status **Active** PolicyStat ID **20445639**

El Camino Health

Origination	09/2025
Last Approved	04/2026
Effective	04/2026
Last Revised	04/2026
Next Review	04/2027

Owner	Sheetal Shah: Sr Director Risk Management and Patient Safety
Area	Risk Management & Patient Safety
Document Types	Plan

FY2026 Patient Safety Plan

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~~ORGANIZATION OVERVIEW~~

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

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

~~El CAMINO HEALTH MISSION~~

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

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~~El CAMINO HEALTH VISION~~

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

~~El CAMINO HOSPITAL VALUES~~

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

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

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

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

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

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

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

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

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~~DEFINITIONS~~

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

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

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PURPOSE

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

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

The purpose of this Patient Safety Plan is to **improve the health and safety of patients** and **reduce preventable patient safety events**, as required by California Health & Safety Code §1279.6.

This plan establishes the structures, processes, and responsibilities necessary to comply with California Health & Safety Code §1279.6, including reporting systems, event analysis, committee oversight, and annual review requirements.The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. ~~The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing quality and patient safety initiatives. In addition, the Patient Safety program at ECH strives to accomplish the requirements listed out in Leapfrog and the NQF Safe Practices in implementation of its program.~~

The Patient Safety Plan outlines a comprehensive program that encompasses high reliability principles and the hospital's commitment to achieving zero preventable harm known as the Safety First/Mission Zero program. In addition, the Patient Safety Plan strives to accomplish the requirements listed out in Leapfrog and the NQF Safe Practices in implementation of its program.

GUIDING PRINCIPLES

A. We believe that patient safety is ~~at the~~a core value of a quality health-care system.

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

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

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

E. We promote a safety culture in which our workforce feel safe reporting adverse events, errors

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and near misses. These reports inform our improvements to care.

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

OBJECTIVES

A. Deliver high quality safe care for every patient.

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

C. Promote a culture of safety and high reliability known as the Safety First/Mission Zero program.

D. Build processes that improve our capacity to identify and address patient safety issues using high reliability principles and the Safety First/Mission Zero leader skill toolkit (Att B).

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

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

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

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

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

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

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

L. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

There are a number of integral and connected structures at El Camino Hospital that address Patient Safety. See Attachment A for Flow of Patient Safety Information.

Governing Board

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

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administration and the committees noted below.

Quality Committee of the Board

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

Enterprise Hospital Committees

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

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

The **Enterprise Patient Safety Committee (aka Patient and Employee Safety Committee(PESC)** has the following duties, and reports to Quality Council monthly. Membership includes physicians, nurses, pharmacists and leaders throughout the organization.

A. Review and approve the patient safety plan annually for each campus, incorporating advancements in patient safety practices.
B. Receive and review reports of patient safety events.
C. Monitors implementation of corrective actions for safety events by receiving reports from the Cause Analysis Oversight Committee defined below.
D. Make recommendations to eliminate future patient safety events by initiating performance improvement related to patient and employee safety concerns based on identified trends and concerns.
E. Receives reports from the following patient safety subcommittees: Medication Safety, Falls,Skin Integrity, Hospital-acquired Infections, Central Safety, and the Grievance Committee.
F. Monitors data and receives reports regarding the hospital's Culture of Safety surveys,

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compliance with National Performance Goals (NPG), Safety/Security concerns, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene program, and Employee Injuries including Workplace Violence.

G. Sets an annual patient and employee safety metrics with quality targets based on any available benchmarks and organizational goals. (See Attachment E: latest FY Patient and Employee Safety Dashboard).

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

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The **Enterprise Patient Safety Oversight Committee (PSOC)** is a subcommittee of PESC and is composed of the Chief of Staff or designees along with hospital senior leadership that meet at least monthly to review new patient safety events and prioritize actions needed for patient safety. Information reviewed is brought forward by Risk and Patient Safety, Medical Staff leadership, Quality and Regulatory leaders. PSOC assists in providing prompt direction to the organization and the medical staff in addressing patient safety concerns.

Risk Management and Patient Safety Department

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

The staff in the Risk Management Patient Safety Department are trained to conduct analysis of patient safety events including root cause analysis, and includes staff with clinical backgrounds in nursing or other clinical areas who shall have appropriate comptencies to do such analyses. The procedure for conducting the analysis is described in the Safety Event Management and Cause Analysis procedure.

Patient Safety events shall be analyzed at least annually on the following sociodemographic factors: age, race, ethcnity, preferred language spoken, disabilty status, payor, sex, and if provided by the patient, gender identity and sexual orientation and reported to the PESC for identification of any disparities.

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

- Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment D) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.
- Coordination of any requested Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.
- Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
- Review National Performance Goals (NPG) and collaborate with Accreditation to conduct gap analyses.
- Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach peer coaching program
- In partnership with Quality, performance of Failure and Effects Mode Analysis (FMEA).
- Implementation of performance improvement related to culture of safety, patient safety based on trends or needed risk mitigation.
- Regulatory follow up needed related to patient safety
- Promote transparency of errors and mistakes through sharing lessons learned
- Annual assessment of culture of safety and identification of opportunities for improvement
- Assist and facilitate the coordination and delivery of any needed training and education related to improving the culture of safety based on the hospital's culture of safety results

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Patient Safety Training

A. All staff and medical staff upon hire are provided training on patient safety at new hire orientation/physician on-boarding which includes training on the use of SAFETY skills and behaviors to prevent error (Attachment B).

B. Staff receive annual refreshers and medical staff receive refreshers at time of recredentialing through the hospital's learning information system.

C. Leaders also receive training on leader skills to support Safety First/Mission Zero journey to high reliability (Attachment B) through the manager orientation program.

D. The Board of Directors receive training on patient safety when joining the Board.

Patient Safety Event Reporting

ECH supports and encourages a culture of safety by promoting reporting of patient safety events as follows.

A. ECH has adopted use of an electronic tool called iSAFE to report patient safety events which

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allows anyone including health care practitioners and staff to submit a report concerning patient safety event to the hospital. Reports can also be submitted anonymously by clicking the appropriate box in the iSAFE system.

B. Training is provided to all workforce members upon hire on reporting concerns using ISAFE with the expectation that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/improvements. Details about how to utilize the ISAFE system are found in the Safety Event Reporting procedure.

C. Patients and visitors may share patient safety concerns by contacting the Patient Experience Department by phone or email, or by informing hospital staff. Staff shall then complete a Feedback ISAFE to enter into the electronic patient safety event reporting system. The Patient Experience Department manages the Feedback reports to ensure timely response and follow-up.

D. ECH supports a strong culture of safety by committing to Fair and Just Culture principles surrounding event reporting which include the following:

   1. Non punitive response and zero retaliation for reporting patient safety concerns, near misses and incidents.

   2. Information shared through the iSAFE system shall be used for improvement purposes.

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Process for Addressing Reports of Racism and Discrimination Involving Patients

El Camino Hospital adopts the following process to address racism and discrimination involving patients, and their impact on patient health and safety, that includes, but is not limited to:

A. The Health Equity Department and the Risk Management and Patient Safety Department shall monitor sociodemographic disparities in patient safety events and develop interventions to remedy known disparities. The Health Equity Department shall report out on known disparities and improvement efforts to the PESC at least annually.

B. Encouraging staff to report suspected instances of racism and discrimination involving patients. Risk Management and Patient Safety staff shall work with hospital leadership to ensure that an investigation is completed which may need to involve Human Resources or the Medical Staff Office.

FY26 PATIENT SAFETY ~~PLAN~~PRIORITIES AND INITIATIVES

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

~~A. Incident reporting is a cornerstone of Safety First/Mission Zero and our Culture of Safety. Training is provided to all workforce members upon hire and with refreshers on reporting concerns using ISAFE, the hospital's electronic incident reporting system with the expectation~~

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~~that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/improvements. The ISAFE system also allows for reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to ensure timely response and follow-up, track and trend feedback themes and inform quality improvement opportunities.~~

1. ~~Staff are encouraged to report patient safety concerns involving allegations of racism and discrimination of patients. These events shall be reviewed by relevant leadership and interventions taken as needed.~~

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

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

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

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

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

F. ~~Patient Safety Priorities are based on the following:~~

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

~~PATIENT SAFETY INITIATIVES~~

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A. Each Fiscal Year's priorities are based on the following:

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

B. Ongoing Patient Safety Initiatives

- Safety First Mission Zero SAFETY skill program
- Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis
- Hand Hygiene Audits
- Monthly Leader and Executive Rounding using 4C SAFETY skill scripts
- New hire and manager Orientation to include SAFETY skill education
- HeRO Recognition and Award Program

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

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

ALLOCATION OF RESOURCES

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

CONFIDENTIALITY

The Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Patient Safety and Quality Improvement ~~& Patient Safety Program of El Camino Hospital has been designed to comply with all~~Act of 2005 (PSQIA) and when applicable ~~confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Quality Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable.~~, California's Evidence Code 1157.

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

ANNUAL EVALUATION

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

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

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ATTACHMENTS

Att A Governance Information Flow

Att B Safety First / Mission Zero Leader Skill Toolkit

Att C Safety First / Mission Zero Universal Skill Toolkit

Att ~~E~~D HPI Safety Event Classification Algorithm

Att E PESC Dashboard FY26

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

Attachments

Att A - Governance Information Flow.pdf

Att B - Safety First Mission Zero Leader Skill Toolkit.pdf

Att C - Safety First MIssion Zero Universal Skills Toolkit.pdf

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- Att D - HPI Safety Event Classification Algorithm.pdf
- Att E - PESC Dashboard FY26.pdf
- Signed Memorandum - FY2026 Patient Safety Plan (4-27-26).pdf

Approval Signatures

Step Description	Approver	Date
Administration	Patrick Santos: Policy and Procedure Coordinator	04/2026
	Sheetal Shah: Sr Director Risk Management and Patient Safety	04/2026

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

To: ECH Quality Committee
From: Ryan Lockwood, MBA, CPXP – Vice President of Patient Experience
Date: May 4, 2026
Subject: Patient Story – Opportunity Identified at Outpatient Lab

Purpose:

To share a patient experience scenario that highlights an operational friction point, illustrates the evaluation process, and demonstrates how our team implemented improvements to enhance patient satisfaction and experience.

Summary:

We were recently made aware of a friction point for patients at the Sobrato outpatient lab: delays in getting lab draws completed. These delays were creating frustration for patients and were being reported back to their providers, who considered referring patients elsewhere to ensure a better patient experience.

1. Situation:

Patients visiting the Sobrato lab, both with and without appointments, were experiencing extended wait times at specific periods of the day. This resulted in patient dissatisfaction and had the potential to impact provider loyalty, as providers were concerned about the quality of service their patients were receiving.

2. Background:

The Patient Experience and Lab Operations teams conducted a thorough evaluation of the workflow, identifying the times of day when delays were most prevalent. Both scheduled and unscheduled patients were impacted differently, requiring tailored approaches to improve the experience.

3. Assessment:

This scenario highlighted an opportunity to enhance operational efficiency and patient communication. Key learnings included:

- Scheduled patients could benefit from a streamlined check-in and lab draw process.
- Unscheduled patients needed clearer communication about current wait times and guidance on scheduling for future visits.
- Providing real-time insights and options empowers patients, reduces frustration, and supports provider confidence in the lab experience.

The situation also reinforced the importance of integrating operational data with patient experience insights to drive targeted, actionable improvements.

4. Outcomes:

The lab department implemented a streamlined process for patients with scheduled appointments, improving the speed and predictability of lab draws. New strategies were developed for walk-in patients, including signage, wait-time estimates, and scheduling education to help them plan. These improvements have contributed to measurable performance gains at both the Los Gatos and Mountain View outpatient labs over the past two months, supporting improved performance this fiscal year.

This story demonstrates how identifying friction points, using data to evaluate root causes, and implementing targeted interventions can directly enhance patient experiences, improve operational efficiency, and strengthen provider and patient confidence in our services.

List of Attachments: Not applicable.

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

To: Quality, Patient Care, and Patient Experience Committee
From: Dr. Jaideep Iyengar, MD, FAAOS, ECHMN Quality Chair, Kirstan Smith, BSN, CPHQ, Vice President of Quality Performance, Dr. Alan Muster, MD, MBA, MHA, FCCP, ECHMN President, and Peter Goll, Chief Administrative Officer
Date: April 20, 2026
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:

Over the past three years, the ECHMN Quality Program has undergone significant transformation. We have grown from tracking 8 primary care measures and maintaining a single quality dashboard into a more mature, enterprise-wide effort with 21 measures across 10 programs and distinct provider performance dashboards. This expansion reflects a shift to a broader, proactive framework that improves visibility, strengthens accountability, and supports better decision-making as we scale.

The ECHMN Quality Committee has approved and ratified the quality metrics and targets for calendar year 2026. These measures are now strategically organized to better reflect the unique needs of our diverse practices and specialties, with metrics grouped into five categories: Primary Care, Specialists, Urgent Care, Pediatrics, or specialty-specific Merit-based Incentive Payment System Value Pathways (MVPs). In addition, these metrics have been developed to encompass health plan priorities, ensuring alignment with payer expectations and supporting value-based care initiatives across our network.

Our program continues to follow the framework established by the Centers for Medicare & Medicaid Services (CMS), which has guided our efforts for several years. As CMS prepares to sunset the Traditional MIPS program by 2029 and transition to MVPs, we are proactively aligning our quality initiatives with this direction. This approach allows us to implement more meaningful and relevant measures, particularly for specialists, and ensures a smooth transition for all providers in our network.

Beginning this year, six specialties in addition to primary care: cardiology, gastroenterology, nephrology, ophthalmology, orthopedics, and women’s health will have MVP-specific measures displayed on their provider performance dashboards. Specialties without an MVP scheduled for rollout in 2026 will continue to participate in our specialists subgroup quality measures until an applicable MVP becomes available. Our long-term objective is to align all specialists with quality metrics tailored to their specific fields, ideally within the MVP framework, to highlight and recognize the valuable work they do. To guide this transition, we have developed a comprehensive three-year roadmap to expand our quality program across as many specialties as possible and continue advancing the program’s impact.

Our IPA proposal includes prioritizing standardized data reporting to foster continuous improvement and accountability in patient care. While we research data aggregator solutions to

consolidate information from 15 EMRs, our immediate focus will be on the Community Connect providers, whose unified data has enabled analysis of three quality measures. Proposed performance measures and targets are included for review in the attached slides. This information was presented to the IPA Advisory Board in March.

In addition, the ECHMN Quality Department is leading the implementation of an electronic incident reporting system to further enhance patient and employee safety and streamline the documentation of adverse events. This initiative is designed to improve the accuracy, timeliness, and accessibility of incident data, enabling more effective analysis and follow-up. The system will also support the advancement of a just culture by promoting transparency, encouraging open reporting, and facilitating non-punitive responses to safety events affecting both patients and staff. By spearheading this effort, we are reinforcing our commitment to a culture of transparency, accountability, and continuous quality improvement across the organization.

In summary, these initiatives position ECHMN to advance quality and safety across our network. By aligning our metrics with national standards, enhancing specialty-specific performance monitoring, and investing in a robust reporting and safety system, we are strengthening our commitment to continuous improvement, transparency, and accountability. Collectively, these efforts further support our mission to deliver high-quality, patient-centered care.

List of Attachments:

1. PPT - El Camino Health Medical Network Quality Program.

Suggested Committee Discussion Questions:

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

El Camino Health Medical Network Quality Program

Presented by:
Alan R. Muster, MD, MBA, MHA, FCCP, President ECHMN
Jaideep Iyengar, MD, FAAOS, Chair, ECHMN Quality
Kirstan Smith BSN, RN, CNN, CPHQ, Vice President of Quality Performance
Peter Goll, CAO ECHMN

May 4, 2026

El Camino Health Medical Network

Agenda

- ECHMN Quality Program Evolution
- CY 2026 Quality Program
- 3-Year Roadmap
- CY 2026 Network Quality Measures and Targets
- Quality Department Support
- CY 2026 YTD Performance
- Quality in the IPA
- Quality Department Initiative
  - Electronic Incident Reporting System: SIREN
- Appendix

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ECHMN Quality Program Evolution

ECHMN Quality Program Evolution

- Over the past three years, the ECHMN Quality Program has undergone significant transformation.
- We have expanded from tracking **8** primary care measures with a single quality dashboard to a more mature, enterprise-wide effort encompassing **21** measures across **10** programs and distinct provider performance dashboards.
- This expansion reflects a shift to a broader, proactive framework that improves visibility, strengthens accountability, and supports better decision-making as we scale.

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CY 2026 Quality Program

ECHMN 2026 Calendar Year – Quality Program

- The program is built on the CMS MIPS framework and aligned to health plan priorities.
- CMS will sunset traditional MIPS in 2029, replacing it with MIPS Value Pathways (MVPs) tailored to specialty practice. ECHMN has already begun a structured multi-year transition and is planning to register 7 specialty pathways for 2026.
- This positions ECHMN ahead of the curve and gives specialists more relevant measures.
- The ECHMN Quality Committee approved all 2026 measures and targets (**calendar year** basis, not fiscal year). Measures are organized into five practice-based categories:
    - Primary Care
    - Specialists (not currently participating in an MVP)
    - Urgent Care
    - Pediatrics
    - MIPS Value Pathways (6 MVPs)

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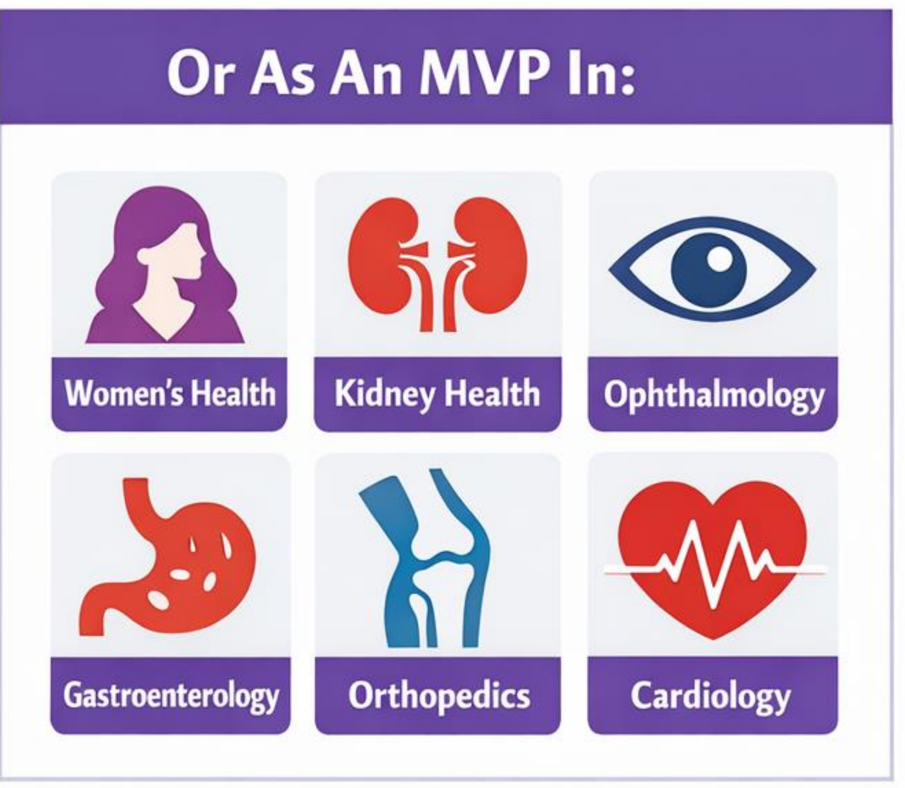
ECHMN 2026 Calendar Year – Quality Program

Our Providers Participate in Quality



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3-Year Roadmap

Specialist Expansion Roadmap

3-Year MIPS MVP Roadmap

Target: >90% of specialists in an MVP by 2029 when traditional MIPS sunsets.

Year	Target
2026	>60%
2027	>75%
2028	>90%
2029	Sunset

2026

- Primary Care
- Women's Health
- Kidney Health
- Ophthalmology
- Gastroenterology
- Orthopedics
- Cardiology

- IPA Data Aggregation
- Stakeholder Engagement
- Workflow Development
- Provider Dashboards & Feedback

Goal: >60%

2027

- Surgical Care
- Otolaryngology
- Podiatry
- Vascular Surgery

- Broaden MVP Participation
- IPA Quality Expansion
- Year 3 Measure Planning

Goal: >75%

2028

- Pulmonology Care
- Neurology
- Rheumatology
- Urology
- Cancer Care

- Full Network Launch
- Advanced Analytics
- Continuous Improvement

Goal: >90%

2029

MIPS Sunset

Proposed Sunset Date

- Traditional MIPS sunsets
- All specialists in MVP pathways
- >90% participation achieved

Goal: Sunset

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CY 2026 Network Quality Measures and Targets

CY 2026 Network Quality Measures and Targets

Quality Measures	2026 Target
Screening for Depression and Follow-Up Plan	90%
Diabetes: Hemoglobin A1c > 9%	**12.5%**
Controlling High Blood Pressure	77%
Documentation of Current Medications in the Medical Record	98%
Kidney Health Evaluation	**65%**
Screening for Future Fall Risk	98%
Breast Cancer Screening	**75%**
Colorectal Cancer Screening	75%
Tobacco Screening and Cessation Intervention	97%
Blood Pressure Remeasurement	80%
Radar Measure (measure for future implementation)	
Advance Care Plan*	---

Key Facts

- Total of 10 Measures
- Statin Therapy and Cervical Cancer Screening removed
- Breast Cancer Screening target reduced by 5% to reflect lowering the eligible age from 50 to 40 years
- BP Remeasurement added

*Advance Care Plan is being introduced as a radar measure. The Quality Department is still finalizing the workflow but wanted to put this measure on the radar of providers so it can be considered for future integration into practice. This measure is planned for implementation in 2027.

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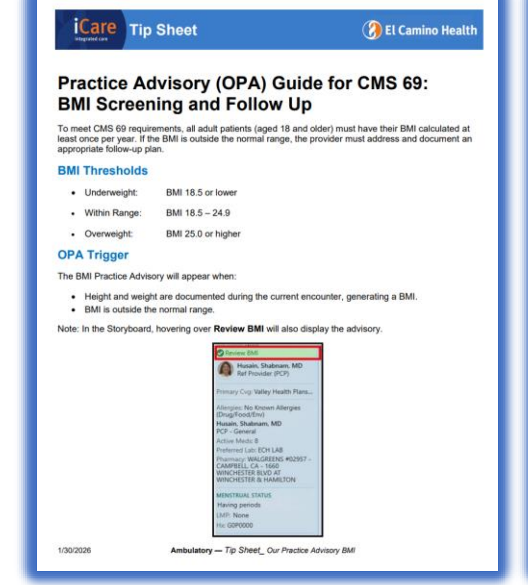
Quality Department Support

- Memo to all providers, practice managers, and operations directors
- Site leader meetings and individual clinic/provider visits
- Provider performance dashboards
- Clinical support meeting (site leaders and Operations)
- Best practice guides for providers and MAs
- Epic tip sheets (release pending)
- Provider Quarterly Quality Reports (PQQRs)



iCare Tip Sheet — El Camino Health

Practice Advisory (OPA) Guide for CMS 69: BMI Screening and Follow Up

To meet CMS 69 requirements, all adult patients (aged 18 and older) must have their BMI calculated at least once per year. If the BMI is outside the normal range, the provider must address and document an appropriate follow-up plan.

BMI Thresholds

- Underweight: BMI 18.5 or lower
- Within Range: BMI 18.5 – 24.9
- Overweight: BMI 25.0 or higher

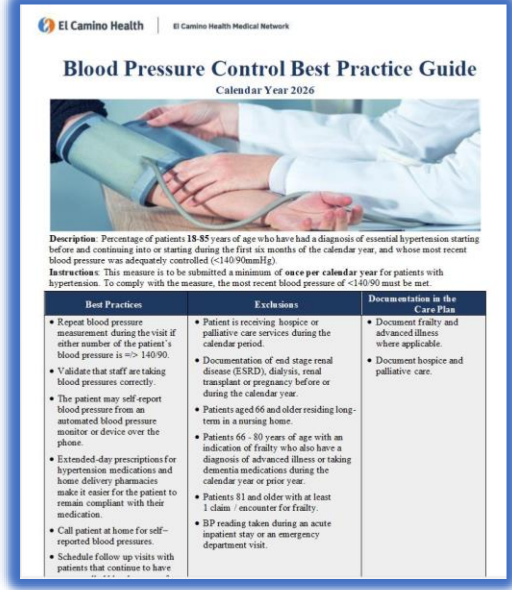
OPA Trigger

The BMI Practice Advisory will appear when:

- Height and weight are documented during the current encounter, generating a BMI.
- BMI is outside the normal range.

Note: In the Storyboard, hovering over **Review BMI** will also display the advisory.

1/30/2026 Ambulatory — *Tip Sheet_ Our Practice Advisory BMI*



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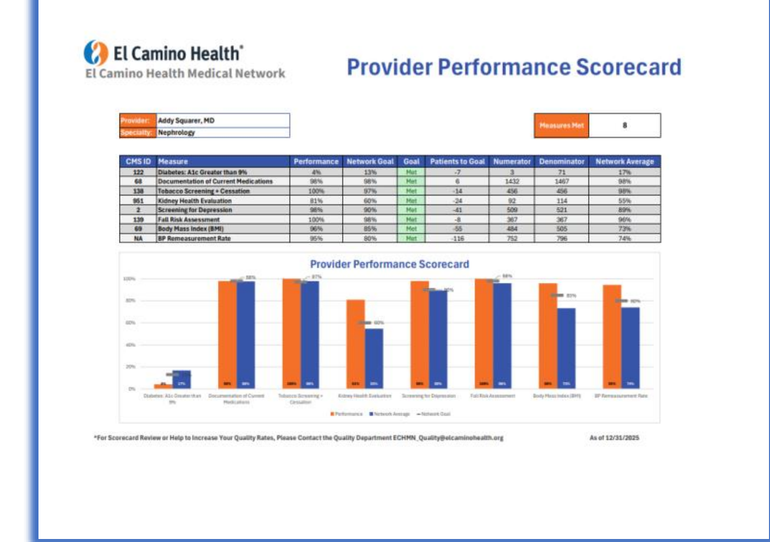
Blood Pressure Control Best Practice Guide

Calendar Year 2026

Description: Percentage of patients **18-85** years of age who have had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the calendar year, and whose most recent blood pressure was adequately controlled (<140/90mmHg).

Instructions: This measure is to be submitted a minimum of **once per calendar year** for patients with hypertension. To comply with the measure, the most recent blood pressure of <140/90 must be met.

Best Practices	Exclusions	Documentation in the Care Plan
• Repeat blood pressure measurement during the visit if either number of the patient's blood pressure is =/> 140/90. • Validate that staff are taking blood pressures correctly. • The patient may self-report blood pressure from an automated blood pressure monitor or device over the phone. • Extended-day prescriptions for hypertension medications and home delivery pharmacies make it easier for the patient to remain compliant with their medication. • Call patient at home for self–reported blood pressures. • Schedule follow up visits with patients that continue to have	• Patient is receiving hospice or palliative care services during the calendar period. • Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy before or during the calendar year. • Patients aged 66 and older residing long-term in a nursing home. • Patients 66 - 80 years of age with an indication of frailty who also have a diagnosis of advanced illness or taking dementia medications during the calendar year or prior year. • Patients 81 and older with at least 1 claim / encounter for frailty. • BP reading taken during an acute inpatient stay or an emergency department visit.	• Document frailty and advanced illness where applicable. • Document hospice and palliative care.



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Provider Performance Scorecard

Provider: Addy Squarer, MD
Specialty: Nephrology

Measures Met: 8

CMS ID	Measure	Performance	Network Goal	Goal	Patients to Goal	Numerator	Denominator	Network Average
122	Diabetes: A1c Greater than 9%	4%	13%	Met	-7	3	71	17%
68	Documentation of Current Medications	98%	98%	Met	6	1432	1467	98%
138	Tobacco Screening + Cessation	100%	97%	Met	-14	456	456	98%
951	Kidney Health Evaluation	81%	60%	Met	-24	92	114	55%
2	Screening for Depression	98%	90%	Met	-41	509	521	89%
139	Fall Risk Assessment	100%	98%	Met	-8	367	367	96%
69	Body Mass Index (BMI)	96%	85%	Met	-55	484	505	73%
NA	BP Remeasurement Rate	95%	80%	Met	-116	752	796	74%

*For Scorecard Review or Help to Increase Your Quality Rates, Please Contact the Quality Department ECHMN_Quality@elcaminohealth.org

As of 12/31/2025

El Camino Health Medical Network

CY 2026 Year-to-Date Performance

CY 2026 YTD Network Performance (thru April 10)

Measure	CY25 Final Results	YTD Performance	Target
Controlling Blood Pressure	78%	72%	77%
Diabetes: A1c Greater Than 9% (Lower is better)(*)(**)	13%	33%	12.5%
Documentation of Current Medications in the Medical Record	99%	99%	98%
Kidney Health Evaluation*	67%	30%	65%
Screening for Depression and Follow-Up Plan	97%	93%	90%
Breast Cancer Screening	81%	68%	75%
Blood Pressure Remeasurement		85%	80%
Colorectal Cancer Screening	76%	73%	75%
Falls: Screening for Future Fall Risk	99%	98%	98%
Tobacco Screening and Cessation Intervention for Tobacco Users	98%	98%	97%

5 of 10 measures on target — remaining 5 on track

*Some CMS quality measures reset at the start of each year, so rates may appear low early as data collection restarts.

**For inverse measures like A1c, lower rates indicate better performance, so rates improve as more patients meet target over time.

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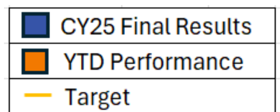
YTD Quality Metric Performance 2026



Measure	YE 2025	Goal	Previous Month	Current Month	Patients from Goal	% Increase	YTD Trend
Controlling Blood Pressure	**78%**	**77%**	**72%**	**72%**	**299**	**0.6%**	80% 78% 76% 74% 72% 70% / Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Glycemic Status Assessment (Lower Is Better)	**12.6%**	**12.5%**	**43%**	**33%**	**-725**	**-10.2%**	45% 40% 35% 30% 25% 20% 15% 10% / Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Kidney Health Evaluation	**67%**	**65%**	**24%**	**30%**	**813**	**6.5%**	70% 50% 30% 10% / Mar Apr May Jun Jul Aug Sep Oct Nov Dec

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*Data for Jan and Feb 2025 is not comparable due to a change in our attribution model. Consequently, the trending graphs above begin with data from Mar 2025.

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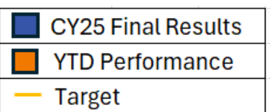
YTD Quality Metric Performance 2026



Measure	YE 2025	Goal	Previous Month	Current Month	Patients from Goal	% Increase	YTD Trend
Documentation of Current Medications	99%	98%	99%	99%	-391	0.0%	
Screening for Depression + Follow Up Plan	97%	90%	93%	93%	-558	0.4%	
Breast Cancer Screening	81%	75%	68%	68%	265	0.4%	

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*Data for Jan and Feb 2025 is not comparable due to a change in our attribution model. Consequently, the trending graphs above begin with data from Mar 2025.

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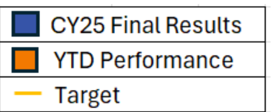
YTD Quality Metric Performance 2026



Measure	YE 2025	Goal	Previous Month	Current Month	Patients from Goal	% Increase	YTD Trend
Colorectal Cancer Screening	77%	75%	72%	73%	168	1.4%	
Tobacco Screening and Cessation Intervention	98%	97%	98%	98%	-122	0.2%	
Falls: Screening for Future Fall Risk	99%	98%	98%	98%	9	-0.1%	
Blood Pressure Remeasurement	N/A	80%	85%	85%	-323	0.5%	

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Quality in the IPA

IPA Proposal

Presented to the IPA Advisory Board in March:

Objective: Build a collaborative, data-driven program integrating IPA and all network providers — driving continuous improvement, accountability, and excellence in patient care.

Immediate priority: standardized data reporting across the IPA.

- Researching data aggregator solutions to consolidate information from **15** different EMRs into a single location.
- In the interim, we have proposed to focus on Community Connect providers, where unified data is already available. CY 2025 results for three measures have been analyzed; proposed targets are included for committee review.

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IPA Proposal

	Documentation of Current Medications	Screening for Future Fall Risk	Tobacco Screening and Cessation Intervention
CY25 ECHMN PSA	99%	99%	98%
CY25 ECHMN IPA	85%	69%	86%
Proposed Target CY26	88%	72%	90%
CY26 CMS Benchmarking Decile	3rd	5th	7th

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ECHMN Quality Department Initiative

SIREN launches May 2026: electronic incident reporting replacing paper-based process

- ECHMN launches SIREN in May 2026 — replacing the paper-based process with a fully electronic system.
- SIREN enables electronic tracking and analysis of incidents, complaints, compliments, and grievances — improving trend identification and patient safety.

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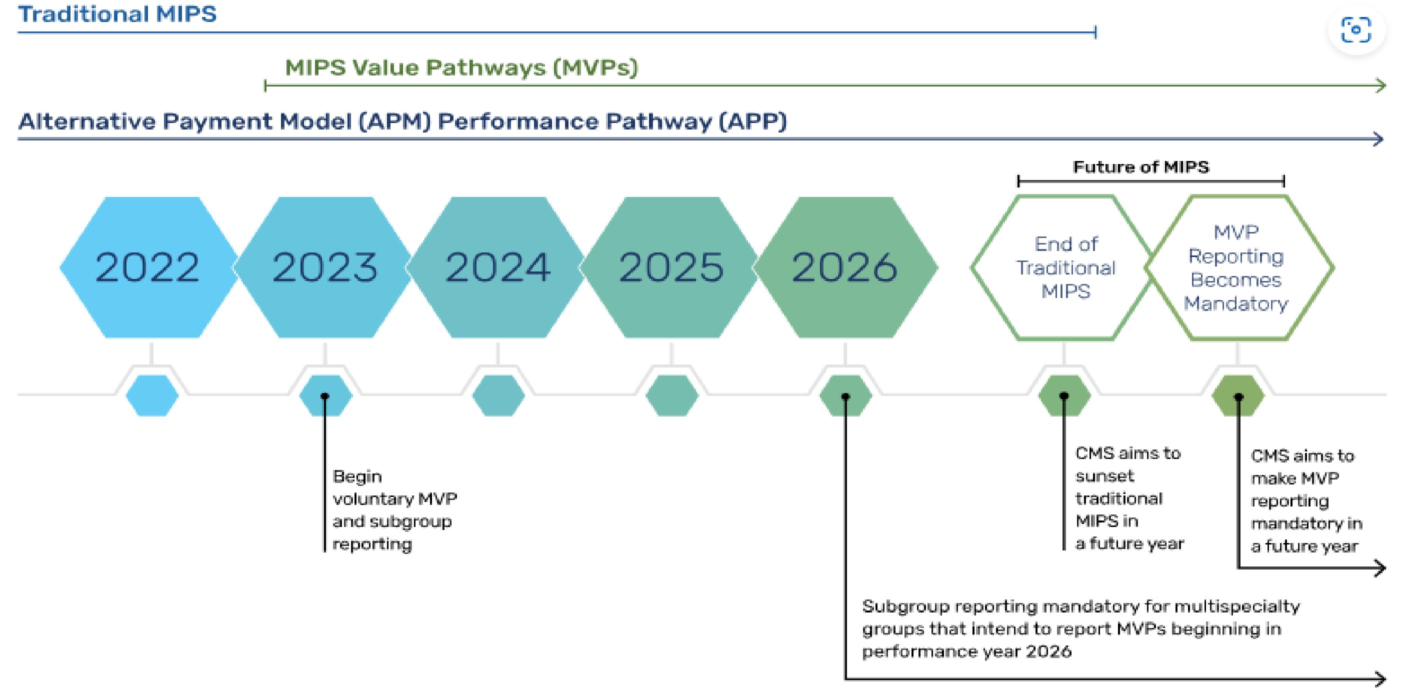
Appendix

Transition from Traditional MIPS to MVPs

- CMS announced the plan to sunset traditional MIPS in future years (~2029).
- MVPs align measures into specific pathways based on specialties.
- During the transition period, CMS is allowing clinicians to submit both traditional MIPS and MVPs and will honor whichever score is higher.
- In 2026, we are planning to register for the following 7 MVP specialties:
  - Primary Care
  - Kidney Health
  - Women's Health
  - Gastroenterology
  - Ophthalmology
  - Cardiology
  - Orthopedics



ECHMN 2026 Calendar Year — Quality Measures

Measure	Applies To	Description	2026 Target
Breast Cancer Screening	*Primary Care · Women's Health*	Women 40–74 who had a mammogram in the 27 months prior to year end.	**75% (Primary)** **80% (Women's Health)**
Diabetes: Glycemic Status Assessment >9%	*Primary Care · Specialist · Urgent Care · Kidney Health · Orthopedics*	Patients 18–75 with diabetes who had HbA1c >9% during the measurement period. Submitted minimum once per calendar year.	**12.5%** **17.5% (Urgent Care)**
Colorectal Cancer Screening	*Primary Care · Gastroenterology*	Adults 45–75 with appropriate CRC screening (colonoscopy, sigmoidoscopy, FOBT, stool DNA/FIT, or CT colonography).	**75% (Primary)** **80% (Gastro)**
Tobacco Screening & Cessation Intervention	*Primary Care · Specialist · Urgent Care · Pediatrics · Women's Health · Ophthalmology · Gastroenterology · Orthopedics · Cardiology*	Patients 12+ screened for tobacco use; cessation intervention provided if identified as a tobacco user.	**97%**
Screening for Future Fall Risk	*Primary Care · Specialist · Urgent Care · Orthopedics*	Patients 65+ screened for future fall risk during the calendar year.	**98%**
Controlling Blood Pressure	*Primary Care · Kidney Health*	Patients 18–85 with essential hypertension whose most recent BP was adequately controlled (<140/90 mmHg).	**77% (Primary)** **75% (Kidney Health)**
Documentation of Current Medications	*Primary Care · Specialist · Urgent Care · Pediatrics · Kidney Health · Ophthalmology · Gastroenterology · Orthopedics*	Visits where the clinician documents a current medication list using all available resources on the date of the encounter.	**98%**

ECHMN 2026 Calendar Year — Quality Measures

Measure	Applies To	Description	2026 Target
Screening for Depression & Follow-Up Plan	*Primary Care · Specialist · Urgent Care · Pediatrics · Women's Health · Kidney Health*	Patients 12+ screened using an age-appropriate standardized tool; follow-up plan documented within 2 days if positive.	**90%**
BMI Screening & Follow-Up Plan	*Specialist · Gastroenterology · Orthopedics · Cardiology*	Patients 18+ with BMI documented; follow-up plan required if BMI is outside normal range (<18.5 or ≥25 kg/m²).	**85%**
Kidney Health Evaluation	*Primary Care · Kidney Health*	Patients 18–85 with diabetes who received both an eGFR and uACR evaluation within the measurement period.	**65% (Primary)** **85% (Kidney Health)**
Blood Pressure Remeasurement	*Primary Care · Specialist · Urgent Care · Women's Health · Gastroenterology · Cardiology*	Patients who received a second BP check when the initial reading was ≥140/90 mmHg (systolic, diastolic, or both).	**80%**
Cervical Cancer Screening	*Women's Health*	Women 21–64 screened using cervical cytology (every 3 years) or cervical HPV testing (every 5 years).	**85%**
Weight Assessment & Counseling: Nutrition & Physical Activity	*Pediatrics*	Patients 3–17 with BMI percentile documented AND counseling provided for both nutrition and physical activity.	**70%**
Childhood Immunization Status	*Pediatrics*	Children age 2 with complete immunization series including DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and influenza vaccines.	**36%**

ECHMN 2026 Calendar Year — Quality Measures

Measure	Applies To	Description	2026 Target
Diabetes: Eye Exam	*Ophthalmology*	Patients 18–75 with diabetes who had a retinal or dilated eye exam by an eye care professional during the period or prior 12 months.	**98%**
Cataracts: 20/40 or Better Visual Acuity within 90 Days	*Ophthalmology*	Cataract surgeries in patients 18+ where best-corrected visual acuity of 20/40 or better was achieved within 90 days post-surgery.	**98%**
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	*Ophthalmology*	Patients 18+ with POAG diagnosis who had an optic nerve head evaluation during at least one visit in the measurement period.	**70%**
Functional Status Assessment for Total Hip Replacement	*Orthopedics*	Patients 19+ receiving elective total hip arthroplasty who completed a functional status assessment within 90 days before and 300–425 days after surgery.	**33%**
Total Knee/Hip Replacement: Shared Decision-Making — Conservative Therapy Trial	*Orthopedics*	Patients undergoing total knee or hip replacement with documented shared decision-making discussion of conservative non-surgical options prior to procedure.	**98%**
Heart Failure: Beta-Blocker Therapy for LVSD	*Cardiology*	Patients 18+ with HF and LVEF ≤40% who were prescribed or already taking beta-blocker therapy during the measurement period.	**95%**
Heart Failure: ACE Inhibitor / ARB / ARNI Therapy for LVSD	*Cardiology*	Patients 18+ with HF and LVEF ≤40% who were prescribed or already taking ACE inhibitor, ARB, or ARNI therapy during the measurement period.	**80%**

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

To: Quality, Patient Care, and Patient Experience Committee
From: Shreyas Mallur, M.D, Chief Quality Officer, and Lyn Garrett, MHA, MS, CPHQ
Date: May 4, 2026
Subject: Enterprise Quality, Safety, and Experience and STEEEP Dashboards through March 2026

Purpose: To update the Quality, Patient Care, and Patient Experience Committee on quality, safety, and experience measure performance through **March 2026** (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 quarterly and contains 17 measures. The STEEEP dashboard is intended to serve as a Governance Level report, 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.

A. Safe Care:

1. **C. Difficile Infection:** There have been 6(0.67 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 4 CAUTI's cases year-to-date in FY2026, against a target of ≤12 for the fiscal year. Prompt removal of urinary catheters, when clinically appropriate and consistent adherence to best practices for insertion and maintenance remain key focus areas. To minimize catheter duration, the frontline nursing managers and the infection prevention team review all patients with indwelling catheters in place for more than three days and collaborate with nursing and physician teams to confirm ongoing clinical indications and reinforce 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 (2) 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).

Memo: Q3 FY2026 STEEEP Dashboard Review /Enterprise Quality, Safety, and Experience Dashboard FY26 through March 2026
May 4, 2026

4. **Surgical Site Infection**. The number of surgical site infections for FY 26 (26) is unfavorable 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**: Though the absolute number of SSIs are high, the rate of SSIs has been stable without a significant increase. However, we have implemented all evidence-based practices and are now monitoring specific SSI reduction measures for colon surgeries and biliary surgeries)

5. **Hand Hygiene Combined Compliance rate:** Performance for YTD FY2026 is favorable (86.7%) to the target of 84%. (**Timeline for improvement**: We are on track to meet this measure. We are instituting real-time coaching for failures in compliance, as well as socializing this in our nursing and physician councils)

B. Timely:

1. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes:** YTD FY2026 performance of 76.6% fell below the 84% target, driven primarily by radiology staffing challenges with the contracted physician reading services vendor. In response, management transitioned to a new radiology reading group, which began service on December 30, 2025. (**Timeline for improvement**: Early results are promising: Q2 FY2026 performance has improved to 90%, exceeding target. As this improved run rate is sustained through the remainder of the fiscal year, we anticipate YTD performance will normalize above target by Q3 FY2026).

C. Effective:

1. **30 Day Readmission Observed Rate:** Performance YTD through February of 2026 (10.9%) is unfavorable to target (</=10.6 %) El Camino Health remains committed to ensuring timely follow-up care for patients under primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital. In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital. (**Timeline for improvement:** We are close to our target and are confident we will continue to maintain our FY 25 trend)

2. **Risk Adjusted Mortality Index.** Performance YTD FY26 (0.90) is favorable to target (1.05). 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. In addition, we are optimizing the expected mortality to accurately reflect the acuity of illness of our patients. (**Timeline for improvement:** We are on track to meet this measure.)

3. **Sepsis Mortality Index:** Performance through FY2026 is 1.12, which is favorable to the target of 1.15. Observed sepsis mortality is influenced by early goal-directed therapy, and El Camino Health continues to perform strongly on SEP-1 measures compared with national benchmarks. Ongoing efforts remain focused on reliable execution of SEP-1 components, including timely antibiotic administration and appropriate fluid and vasopressor management. In parallel, we are implementing a more robust approach to expected mortality management to better reflect patient severity of illness. These combined efforts have resulted in a downward trend in the sepsis mortality index. (**Timeline for improvement:** We continue to see sustained improvement month over month and are on track to meet this measure)

4. **PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV)**. FY26 performance through January of 2026 (25.8%) is unfavorable to target of 23.9%.The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2 of FY2024. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (**Timeline for improvement**: This metric has been challenging for the organization as well as like hospitals in California. We will continue with our efforts to reduce this metric)

D. Efficient:

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance 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.

    1.1. Multidisciplinary rounds with the hospitalist group have contributed to reductions in length of stay through improved care coordination, earlier identification of discharge barriers, and more timely insurance authorization for patients transitioning to skilled nursing facilities or home care.

1.2. We now have skilled nursing facility transfer agreements in place to help us expedite discharge self-pay and MediCal patients. (**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 (152 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). (**Timeline for improvement:** We are on track to meet this measure).

E. Equitable:

1. **Social Drivers of Health Screening rate:** FY 26 performance YTD is (84%) is favorable to target of 70%. This is a new measure and steps 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:** This is a new measure for FY26. FY 26 YTD is (81.8%) is favorable 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**: We are on track to meet this measure).

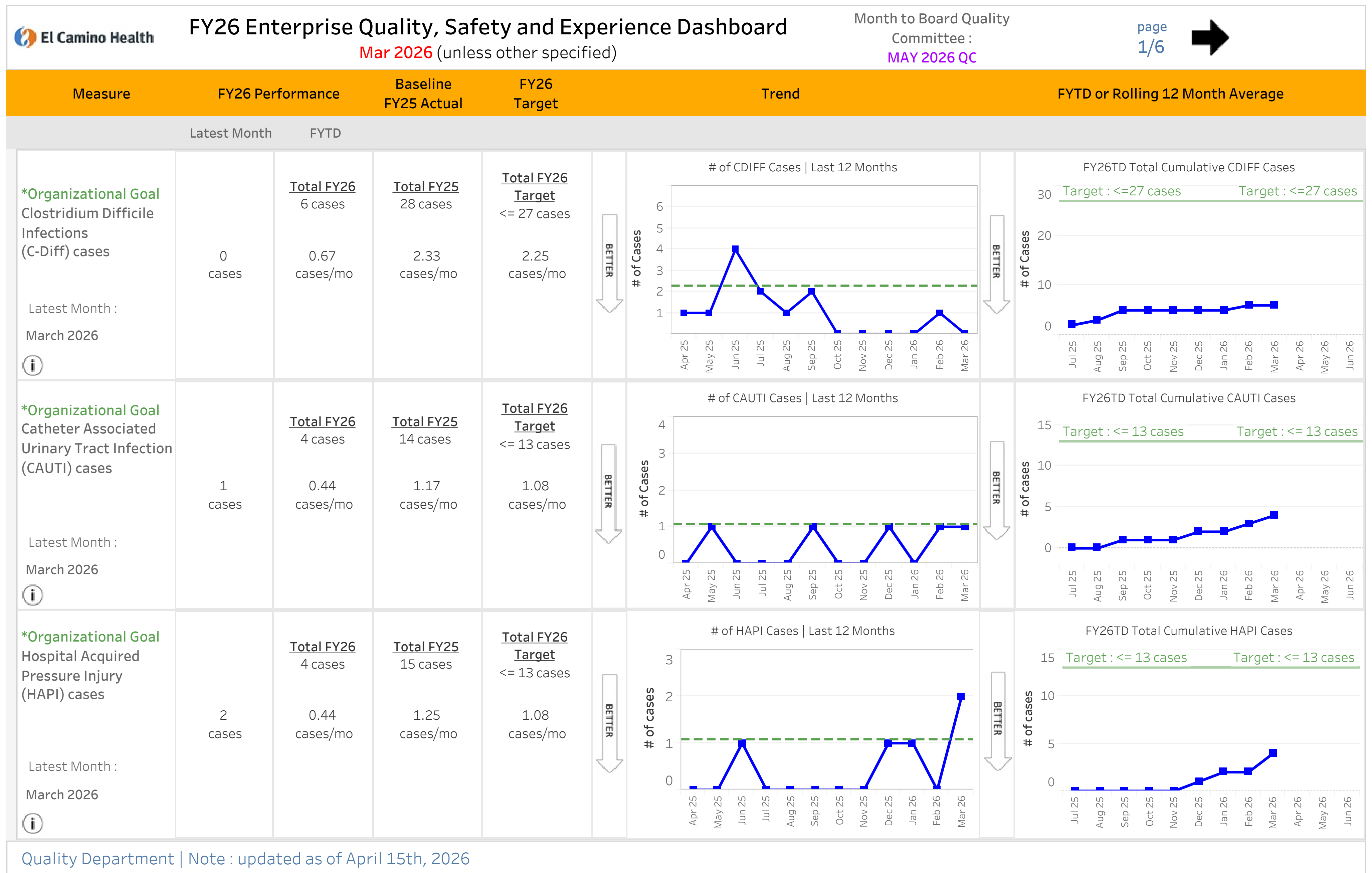
F. Patient/Family Centered:

1. **Inpatient Performance:** Inpatient patient experience performance continues to show sustained improvement across the enterprise, with the composite LTR reaching 84.6% YTD, exceeding the FY26 target of 83.4% and maintaining performance above baseline. Core drivers, including inpatient and emergency services, are demonstrating meaningful gains, with inpatient performance improving to 82.6% YTD (+1.1 vs baseline) and emergency department performance to 79.8% YTD (+1.6 vs baseline), alongside notable year over year improvements. High performing areas such as Maternal Child Health (86.6% YTD) continue to operate at top decile levels, while historically variable areas, including Los Gatos inpatient and lab services, are showing measurable improvement. Overall, performance reflects increased reliability, reduced variation, and stronger adoption of leader standard work, positioning inpatient experience as a consistent organizational strength.

2. **Medical Network Performance:** The El Camino Health Medical Network continues to perform above target and demonstrate strong national competitiveness, with an overall LTR of 86.1%, exceeding the FY26 target of 83.2%. Multiple clinics are achieving top box scores above 90%, with several ranking in the highest national percentiles, reinforcing a strong patient perception of care delivery. Urgent care performance remains stable at 84.3%, exceeding target and reflecting consistency across sites. These results indicate effective standardization across ambulatory settings, supporting both patient retention and growth. Continued focus on reducing variability and strengthening communication and care coordination will be key to sustaining performance and further enhancing market differentiation.

Attachments:

1. Enterprise Quality Dashboard FY 26 through March 2026.
2. STEEEP Dashboard through March 2026



El Camino Health
FY26 Enterprise Quality, Safety and Experience Dashboard
Mar 2026 (unless other specified)
Month to Board Quality Committee :
MAY 2026 QC
page
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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 :
March 2026
0 cases
Total FY26
6 cases
0.67 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
# of Cases
FY26TD Total Cumulative CDIFF Cases
Target : <=27 cases
# of cases
*Organizational Goal
Catheter Associated Urinary Tract Infection (CAUTI) cases
Latest Month :
March 2026
1 cases
Total FY26
4 cases
0.44 cases/mo
Total FY25
14 cases
1.17 cases/mo
Total FY26 Target
<= 13 cases
1.08 cases/mo
# of CAUTI Cases | Last 12 Months
FY26TD Total Cumulative CAUTI Cases
Target : <= 13 cases
*Organizational Goal
Hospital Acquired Pressure Injury (HAPI) cases
Latest Month :
March 2026
2 cases
Total FY26
4 cases
0.44 cases/mo
Total FY25
15 cases
1.25 cases/mo
Total FY26 Target
<= 13 cases
1.08 cases/mo
# of HAPI Cases | Last 12 Months
FY26TD Total Cumulative HAPI Cases
Target : <= 13 cases
Quality Department | Note : updated as of April 15th, 2026

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (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
Mar 2026 (unless other specified)
Month to Board Quality Committee :
MAY 2026 QC
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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 :
March 2026
0 cases
Total FY26
2 cases
0.22 cases/mo
Total FY25
4 cases
0.33 cases/mo
Total FY26 Target
<= 5 cases
0.42 cases/mo
BETTER
# of CLABSI Cases | Last 12 Months
# of cases
FY26TD Total Cumulative CLABSI Cases
Target : <= 5 cases
Surgical Site Infections (SSI) cases
Latest Month :
March 2026
0 cases
Total FY26
26 cases
2.89 cases/mo
Total FY25
38 cases
3.17 cases/mo
Total FY26 Target
<= 34 cases
2.83 cases/mo
# of SSI Cases | Last 12 Months
FY26TD Total Cumulative SSI Cases
Target : <= 34 cases
Serious Safety Event Rate (SSER)
Latest Month :
March 2026
1 events
0.17 (3 / 174751)
0.61 (13 / 214277)
n/a
# of Events
Average : 0.33
Rolling 12 Month Average Rate
Rate Per 10000 PDs
Quality Department | Note : updated as of April 15th, 2026

El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (unless other specified)

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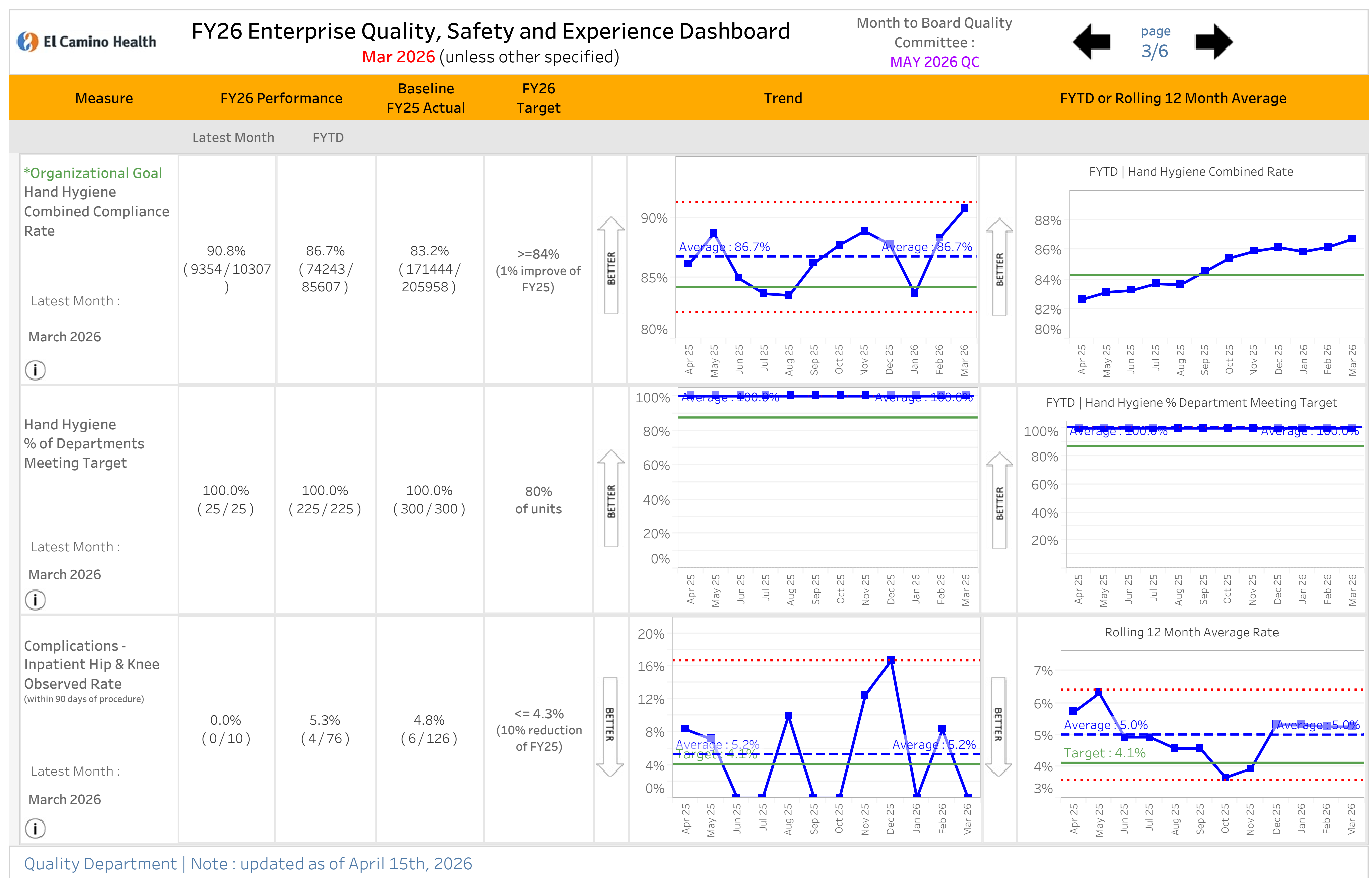
Measure	Definition Owner	Metric Definition	Data Source
Central Line Associated Blood Stream Infection (CLABSI) cases	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
Surgical Site Infections (SSI) cases	C. Nalesnik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



Quality Department | Note : updated as of April 15th, 2026

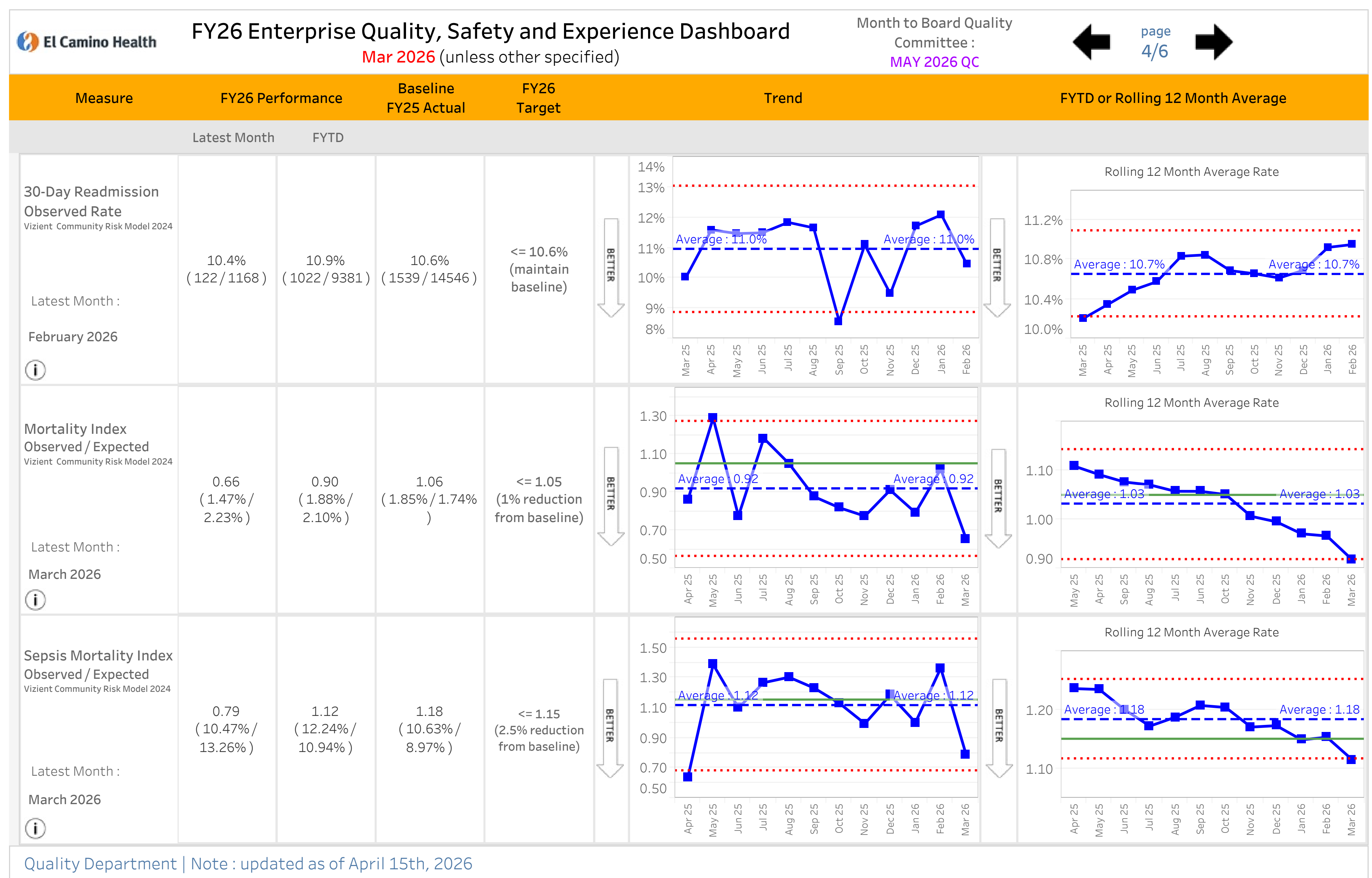
El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (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
Mar 2026 (unless other specified)
Month to Board Quality Committee :
MAY 2026 QC
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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 Community Risk Model 2024
Latest Month :
February 2026
10.4% (122 / 1168)
10.9% (1022 / 9381)
10.6% (1539 / 14546)
<= 10.6% (maintain baseline)
BETTER
Average : 11.0%
Rolling 12 Month Average Rate
Average : 10.7%
Mortality Index Observed / Expected
Vizient Community Risk Model 2024
Latest Month :
March 2026
0.66 (1.47% / 2.23%)
0.90 (1.88% / 2.10%)
1.06 (1.85% / 1.74%)
<= 1.05 (1% reduction from baseline)
Average : 0.92
Average : 1.03
Sepsis Mortality Index Observed / Expected
Vizient Community Risk Model 2024
Latest Month :
March 2026
0.79 (10.47% / 13.26%)
1.12 (12.24% / 10.94%)
1.18 (10.63% / 8.97%)
<= 1.15 (2.5% reduction from baseline)
Average : 1.12
Average : 1.18
Quality Department | Note : updated as of April 15th, 2026

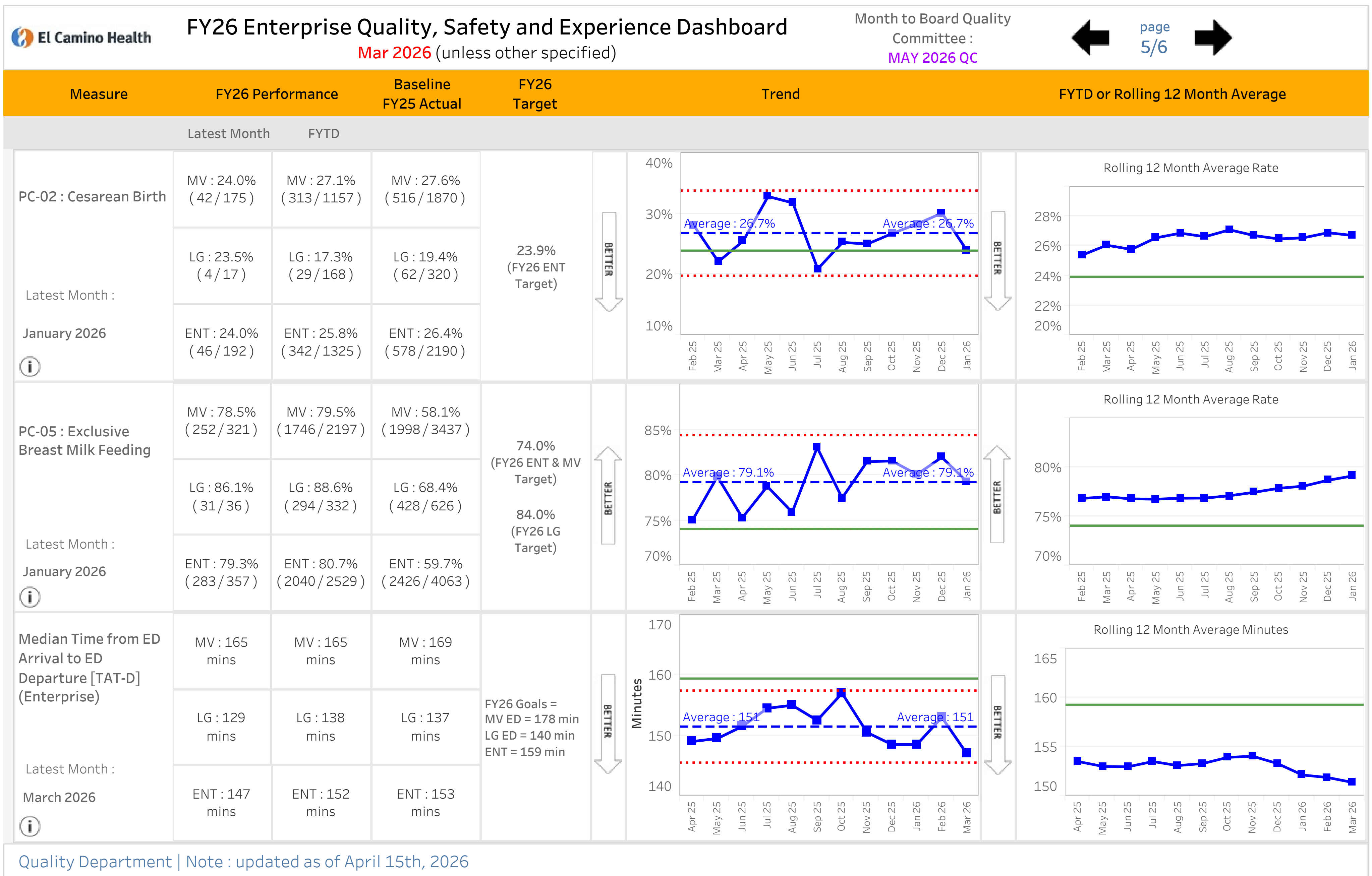
El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (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 Community Risk Model 2024	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 (exclude Behavioral Health Service Line, Rehab, Nonviable Neonates, Normal Newborn, Pediatrics, Hospice). OB is included by default	Vizient Clinical Database Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Vizient Community Risk Model 2024	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. (exclude Rehab, Nonviable Neonates & Hospice). Behavioral Health Service Line, Normal Newborn, Pediatrics & OB are included by default. 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 Community Risk Model 2024	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



FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (unless other specified)

Month to Board Quality Committee : MAY 2026 QC

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Measure	FY26 Performance Latest Month	FY26 Performance FYTD	Baseline FY25 Actual	FY26 Target
PC-02 : Cesarean Birth (Latest Month : January 2026)	MV : 24.0% (42 / 175)	MV : 27.1% (313 / 1157)	MV : 27.6% (516 / 1870)	23.9% (FY26 ENT Target)
	LG : 23.5% (4 / 17)	LG : 17.3% (29 / 168)	LG : 19.4% (62 / 320)	
	ENT : 24.0% (46 / 192)	ENT : 25.8% (342 / 1325)	ENT : 26.4% (578 / 2190)	
PC-05 : Exclusive Breast Milk Feeding (Latest Month : January 2026)	MV : 78.5% (252 / 321)	MV : 79.5% (1746 / 2197)	MV : 58.1% (1998 / 3437)	74.0% (FY26 ENT & MV Target) 84.0% (FY26 LG Target)
	LG : 86.1% (31 / 36)	LG : 88.6% (294 / 332)	LG : 68.4% (428 / 626)	
	ENT : 79.3% (283 / 357)	ENT : 80.7% (2040 / 2529)	ENT : 59.7% (2426 / 4063)	
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) (Latest Month : March 2026)	MV : 165 mins	MV : 165 mins	MV : 169 mins	FY26 Goals = MV ED = 178 min LG ED = 140 min ENT = 159 min
	LG : 129 mins	LG : 138 mins	LG : 137 mins	
	ENT : 147 mins	ENT : 152 mins	ENT : 153 mins	

Quality Department | Note : updated as of April 15th, 2026

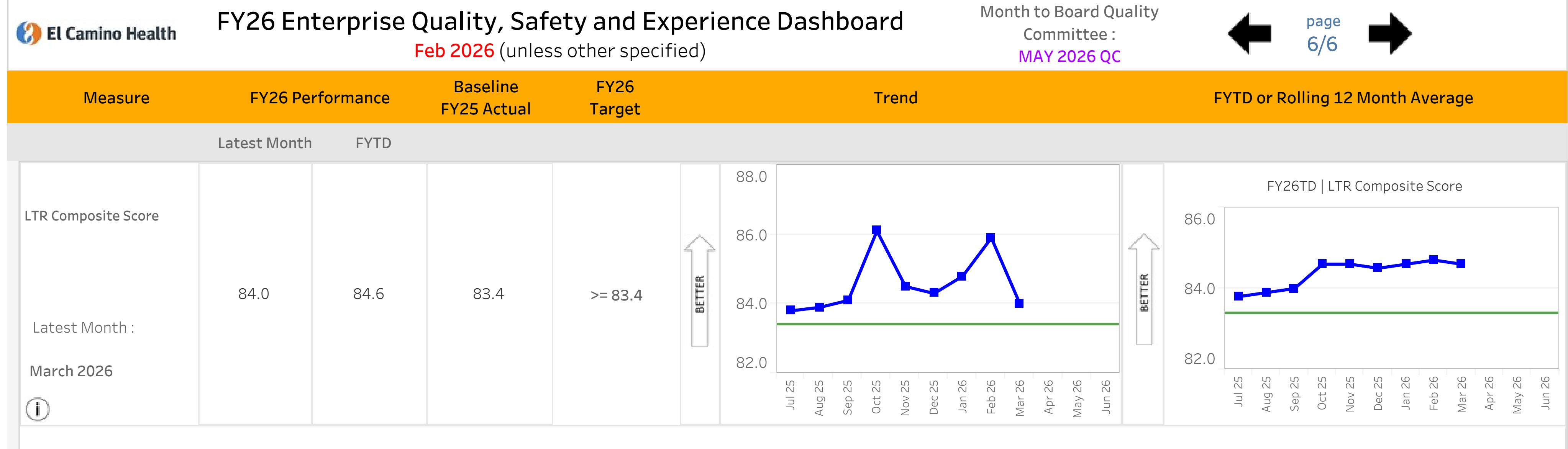
El Camino Health

FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (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**

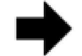


Quality Department | Note : updated as of April 15th, 2026

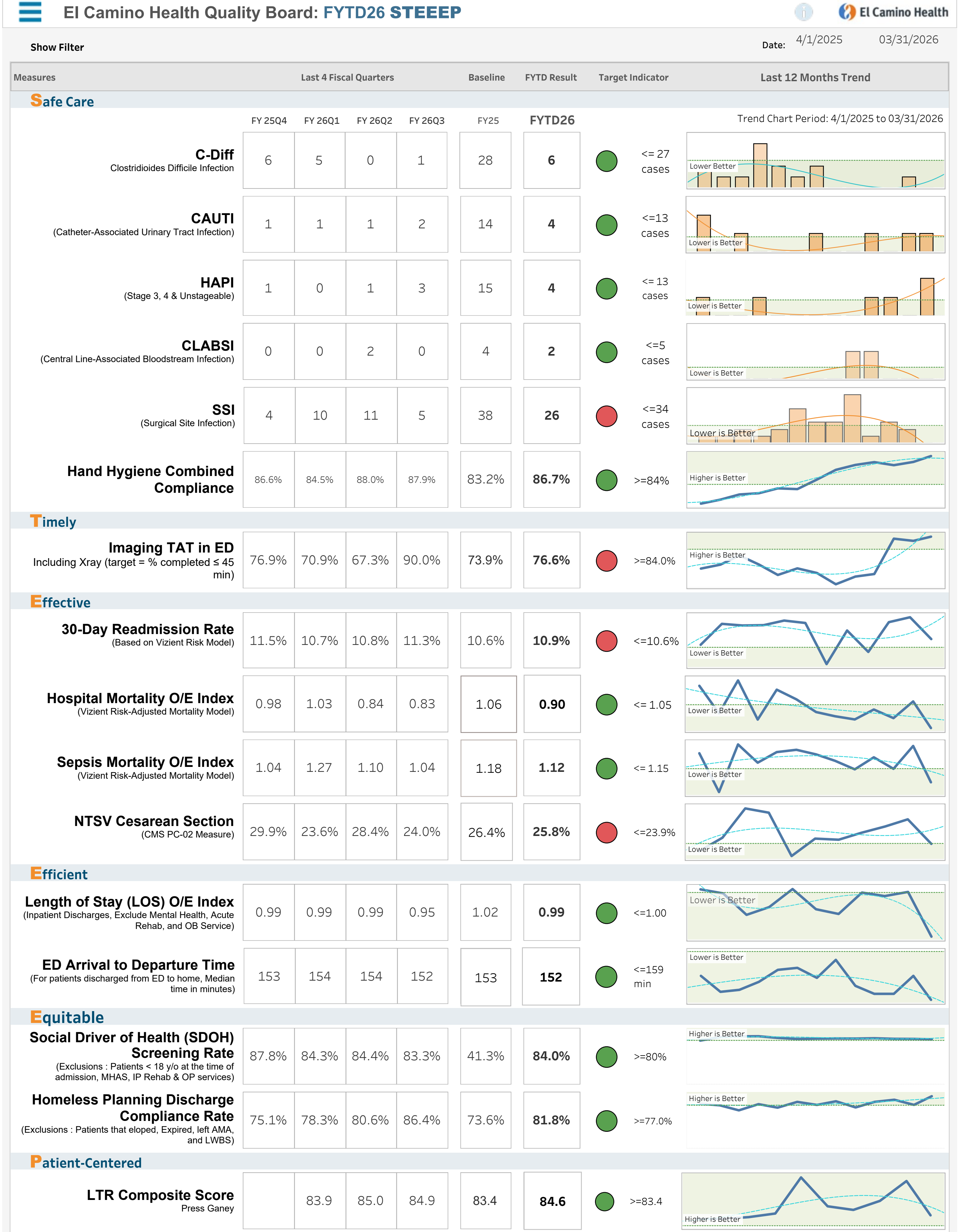
FY26 Enterprise Quality, Safety and Experience Dashboard

Mar 2026 (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

El Camino Health

Show Filter

Date: 4/1/2025 03/31/2026

Trend Chart Period: 4/1/2025 to 03/31/2026

Measures	FY 25Q4	FY 26Q1	FY 26Q2	FY 26Q3	Baseline FY25	FYTD Result FYTD26	Target Indicator	Target	Last 12 Months Trend
Safe Care									
C-Diff Clostridioides Difficile Infection	6	5	0	1	28	**6**	Green	<= 27 cases	Lower Better
CAUTI (Catheter-Associated Urinary Tract Infection)	1	1	1	2	14	**4**	Green	<=13 cases	Lower is Better
HAPI (Stage 3, 4 & Unstageable)	1	0	1	3	15	**4**	Green	<= 13 cases	Lower is Better
CLABSI (Central Line-Associated Bloodstream Infection)	0	0	2	0	4	**2**	Green	<=5 cases	Lower is Better
SSI (Surgical Site Infection)	4	10	11	5	38	**26**	Red	<=34 cases	Lower is Better
Hand Hygiene Combined Compliance	86.6%	84.5%	88.0%	87.9%	83.2%	**86.7%**	Green	>=84%	Higher is Better
Timely									
Imaging TAT in ED Including Xray (target = % completed ≤ 45 min)	76.9%	70.9%	67.3%	90.0%	73.9%	**76.6%**	Red	>=84.0%	Higher is Better
Effective									
30-Day Readmission Rate (Based on Vizient Risk Model)	11.5%	10.7%	10.8%	11.3%	10.6%	**10.9%**	Red	<=10.6%	Lower is Better
Hospital Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	0.98	1.03	0.84	0.83	1.06	**0.90**	Green	<= 1.05	Lower is Better
Sepsis Mortality O/E Index (Vizient Risk-Adjusted Mortality Model)	1.04	1.27	1.10	1.04	1.18	**1.12**	Green	<= 1.15	Lower is Better
NTSV Cesarean Section (CMS PC-02 Measure)	29.9%	23.6%	28.4%	24.0%	26.4%	**25.8%**	Red	<=23.9%	Lower is Better
Efficient									
Length of Stay (LOS) O/E Index (Inpatient Discharges, Exclude Mental Health, Acute Rehab, and OB Service)	0.99	0.99	0.99	0.95	1.02	**0.99**	Green	<=1.00	Lower is Better
ED Arrival to Departure Time (For patients discharged from ED to home, Median time in minutes)	153	154	154	152	153	**152**	Green	<=159 min	Lower is Better
Equitable									
Social Driver of Health (SDOH) Screening Rate (Exclusions : Patients < 18 y/o at the time of admission, MHAS, IP Rehab & OP services)	87.8%	84.3%	84.4%	83.3%	41.3%	**84.0%**	Green	>=80%	Higher is Better
Homeless Planning Discharge Compliance Rate (Exclusions : Patients that eloped, Expired, left AMA, and LWBS)	75.1%	78.3%	80.6%	86.4%	73.6%	**81.8%**	Green	>=77.0%	Higher is Better
Patient-Centered									
LTR Composite Score Press Ganey		83.9	85.0	84.9	83.4	**84.6**	Green	>=83.4	Higher is Better

Quality Committee
Proposed FY2027 Meeting Dates

RECOMMENDED QC DATES	CORRESPONDING HOSPITAL BOARD DATE
Monday, August 31, 2026	Wednesday, September 16, 2026
Monday, November 2, 2026	Wednesday, November 18, 2026
Monday, February 1, 2027	Wednesday, February 10, 2027
Monday, March 1, 2027	Wednesday, March 10, 2027
Monday, May 3, 2027	Wednesday, May 12, 2027
Monday, June 7, 2027	Wednesday, June 16, 2027

PROPOSED

FY27 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

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

STAFF: Chief Quality Officer (Executive Sponsor)

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

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan.	Q4FY26 review and update which measures to include on the FY27 Quality Dashboards.	Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered.
2. Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY26 review FY27 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY27.	Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report".
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee.	Fiscal Year 2027	• Attend a minimum of 4 meetings in person. • Actively participate in discussions at each meeting. • Review of annual committee self-assessment results
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2027	Committee attendance rate at conference and/or session with a subject matter expert of at least 50%. • Verbal/Written report of key learnings to the Quality Committee.

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

PROPOSED FOR QC APPROVAL

Quality, Patient Care, and Patient Experience Committee
DRAFT FY27 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		✓			✓			✓			✓	
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)

For approval at the May 4 QC Meeting

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

To: ECH Quality Committee
From: Shreyas Mallur, M.D, MBA Chief Quality Officer
Date: May 4, 2026
Subject: Organizational Quality Incentive Goals – Methodology, Calibration and Proposed Targets

Motion: Recommend Board approval of the proposed FY2027 organizational quality incentive goals under the Quality and Safety Strategic Pillar, as presented, including the Risk-Adjusted Mortality Index (RAMI) Observed/Expected Ratio and Hospital-Acquired Pressure Injuries (HAPI) Stage II+ Monthly Average goals, each weighted at 17% of the overall incentive plan, with performance tiers set at Threshold, Target, and Stretch levels.

FY2027 PROPOSED QUALITY GOALS – SUMMARY

Both goals fall under the **Quality and Safety Strategic Pillar** and together represent **34% of the overall incentive plan** (17% each) and 100% of the Quality and Safety pillar weighting.

Quality Goal	FY26 Baseline	Threshold	Target	Stretch	Weighting
Risk-Adjusted Mortality Index (RAMI) O/E Ratio	0.99 O/E (FY26 YTD)	0.96(−2.5%)	0.94 (−5%)	0.89 (−10%)	17% of Plan 50% of Q&S Pillar
Hospital-Acquired Pressure Injuries (HAPI) Stage II+ Monthly Avg.	6.17 / mo. (Apr'25–Mar'26)	5.84 / mo. (−5.3%)	5.52 / mo. (−10.6%)	5.19 / mo. (−15.8%)	17% of Plan 50% of Q&S Pillar