El Camino Health

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

Monday, March 4, 2024 – 5:30 pm

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

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 950 2003 1821#. No participant code. Just press #.

John Zoglin will be participating via teleconference from 5 Milton Place, Rancho Mirage, CA 92270

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).

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:33 – 5:34**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:37 – 5:52**
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (02/05/2024) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (02/05/2024) c. Receive Progress against FY24 Committee Goals d. Receive FY24 Enterprise Quality Dashboard e. Receive Value Based Purchasing Report f. Receive Follow-Up Item: Fecal Implant			

A copy of the agenda for the Regular 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) 988-7609** 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
6.	**VERBAL CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair	Information	**5:52 – 5:57**
7.	**PATIENT STORY REPORT**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Information	**5:57 – 6:02**
8.	**PATIENT EXPERIENCE REPORT**	Christine Cunningham, MBA Chief Experience Officer	Information	**6:02 – 6:22**
9.	**FY25 COMMITTEE PLANNING ITEMS:** a) Committee Dates b) Committee Goals c) Pacing Plan d) QC Charter	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**6:22 – 6:47**
10.	**FY25 ENTERPRISE QUALITY AND EXPERIENCE GOAL**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**6:47 – 7:02**
11.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:02 – 7:03**
12.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **QUALITY COUNCIL MINUTES** a. Receive Quality Council Minutes (02/07/2024)	Carol Somersille, MD Quality Committee Chair	Discussion	**7:03 – 7:08**
13.	*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* **APPROVE CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer	Motion Required	**7:08 – 7:18**
14.	*Health and Safety Code section 32155 – Deliberations concerning reports on Medical Staff quality assurance committee* **VERBAL SERIOUS SAFETY/RED ALERT EVENT REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**7:18 – 7:23**
15.	**RECONVENE TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:23 – 7:24**
16.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:24 – 7:25**
17.	**COMMITTEE ANNOUNCEMENTS**	Carol Somersille, MD Quality Committee Chair	Information	**7:25 – 7:29**
18.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:29 – 7:30 pm**

Next Meeting: May 6, 2024, June 3, 2024

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Monday, February 5, 2024
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Melora Simon
John Zoglin
Pancho Chang
Jack Po, MD (*at 5:34 p.m.)*
Krutica Sharma, MD **
Prithvi Legha, MD
Philip Ho, MD *(at 5:47 p.m.)*

Members Absent

Others Present
Holly Beeman, MD, MBA, CQO
Dan Woods, CEO **
Mark Adams, MD, CMO
Theresa Fuentes, CLO
Shahab Dadjou, President, El Camino Health Medical Network **
Lyn Garrett, Senior Director, Quality
Ute Burness, VP of Quality and Payer Relations
Tracy Fowler, Director, Governance Services **
Nicole Hartley, Executive Assistant II
Gabriel Fernandez, Coordinator, Governance Services

**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Health (the "Committee") was called to order at **5:31 p.m.** by Chair Carol Somersille. A verbal roll call was taken. A quorum was present. Jack Po arrived at **5:34 p.m**. Dr. Phillip Ho arrived at **5:47 p.m.**	Call to order at **5:31 p.m.**
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	Ms. Hartley shared that we have one member of the Committee, Dr. Krutica Sharma participating remotely due to Just Cause.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Item (e) Follow-Up Item: Hand Hygiene Project Overview was pulled for further discussion. The Committee asked for how the project would continue to be measured and evaluated as an ongoing project. Staff discussed various methods that are being taken to ensure proper and accurate tracking. The Committee also asked if AI monitoring was a potential avenue to explore. Staff explained that this is a method currently being explored, but no decision or timeline for implementation exists right now. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (12/04/2023), (b) Minutes of the Closed Session of the Quality Committee Meeting (12/04/2023) Received: (c) Receive FY24 Pacing Plan, (d) Receive Committee Follow-Up Item: 6/1/2020 Report on Obstetrical Lacerations, (e) Receive Committee Follow-Up Item: Hand Hygiene Project Overview **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Ho **Recused**: None	***Consent Calendar Approved***
6. VERBAL CHAIR'S REPORT AND IHI HIGHLIGHTS	Chair Somersille provided a verbal Chair's report to the committee. In the report, Chair Somersille shared the knowledge she gained from her attendance at the Institute for Healthcare Improvement (IHI) Conference. Dr. Somersille opened with a suggestion that the committee look to attend a conference that interests them and would be beneficial to the committee. Additionally, Dr. Somersille highlighted various areas such as the Quality measurement journey and how a partnership with the organization's data scientists to find ways to continue the improvement of clarity of presentation of data points to the committee. In addition, Dr. Somersille included a brief overview of AI within healthcare, proactive approaches to quality measures, and continued improvement being a signifier of success concerning quality goal setting and reporting.	
7. PATIENT STORY	Dr. Beeman provided the Patient Story report received from the Press Ganey patient comment portal. This included two comments from patients in the Labor and Delivery wing who provided feedback on their experiences in the previous in their respective rooms.	

DRAFT

8. RECEIVE Q2 FY24 STEEEP and Enterprise Quality Dashboard	Dr. Beeman presented an update on measures tracked on the STEEEP and Enterprise Quality Dashboards. Dr. Beeman provided an in-depth analysis of performance, process improvement initiatives, and HAC Index 2.0 performance measures. **Motion**: To receive Q2 FY24 STEEEP and Enterprise Quality Dashboard **Movant**: Chang **Second**: Po **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Motion Approved***
9. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Ms. Ute Burness provided a report on the El Camino Health Medical Network to provide the quarterly report. Ms. Burness provided updates on three key measures of focus for the medical network: (a) Clinical Excellence, (b) Dependable and Convenient Care, and (c) Patient Experience. ECHMN has met/ exceeded all eight-quality metrics and is performing in the 9th and 10th deciles in 5 of those measures with constant improvements to move all measures into those respective deciles. **Motion**: To receive the El Camino Health Medical Network Report **Movant**: Simon **Second**: Chang **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Sharma **Recused**: None	***Motion Approved***
10. RECESS TO CLOSED SESSION	**Motion**: To recess to closed session **Movant**: Zoglin **Second**: Simon **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Recessed to Closed Session at 6:48 PM***

11. AGENDA ITEM 16: CLOSED SESSION REPORT OUT	During the closed session, the Quality Committee approved the Board recommendation of the Credentialing and Privileges Report for approval by the El Camino Hospital Board of Directors, by a unanimous vote of all members present.	
12. AGENDA ITEM 17: COMMITTEE ANNOUNCEMENTS	Mr. Chang raised a question regarding the stated purpose of the Quality Committee. Discussion on the topic ensued and raised points that the committee showed interest in exploring.	***Actions:*** *The committee would like to evaluate the stated purpose and compare it with the committee charter at the March meeting.*
13. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:19 p.m. **Movant**: Simon **Second**: Po **Ayes**: Somersille, Chang, Ho, Legha, Po, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: None **Recused**: None	***Adjourned at 7:19 PM.***

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

_____

Gabriel Fernandez, Governance Services Coordinator

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by: Tracy Fowler, Director of Governance Services

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El Camino Health

FY24 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: **Holly Beeman, MD, MBA,** 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 (Enterprise Quality, Patient Care and Patient Experience dashboard, and STEEEP) are in alignment with the enterprise strategic plan.	Q4FY23 review and update which measures to include on the FY24 quarterly board STEEEP report.	- Enterprise quality dashboard measures and targets - STEEEP dashboard measures and targets.
2. Monitor Quality, Patient Care and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY23, review FY24 Incentive Goal recommendations for Quality, Safety and Patient Experience measures and targets.	- Monthly Enterprise dashboard measures with targets and performance - Quarterly STEEEP dashboard with targets and performance
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY24.	- Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee by implementing regular feedback mechanisms, encouraging open communication, and promoting a shared sense of responsibility for achieving quality outcomes.	Using closing wrap up time, review quarterly at the end of the meeting.	- Attend a minimum of 7 meetings in person - Actively participate in discussions at each meeting - Improvement on baseline metrics for the assessment (Initial assessment to be conducted prior to the beginning of FY24)
5. Participate in the training and development of the Committee.		- Attend a conference and/or session with a subject matter expert - Commit to ongoing learning as needed.

Chair: Carol Somersille, MD
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

El Camino Health

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

To: Quality, Patient Care, and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: March 4, 2024
Subject: Enterprise Quality, Safety, and Experience Dashboard through October 2023

Purpose:

To update the Quality, Patient Care, and Patient Experience Committee on quality, safety, and experience measure performance through January 2024 (unless otherwise noted).

Summary:

Situation: The Fiscal Year 2024 Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. This dashboard is produced monthly and includes trend lines and rolling 12-month average graphs.

Background: A detailed memo supporting the measures on the STEEEP and Enterprise Quality, Safety and Experience dashboard provided in depth analysis of performance, process improvement initiatives and timelines for the recent February 5th, 2024, Quality Committee meeting. Many impacts of interventions do not change notably in three weeks' time (the time of the writing of this memo). This memo is not intended to be as comprehensive as the Quarterly combined STEEEP and Enterprise combined reports.

Assessment:

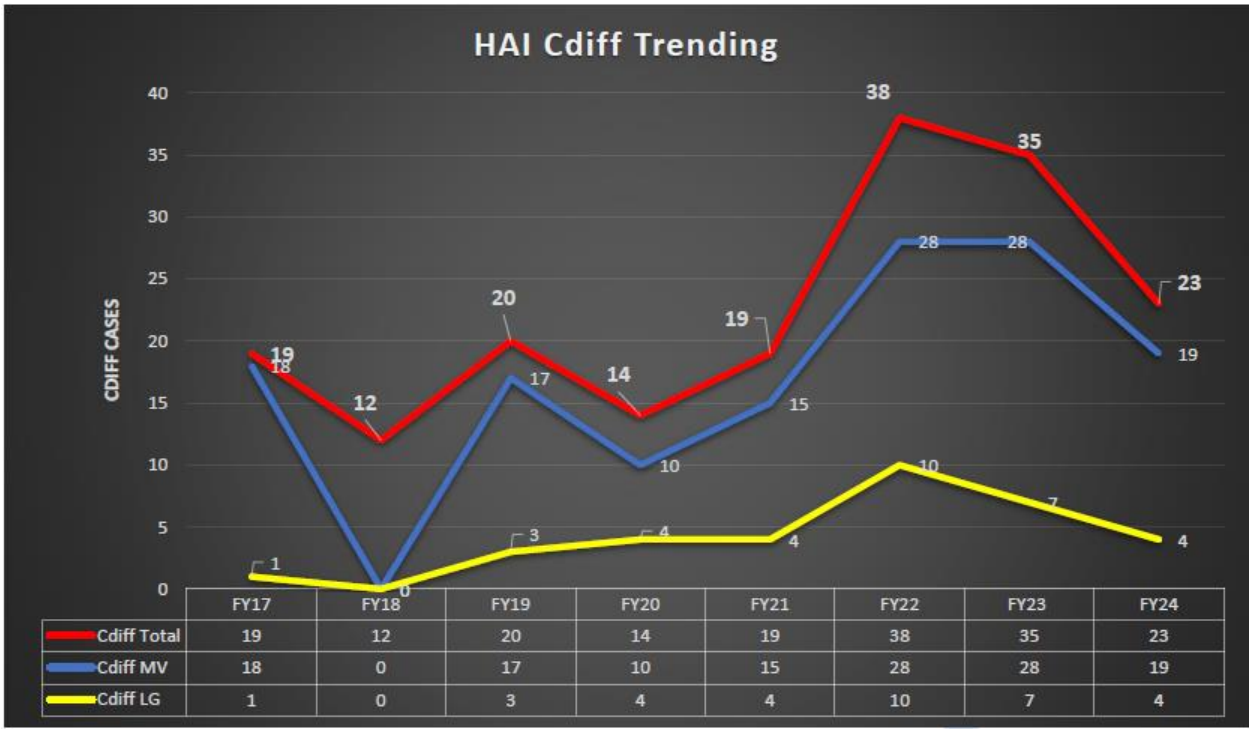
a) Quality Measures

i) **Hospital Acquired Condition Index 2.0** (lower is better). This metric is a composite of the weighted rates of 4 component measures. The table below illustrates the method and measures to formulate the HAC Index.

FY 24 HAC 2.0 weighting and targets			
Component	**Denominator**	**Weighting**	**Weighted Rate**
CLABSI	per 1,000 central line days	25%	aa
CAUTI	per 1,000 catheter days	25%	bb
C. Diff	per patient days x 10,000	25%	cc
nvHAP	per patient days x 1,000	25%	dd
		SUM	HAC Index

The HAC Index 2.0 for the month of January (1.277) is unfavorable to target of 1.201. Year to date the performance of 1.312 is unfavorable to target.

(1) C. Difficile. We are laser sharp focused on reducing hospital onset C. Difficile infections. There were four (unfavorable) in January 2024. One case was in Los Gatos, three in Mountain View. There have been 23 C. Diff infections YTD, our target for FY24 is to have <33 infections. This is achievable, but will require our full attention on hand hygiene, and following our procedures for screening and testing for C. Difficile. The graph below shows ECH C. Diff trends going back to FY 2017.



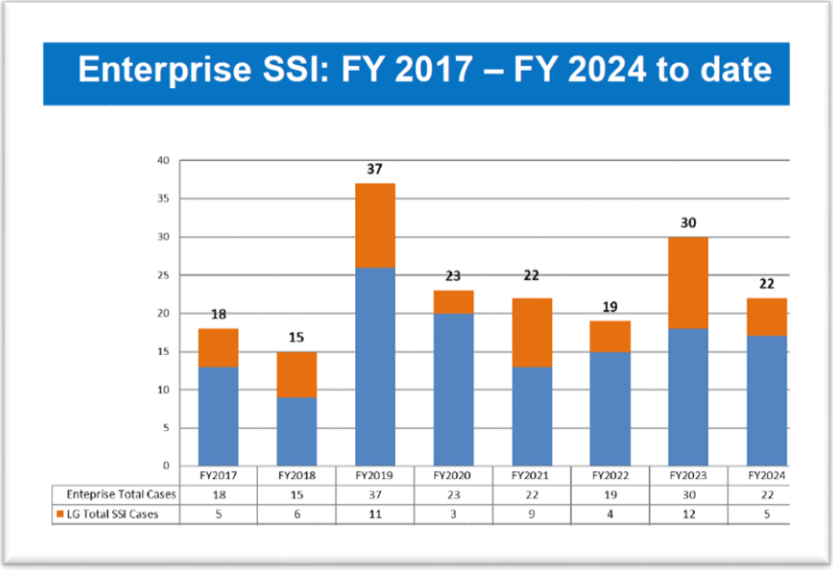
	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24
Cdiff Total	19	12	20	14	19	38	35	23
Cdiff MV	18	0	17	10	15	28	28	19
Cdiff LG	1	0	3	4	4	10	7	4

(2) Catheter Associated Urinary Tract Infection (CAUTI). There were no CAUTI in January 2024 (favorable). Year to date (1.29 cases/month) we are not yet favorable to target (1.05/month). As of February 25th, 2024, it has been **83 days** since the last CAUTI in Mountain View, and **203 days** since the last CAUTI in Los Gatos. With continued focus on decrease duration of catheter dwell time, we are likely to achieve target for CAUTI reduction in FY24.

(3) Central Line Associated Blood Stream Infection (CLABSI). There were 8 CLABSI in FY23, our target for FY24 is to have <= 7 infections. We are on track to achieve target with only 2 CLABSI year to date in FY24.

(4) There were two non-ventilator Hospital Acquired pneumonia infections in January. Improvement focus during the recent "HAC-A-Thon" remains on consistent oral hygiene, getting patients up and out of bed, and reducing the risk of aspiration by having the head of the bed raised. We are not on track to achieve target for nvHAP reduction based on Q1 and Q2 performance. The quality manager and nurse champion supporting nvHAP reduction have increased the frequency and units for rounding and prioritizing nvHAP reduction efforts.

ii) Surgical Site Infections. There have been 22 surgical site infections in FY24. The goal for this fiscal year is to have less than 29 infections. There have been 5 hysterectomy surgical site infections year to date. None of these could have been prevented given the nature of the patients' disease burden and are unfortunately a known and expected complication of surgery to remove metastatic ovarian cancer. There have been zero total knee replacement surgical site infections in FY24 compared to nine in FY23.



iii) Readmission Index. During November and December 2023, the readmission index is trending favorably to our target of 1.0. The twelve-month rolling average continues to decrease (favorably). We continue to focus on post discharge follow up appointment with a primary care provider, and close collaboration with our post-acute partners (Home health and Skilled Nursing Facilities).

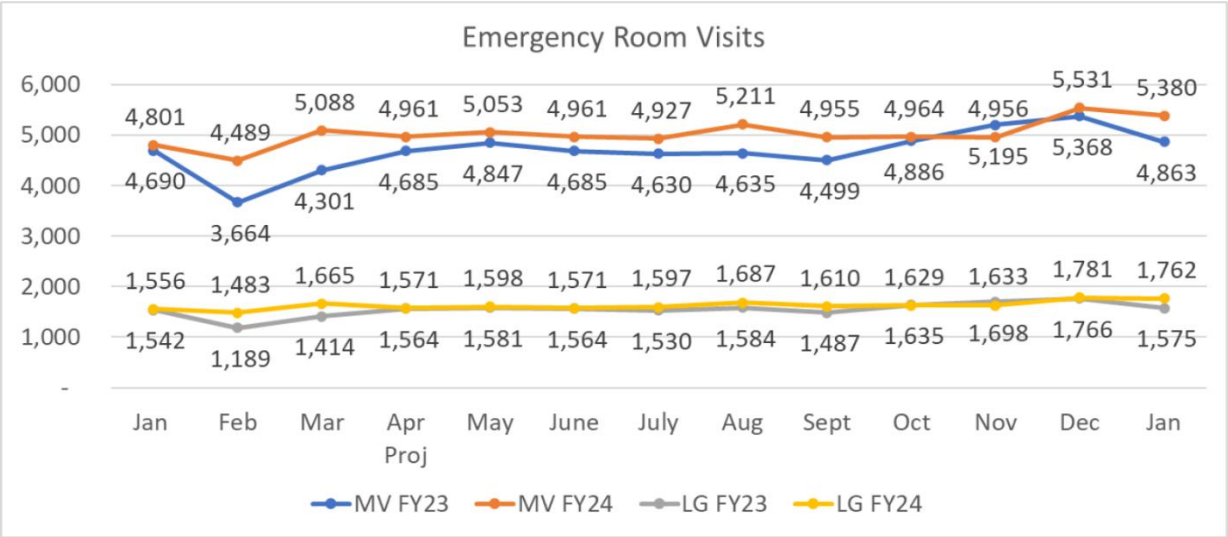
iv) Sepsis and mortality risk adjusted indexes are stable and will improve when our inpatient hospice program gets up and running in the fourth quarter of FY24. There have been personnel changes in our sepsis team which we are taking as an opportunity to re-imagine and optimize our sepsis program further.

v) PC-02 Cesarean Birth. The last two months (October and November 2023) demonstrate significant gains in the Obstetrical departments efforts to reduce cesarean section rates for women presenting with their first pregnancy to deliver a singleton vertex pregnancy. The efforts to achieve this success have been described in detail in previous Quality Committee reports. (2/5/2024, 11/6/2023)

vi) PC-05 Exclusive Breast Milk Feeding continues to improve due to the focused efforts on providing culturally appropriate education and support to expectant and post-partum mothers during their prenatal visits, and during their post-partum hospital stay.

vii) Median time from ED Arrival to ED Departure performance continues to be outstanding. In light of the 10% increase in volumes on both campuses, the team's ability to maintain favorable throughput performance is due to incessant focus on operational patient centered efficiency as described by CNO Cheryl Reinking in our previous committee meetings.

Emergency Room Trend



b) <u>Patient Experience Measures</u>

Likelihood to recommend for inpatient units, maternal child health and the ED are ALL favorable to target year to date for FY24. Christine Cunningham is paced to provide a detailed report on patient experience during the committee meeting on March 4, 2024.

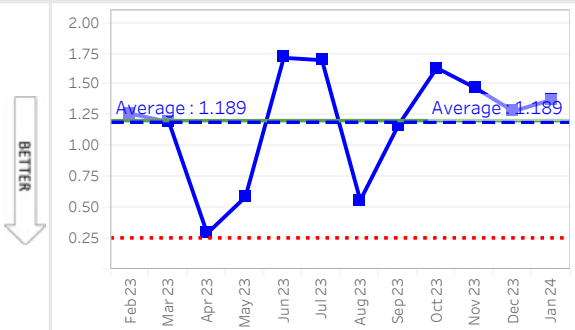
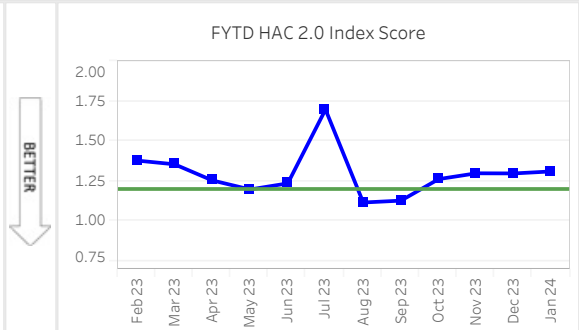
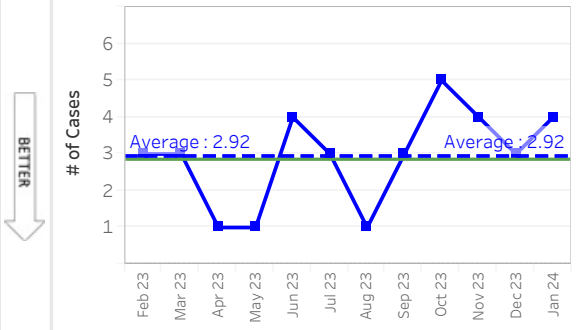
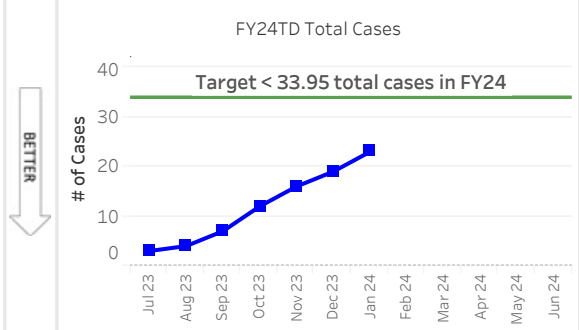
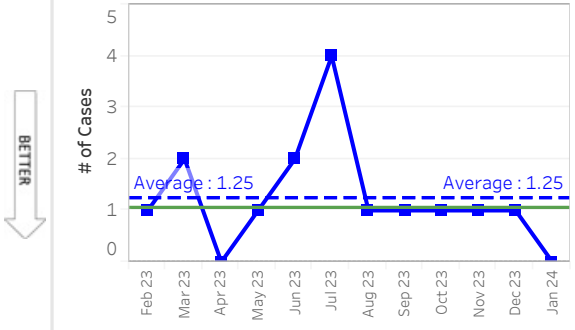
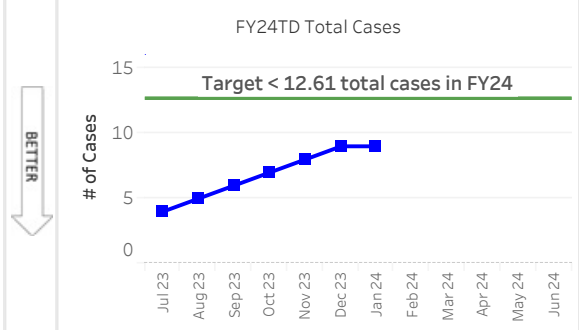
Attachment: FY24 Enterprise Quality, Safety and Experience Dashboard

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

January 2024 (unless other specified)

Month to Board Quality Committee : March 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : January 2024	1.377	1.312	1.238	1.201 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : January 2024	4 cases	3.29 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : January 2024	0 cases	1.29 cases/mo	1.08 cases/mo	1.05 cases/mo		

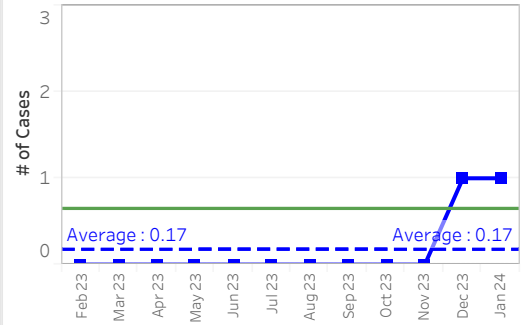
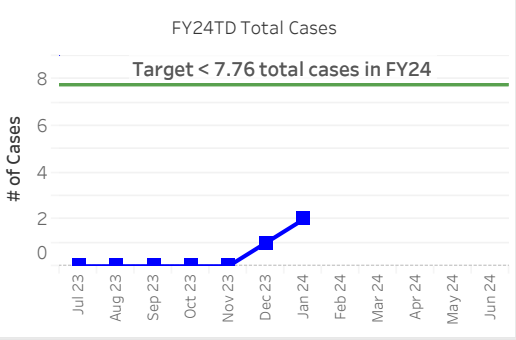
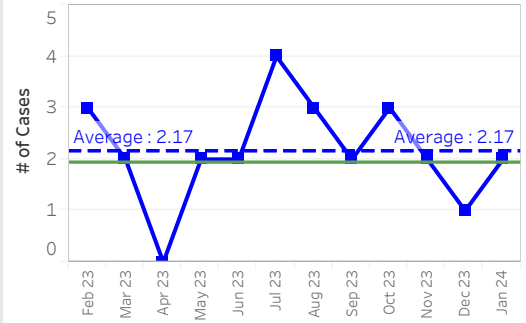
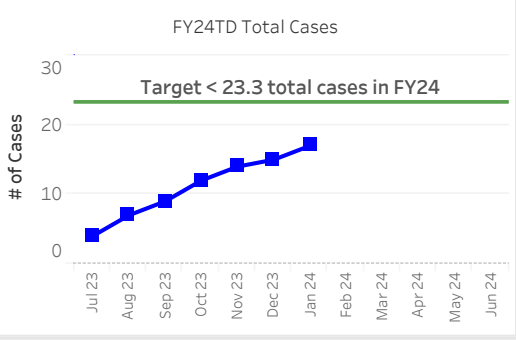
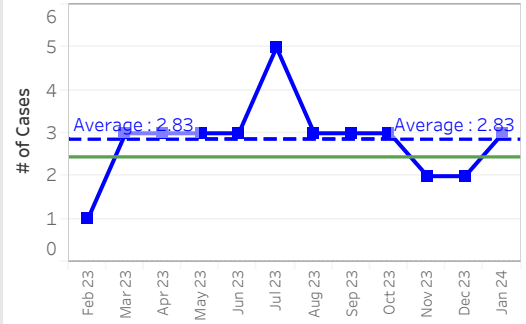
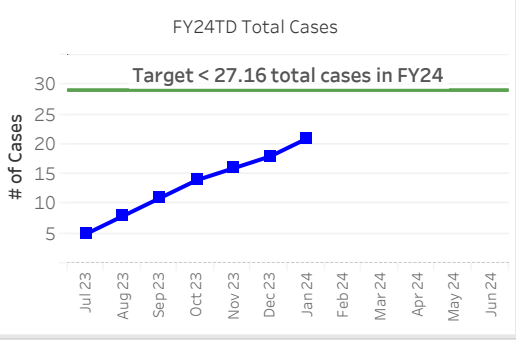
Quality Department | Note : updated as of February 20th, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

January 2024 (unless other specified)

Month to Board Quality Committee : March 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : January 2024	1 cases	0.29 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : January 2024	2 cases	2.43 cases/mo	2.00 cases/mo	1.94 cases/mo		
Surgical Site Infections (SSI) Latest Month : January 2024	3 cases	3.00 cases/mo	2.50 cases/mo	2.42 cases/mo		

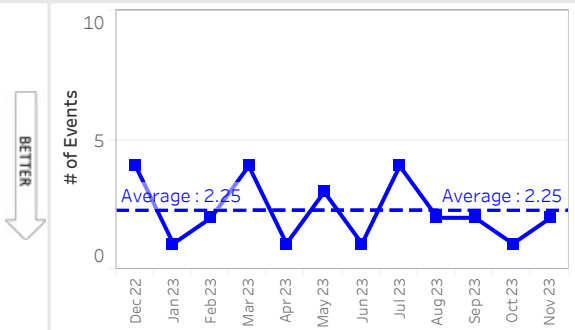
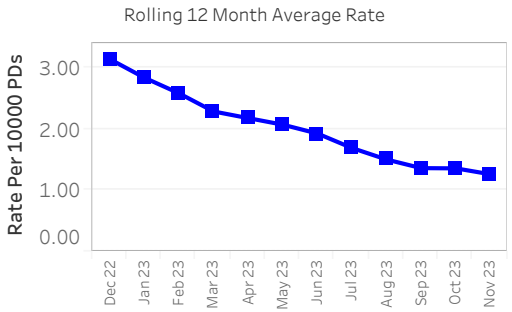
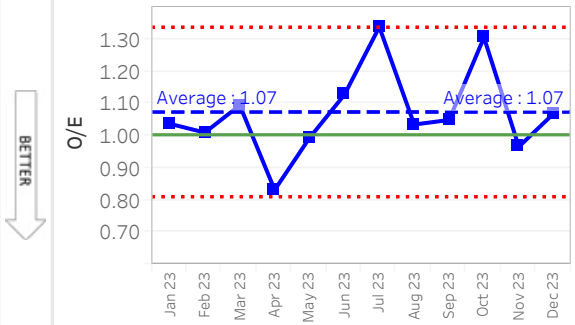
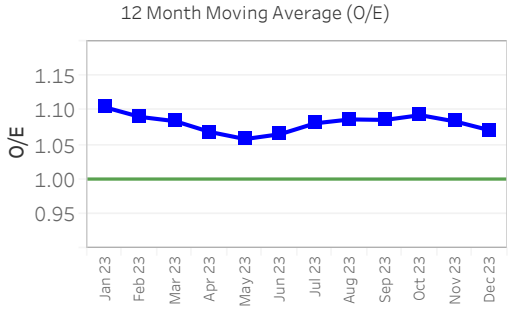
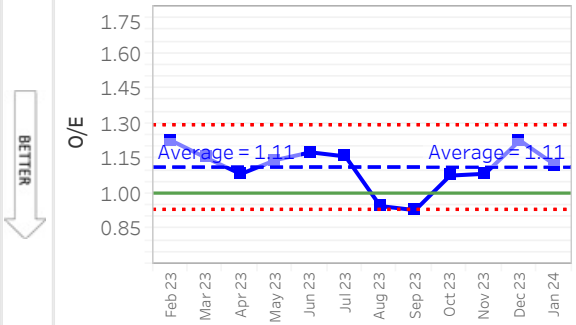
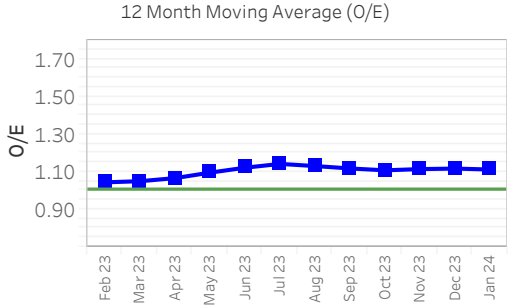
Quality Department | Note : updated as of February 20th, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

January 2024 (unless other specified)

Month to Board Quality Committee : March 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Serious Safety Event Rate (SSER) Latest Month : November 2023	2 events	1.24 (11 / 88844)	1.93 (41 / 212460)	n/a		
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : December 2023	1.07 (8.34% / 7.80%)	1.13 (8.94% / 7.93%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : January 2024	1.12 (2.36% / 2.10%)	1.08 (2.10% / 1.94%)	1.13 (2.21% / 1.96%)	1.00		

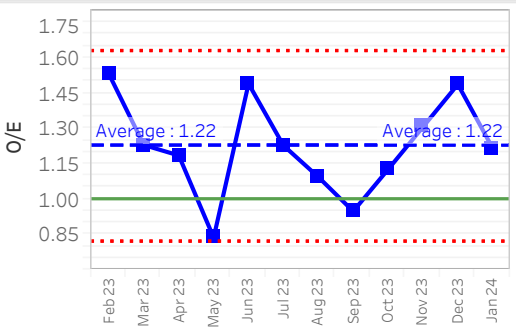
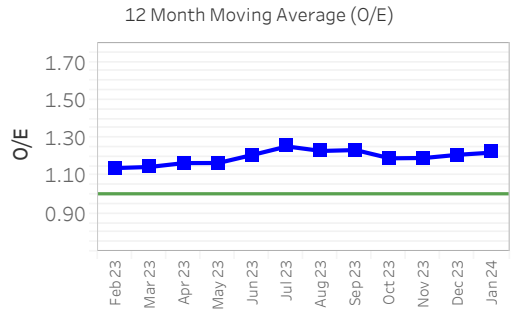
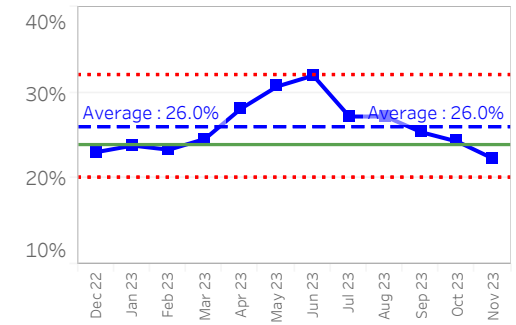
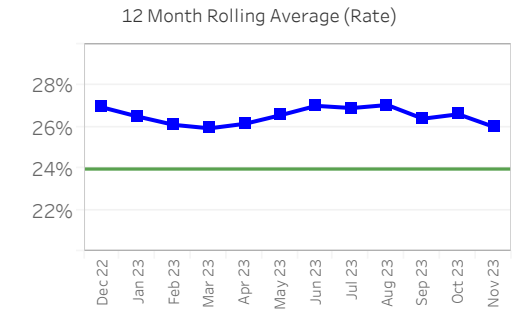
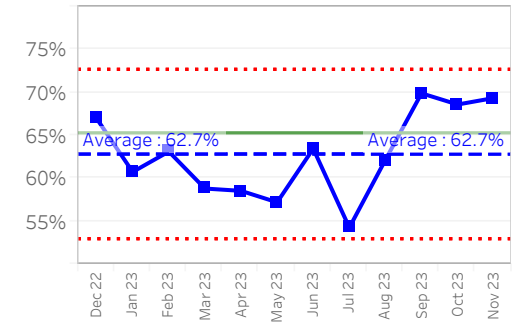
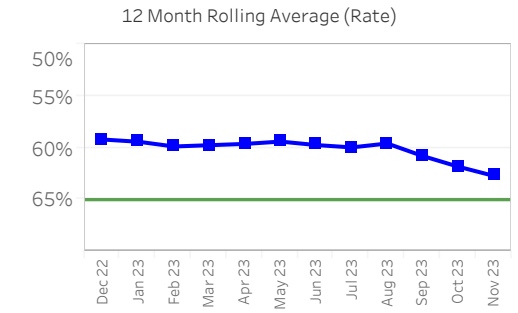
Quality Department | Note : updated as of February 20th, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

January 2024 (unless other specified)

Month to Board Quality Committee : March 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : January 2024	1.22 (14.58% / 12.00%)	1.20 (13.86% / 11.51%)	1.21 (14.07% / 11.59%)	1.00		
PC-02 : Cesarean Birth Latest Month : November 2023	MV : 21.9% (40 / 183) LG : 25.0% (7 / 28) ENT : 22.3% (47 / 211)	MV : 26.3% (222 / 845) LG : 17.8% (21 / 118) ENT : 25.2% (243 / 963)	MV : 28.1% (530 / 1883) LG : 20.1% (65 / 323) ENT : 27.0% (595 / 2206)	23.9% (FY24 ENT Target)		
PC-05 : Exclusive Breast Milk Feeding Latest Month : November 2023	MV : 67.7% (210 / 310) LG : 82.1% (32 / 39) ENT : 69.3% (242 / 349)	MV : 66.7% (1023 / 1534) LG : 83.6% (183 / 219) ENT : 65.0% (1127 / 1734)	MV : 58.1% (1966 / 3385) LG : 68.3% (427 / 625) ENT : 59.7% (2393 / 4010)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		

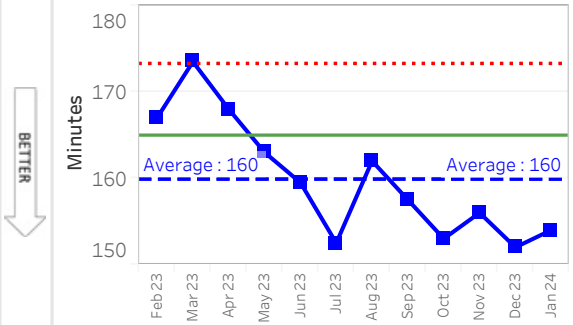
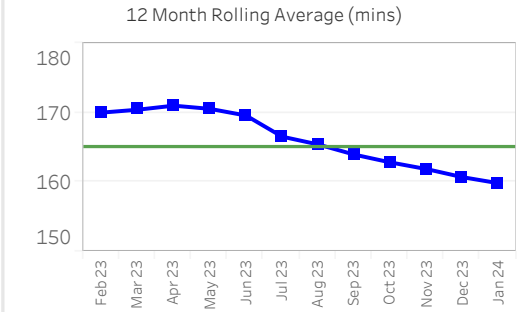
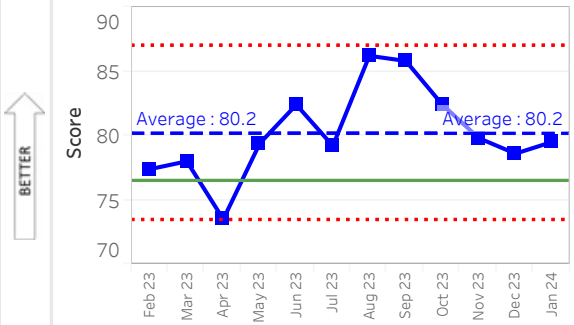
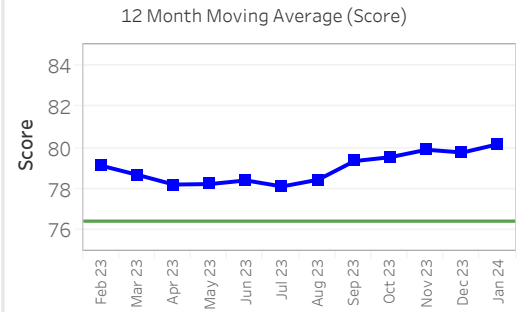
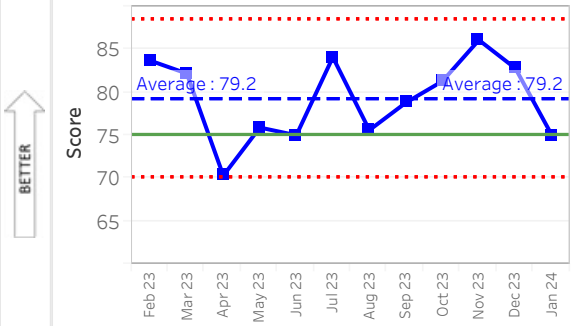
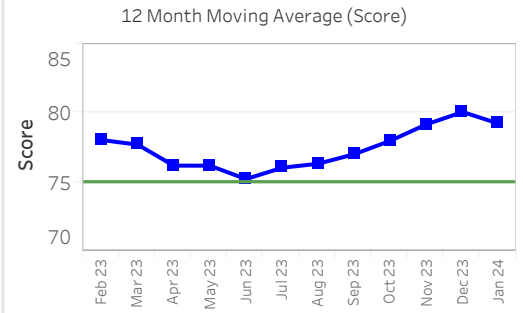
Quality Department | Note : updated as of February 20th, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

January 2024 (unless other specified)

Month to Board Quality Committee : March 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise) Latest Month : January 2024	MV : 172 mins LG : 136 mins ENT : 154 mins	MV : 176 mins LG : 134 mins ENT : 156 mins	MV : 194 mins LG : 142 mins ENT : 168 mins	MV : 191 mins LG : 139 mins ENT : 165 mins		
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : January 2024	79.5	81.7	78.5	76.4		
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : January 2024	75.0	81.7	75.0	75.0		

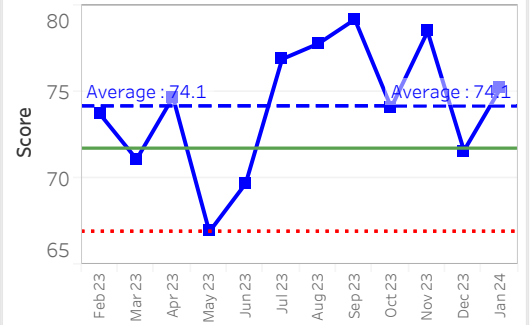
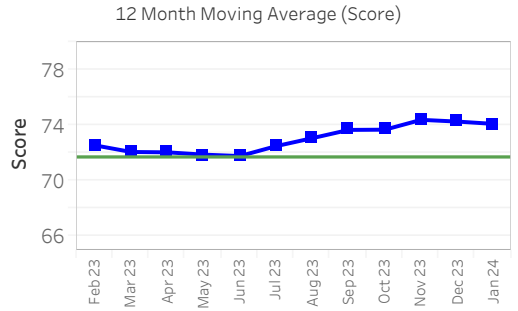
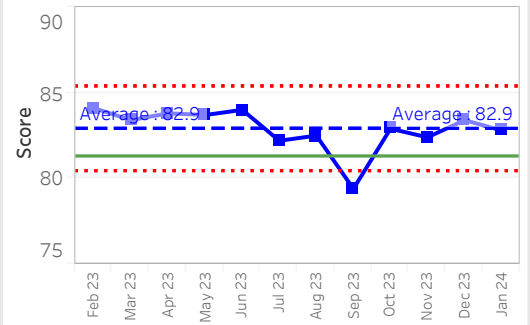
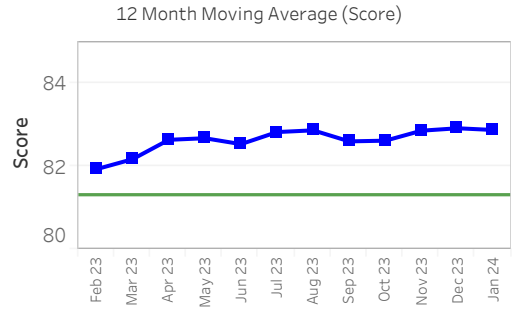
Quality Department | Note : updated as of February 20th, 2024

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

January 2024 (unless other specified)

Month to Board Quality Committee : March 2024

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : January 2024	75.2	76.0	71.7	71.7		
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : January 2024	82.8	82.2	82.7	81.3		

Quality Department | Note : updated as of February 20th, 2024

Measure	Definition Owner	Metric Definition	Data Source
*Organizational Goal HAC Index 2.0	H. Beeman, MD	For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 25%, Catheter Associated Urinary Tract Infection (CAUTI) 25%,Central Line Associated Blood Stream Infection (CLABSI) 25%, and non-ventilator hospital-acquired pneumonia (nvHAP) 25%,	See below
HAC Component Clostridium Difficile Infections (C-Diff)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component Catheter Associated Urinary Tract Infection (CAUTI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator**: Infection control Dept. **Denominator**: EPIC Report

Measure	Definition Owner	Metric Definition	Data Source
HAC Component Central Line Associated Blood Stream Infection (CLABSI)	C. Nalesnik	1) Based on NHSN defined criteria 2) Exclusions : ED & OP	**Numerator:** Infection control Dept. **Denominator**: EPIC Report
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP)	C. Delogramatic	1) Internal metric: Inpatient non-ventilator hospital-acquired pneumonia cases. 2) Numerator inclusions: inpatients (18+yrs) w/ a specified pneumonia diagnosis code(s) with POA (present on admission) status of "N" (acquired during the hospital encounter), that is unrelated to mechanical ventilation; monthly, cases are reviewed & confirmed by the nvHAP workgroup. 3) Denominator EPSI patient days excluding 6070 NICU/Nursery Lvl 2, 6310/6315 MBU, 6340 Behavioral Health, 6440 IP Rehab, 6900 Pre-Op SSU, 7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; **Numerator** identified by nvHAP workgroup; **Denominator**: EPSi patient days nvHAP Tableau Dashboard maintained by: **Mohsina Shakir**
Surgical Site Infections (SSI)	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

Measure	Definition Owner	Metric Definition	Data Source
Serious Safety Event Rate (SSER)	S. Shah	1) An event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. 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: **Michael Moa**
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA	H. Beeman, 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 Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D.	Premier Quality Advisor Readmission Tableau Dashboard maintained by: **Steven Sun**
Mortality Index Observed / Expected Premier Care Sciences Standard RA	H. Beeman, MD	1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice. For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= to zero.	Premier Quality Advisor

Measure	Definition Owner	Metric Definition	Data Source
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA	J. Harkey, H. Beeman, MD	1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & 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.	Premier Quality Advisor
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

Measure	Definition Owner	Metric Definition	Data Source
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 (Dee) Shih**
*Organizational Goal IP Units - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS
IP MCH - HCAHPS LTR Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	HCAHPS

Measure	Definition Owner	Metric Definition	Data Source
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted' For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey
*Organizational Goal ECHMN Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted	C. Cunningham	Switched Vendor NRC to PressGaney in January 2022. Started reporting in FY 23 dashboards 'Top Box, Received Date, and Unadjusted' For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value </= zero.	Press Ganey

Final Notes:
1.) SSER through November 2023
2.) Readmissions through December 2023
3.) PC-02 & PC-05 through November 2023
4.) Updated as of 2024-02-20

El Camino Health

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

To: Quality Committee of the Board
From: Lyn Garrett, Senior Director - Quality
Date: March 4, 2024
Subject: Hospital Value-Based Purchasing (VBP) impact for Federal Fiscal Year (FFY) 2024.

Recommendation: Review report noting measure results in all four domains; Safety, Patient Experience, Clinical Care and Efficiency. ECH will receive back 1.6 of the 2 percent Inpatient Prospective Payment System (IPPS) withholding totaling $430,151 loss in DRG payments over FFY 2024.

Summary: Provide the Committee with a preview of estimated impact of VBP measures on ECH DRG payments effective October 1, 2023 (FFY 2024).

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

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

3. Assessment:

- **A.** The estimated net impact of VBP for FFY 2024 is a loss of **$430,151** for ECH. This compares to a gain of **$78,156** for FFY2023 and a gain of **$375,012** for FFY2022.
- **B.** ECH missed threshold targets for several metrics. This could be related to the COVID restrictions which could have adversely impacted several metric performance periods.
- **C.** Our two lowest performing domains were Medicare Spending Per Beneficiary (MSPB) and Safety (Hospital Acquired Infections – CAUTI/CLABSI/CDIFF).
- **D.** Focused improvement efforts in HAI's and Patient Experience show an improvement opportunity for this measurement period.

List of Attachments: Hospital Valued-Based Purchasing: El Camino Hospital FFY 20224 (effective 10/1/2023)

Hospital Value-Based Purchasing (VBP) impact for Federal Fiscal Year (FFY) 2024

Clinical Outcomes - Domain Score - Unweighted[1]: 38.33 / Weighted[2] 9.58			
Baseline Period (AMI/HF/COPD/CABG/PN): 07/01/2014 - 16/30/2017		Performance Period: 07/01/2019 - 06/30/2022	
Baseline Period (THA/TKA): 04/01/2014 - 03/31/2017		Performance Period: 04/01/2019 - 03/31/2022	
Measure	Threshold	Performance / Points	Benchmark
Acute Myocardial Infarction (AMI) 30 Day Mort	0.869	0.887/9	0.888
Chronic Obstructive Pulmonary Disease (COPD) 30 Day Mort	0.916	0.885/0	0.934
Coronary Artery Bypass Grafting (CABG) 30 Day Mort	0.969	0.975/7	0.980
Heart Failure (HF) 30 Day Mort	0.882	0.899/7	0.908
Pneumonia (PN) 30 Day Mort[3]	0.840	0.831/0	0.873
Total Hip Arthroplasty/Total Knee Arthroplasty Complication	0.025	0.032/0	0.018

Person/Community Engagement - Domain Score - Unweighted[1]: 17 / Weighted[2] 4.25			
Baseline Period: 01/01/2019 - 12/31/2019		Performance Period: 01/01/2022 - 12/31/2022	
Measure	Threshold	Performance / Points	Benchmark
Communication with Nurses	79.42%	77.71%/0	87.71%
Communication with Doctors	79.83%	78.41%0	87.97%
Responsiveness of Hospital Staff	65.52%	61.03%/0	81.22%
Communication about Medicines	63.11%	58.86%/0	74.05%
Cleanliness and Quietness of Hospital Environment	65.63%	60.31%/0	79.64%
Discharge Information	87.23%	87.46%/2	92.21%
Care Transition	51.84%	50.50%/0	63.57%
Overall Rating of Hospital	71.66%	72.96%/1	85.39%

Safety - Domain Score - Unweighted[1]: 12 / Weighted[2] 3			
Baseline Period: 01/01/2019 - 12/31/2019		Performance Period: 01/01/2022 - 12/31/2022	
Measure	Threshold	Performance / Points	Benchmark
Catheter-Associated Urinary Tract Infection	0.65	0.765/0	0
Central Line-Associated Blood Stream Infection	0.589	0.780/0	0
Clostridium difficile Infection	0.52	0.660/0	0.014
Methicillin-Resistant Staphylococcus aureus Bacteremia	0.726	0.692/4	0
Surgical Site Infection (SSI)*	N/A	(N/A)/2	N/A

Efficiency - Domain Score - Unweighted[1]: 17 / Weighted[2] 4.25			
Baseline Period: 01/01/2019 - 12/31/2019		Performance Period: 01/01/2022 - 12/31/2022	
Measure	Threshold	Performance / Points	Benchmark
Medicare Spending per Beneficiary - MSPB	0.98892	1.002602/0	0.84816

Projected Financial Impact	
IPPS Oper Revenue[4]	$106,896,400
2% IPPS Witholding	$2,137,928
VBP Performance Adj.	1.5976
Adj. Impact (1.5976 - 2.0)	-0.4024
Expected Revenue/Loss[5]	($430,151.11)

Footnotes:

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

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

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

[3] - New Measure

[4] - Based on CHA DataSuite

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

El Camino Health

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

To: Quality, Patient Care, and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: March 4, 2024
Subject: February 5, 2024, Quality Committee Follow-up Item, Fecal Transplant

Purpose:

To follow up on an item from the February 5, 2024, the Quality, Patient Care, and Patient Experience Committee meeting.

Background:

During the February 5th, 2024, Quality Committee meeting, members inquired about Fecal Microbiota Transplantation and if this is performed at El Camino Hospital. The following information has been provided by Berit Marcum, the Clinical Manager of Endoscopy at ECH.

- Yes, we have a few physicians who have been performing FMT transplantation for years. We do maybe 1-4 per month, and the proceduralists monitor their patients' success rate post transplantation and report outcomes via an online registry.
- Our current supplier is OpenBiome.
- Sadly, the investigational FMT treatments have not been approved or licensed by the FDA. OpenBiome are a distributor of the FMT preparations that are manufactured by the University of Minnesota under an FDA-reviewed investigational new drug application.
- Currently, there is no reimbursement for FMT, only the endoscopy/colonoscopy.

OPENBIOME

The OpenBiome website has additional information should you like to learn more. https://openbiome.org/fmt-access/patient-faq/

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC, DipACLM
Date: March 4, 2024
Subject: Voice of the Patient/Family Feedback

Purpose: To provide the Committee with written patient feedback that is received by the hospital from patients and/or families who received care at El Camino Health.

Summary:

1. Situation: The family provided feedback through the Cipher discharge phone call process related to their stay in MV Maternity.

2. Authority: To provide insight into the experience our patients and families have while being provided care at El Camino Health.

3. Background: This family experienced a disruptive situation during the discharge process of the mother and newborn. The newborn's security bracelet was not removed as per protocol when the family was being discharged which sounded the alarm when the baby passed through the building doors which was loud and disruptive. The staff and manager provided service recovery after the incident.

4. Assessment: Every baby is provided a security ankle bracelet. This is a common practice in maternity units across the country. It is a safety mechanism to prevent newborn abductions. While the security program is effective as demonstrated in this case, it must be used appropriately. The managers and staff have reviewed the protocol and ensured the checklist for discharge patients is completed including the removal of the security band.

5. Other Reviews: None

6. Outcomes: El Camino Health Maternity leaders and team will be monitoring to ensure the protocols are in place for security monitoring and band removal.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What is the requirement to have an infant security system in health systems?

2. How is service recovery done to overcome such events?

Patient Feedback through Cipher Discharge Call

My discharge experience was a little rough. It was somehow forgotten my baby had an ankle monitor on still. As we said goodbye to all our nurses and went through the doors, the alarms were sounding off extremely loud and the nurses were trying to take the monitor off and the alarm was still going off. Everything else was absolutely wonderful and perfect, but it was a little traumatic and even traumatizing having all the alarms go off.

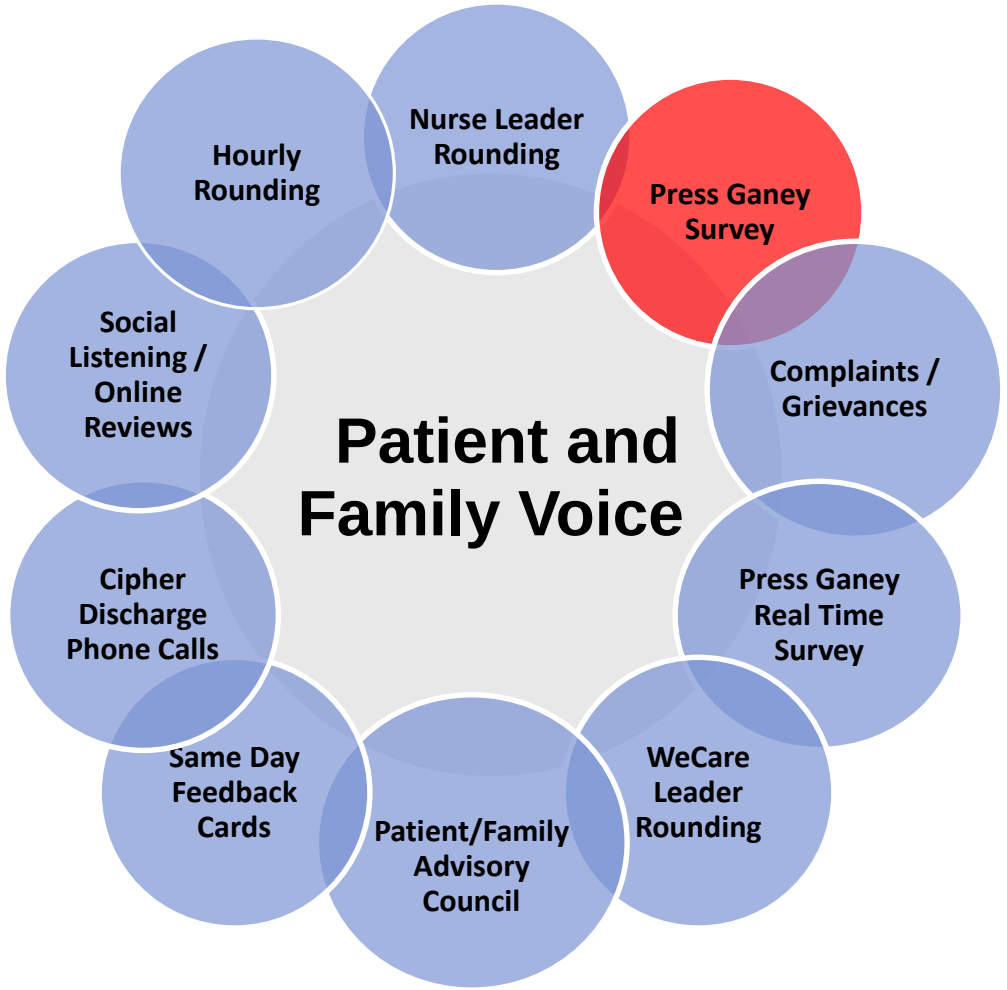
El Camino Health

Quality Committee
Patient Experience Update
March 4th, 2024

Christine L. Cunningham, CPXP, MBA

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

Listening to the Power of Patient and Family Voice



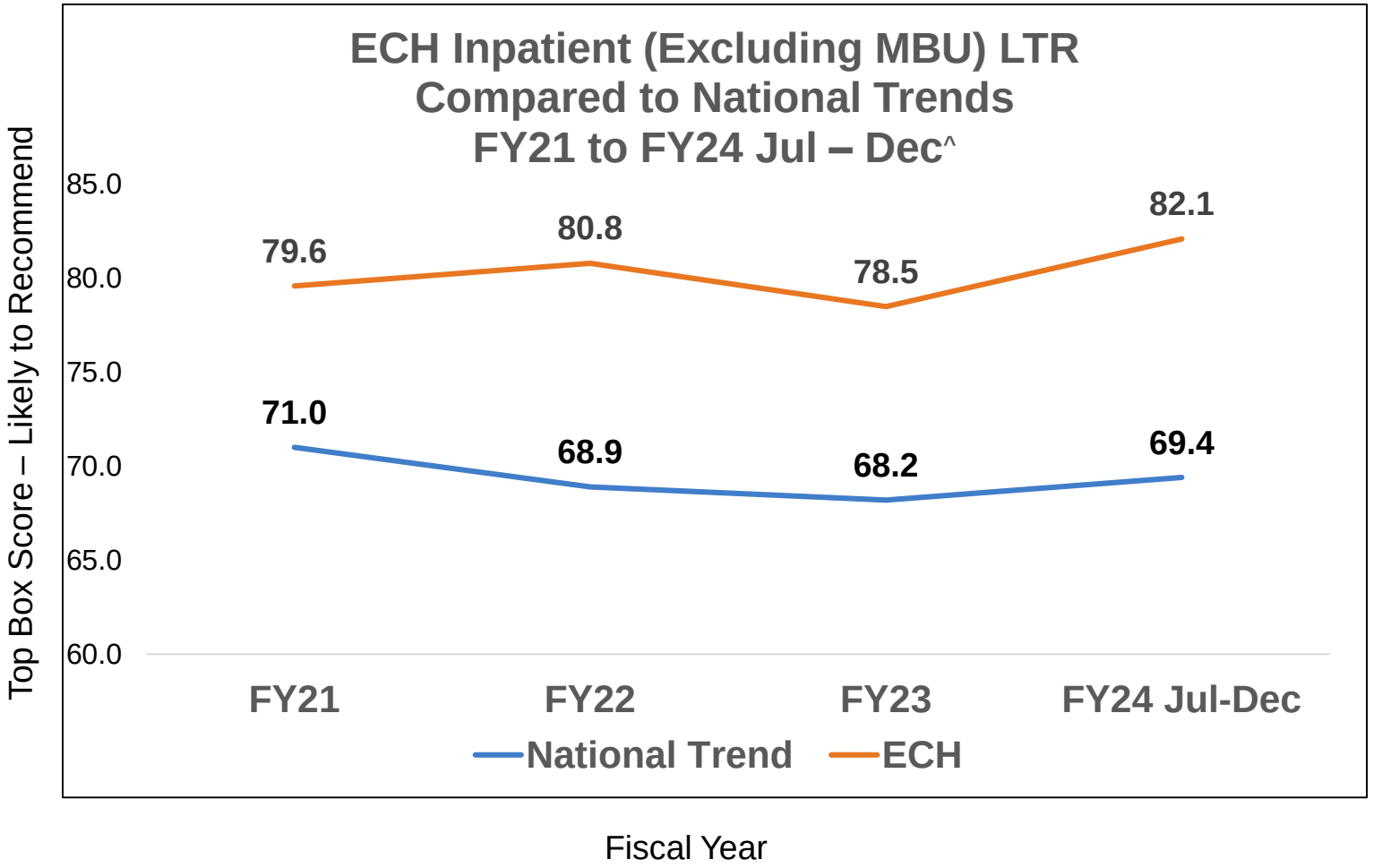
The voices of our patients and families can bring to light ***both*** opportunities for **improvement** as well as **successes** to be celebrated.

Patient Experience National Trends

Inpatient LTR – where are we now?

Inpatient Top Box Score- Likely to Recommend
FY21 to FY24 YTD

ECH (excluding MBU) vs. All Press Ganey Hospitals



In FY24, ECH's "Likely to Recommend" score performed:

- **88% better** than all US hospitals
- **81% better** than all California hospitals
- **87% better** than all Bay Area hospitals

Source: Press Ganey

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El Camino Health Performance Inpatient

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How do we turn 4's to 5's, good to great, probably recommend to definitely recommend??

How *the best* practice

DAILY WORK OF PG TOP PERFORMERS

Behavior Standards

Team Huddles

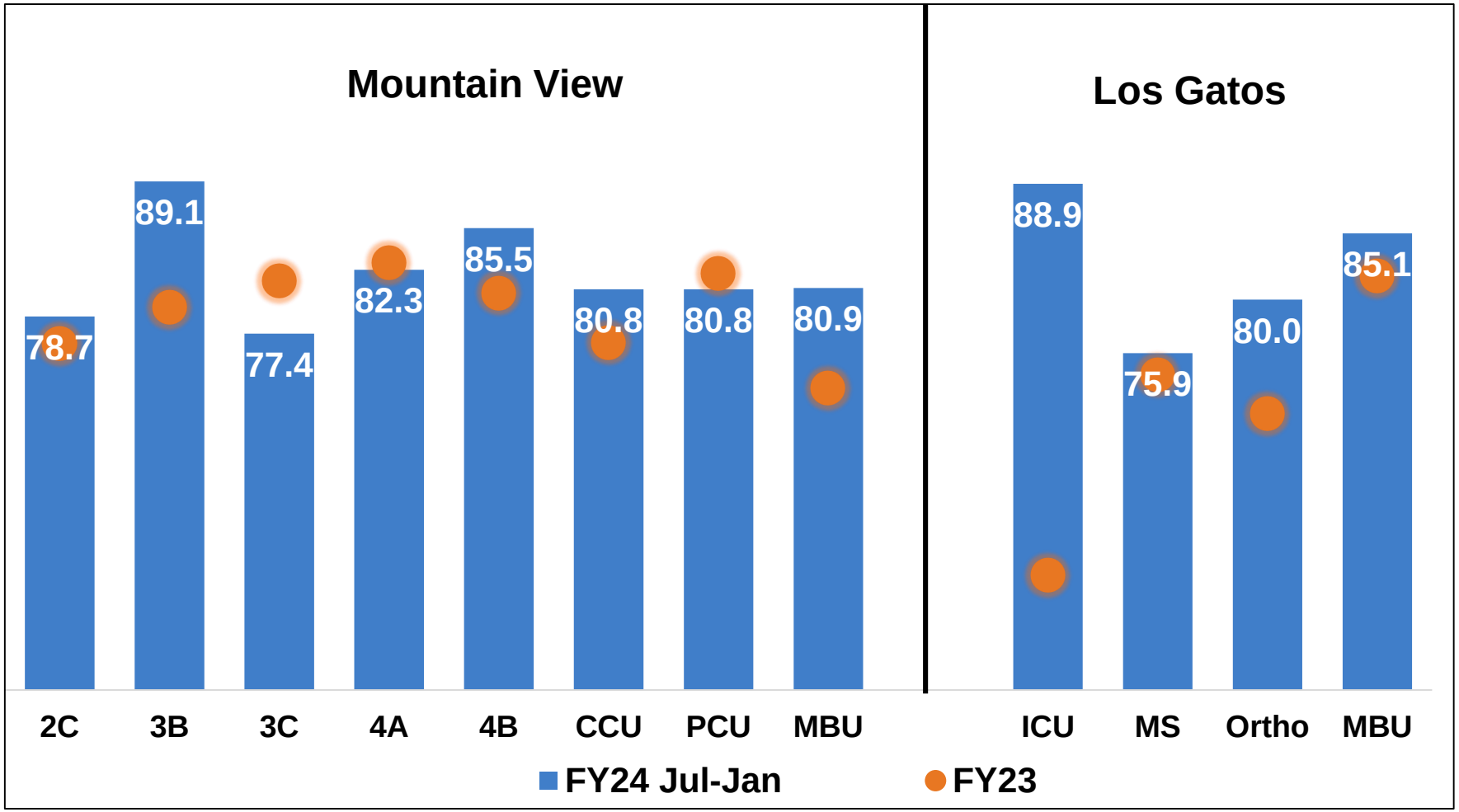
Leader Rounds

90%

of organizations performing in the top decile for more than 2 years rely on these activities

- Consistency
- Standard Work
- Repetition
- A culture of 'always'

LTR by Unit: Current State

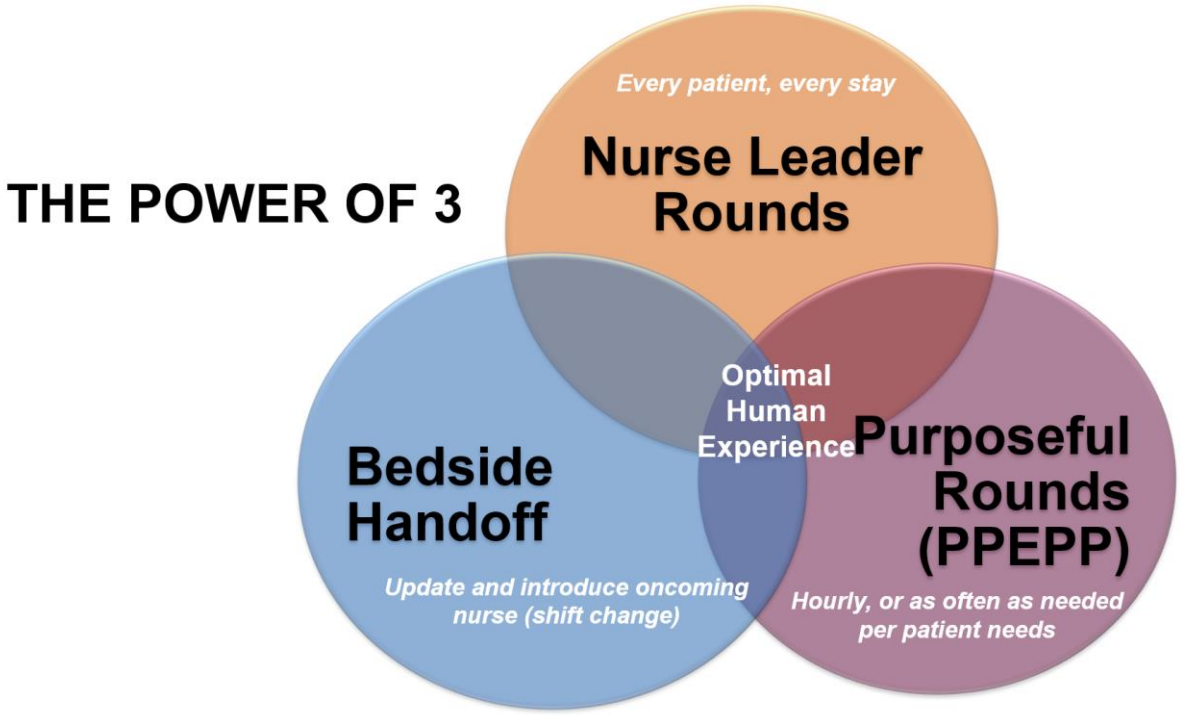


Congratulations! | Patient Experience

January 2024 WOW Cup Winner

Congrtulations to the Mountain View 4B Inpatient Unit for achieving a top-box score of **92.9** percent for Likelihood to Recommend in January 2024, exceeding the organizational goal of 80.5. Great Job!

Data Driven Best Practice – Power of 3



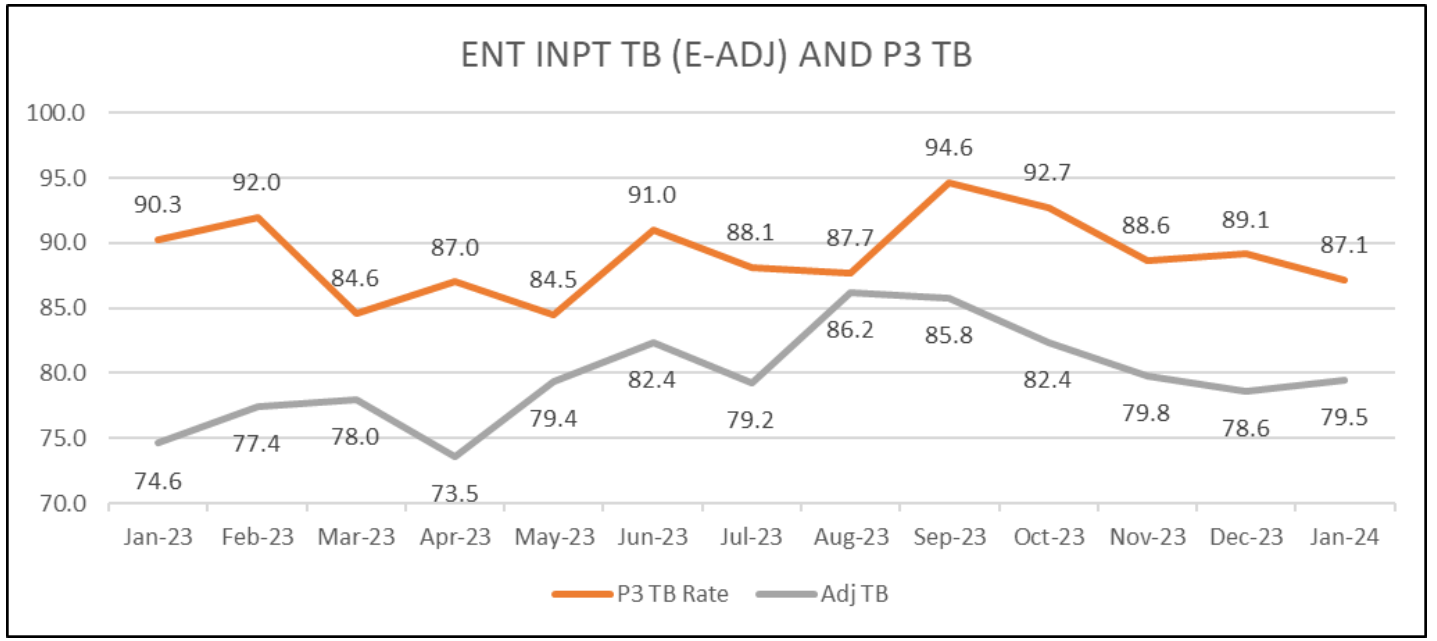
Questions we ask patients on our survey

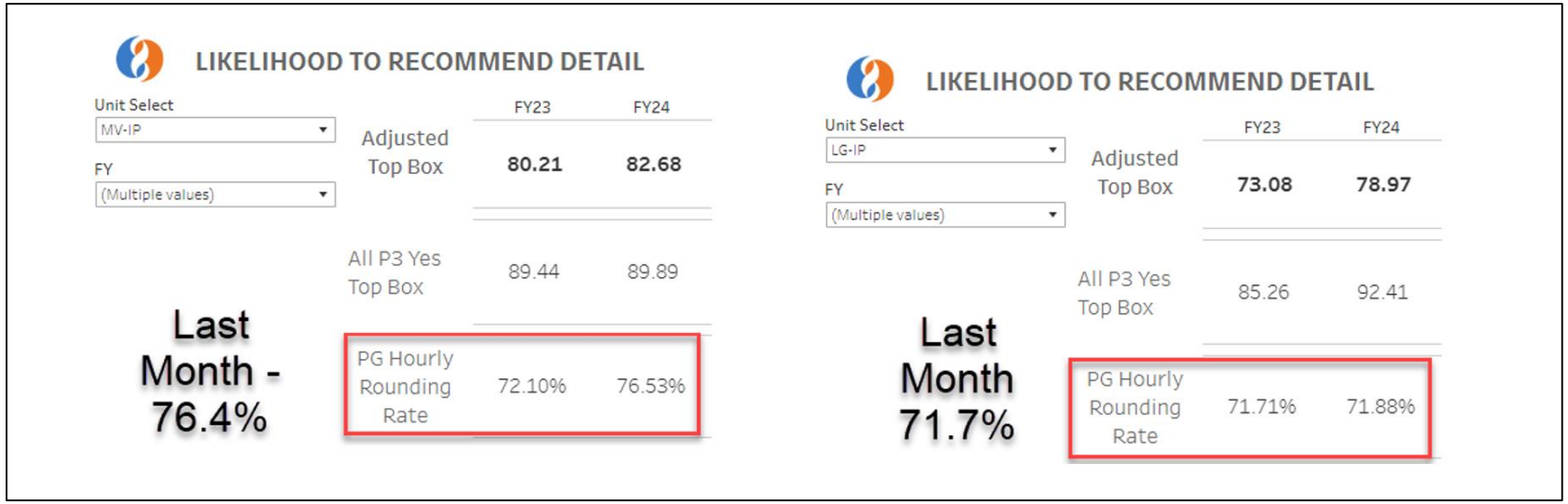
- Hourly Rounding
  - During your stay, did someone from the nursing team check on you hourly?
    - Yes/No
- Bedside Shift
  - When nurses changed shifts, the nurse caring for me introduced me to the new nurse.
    - Yes/No
- Leader Rounding
  - Were you visited by a member of the leadership team during your stay?
    - Yes/No

The Benefits of Power of 3 when consistently and effectively done:

- Reduction in safety events (falls, pressure injuries, etc.)
- Reduce call lights for increased nurse efficiency and satisfaction
- Improve patient perceptions of their care
- Improve HCAHPS and patient experience scores
- Give nurses more time for patient care tasks – you are more in control of your time by being proactive rather than reactive
- Increased employee engagement

Data for P3





El Camino Health

Top Key Drivers - Inpatient

Inpatient	
Los Gatos	**Mountain View**
Nurses treat with courtesy/respect	**Nurses treat with courtesy/respect**
Staff worked together to care for you	**Staff worked together to care for you**
Nurses explain in a way you understand	**Doctors treat with courtesy/respect**

Action Plan:

- Power of 3 - Emphasis on Hourly Rounding
  - ✓ Monthly LTR Meetings
  - ✓ Leader Rounding
  - ✓ New Employee Orientation & Nursing Orientation (training, setting expectations)
- Patient experience partnership with unit managers – rounding and coaching (WeCare behavior standards)
- Teamwork Key Driver
  - ✓ Wow Cup highlighting units Exceeding Target for 3 plus consecutive months
  - ✓ Sharing positive comments
  - ✓ Wellness Cart to promote / support teams when volumes escalate
- Physician Communication – share comments / scores / Care Team Coaching, shadowing

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Based on surveys received July - December 2023

El Camino Health Performance
Emergency Department

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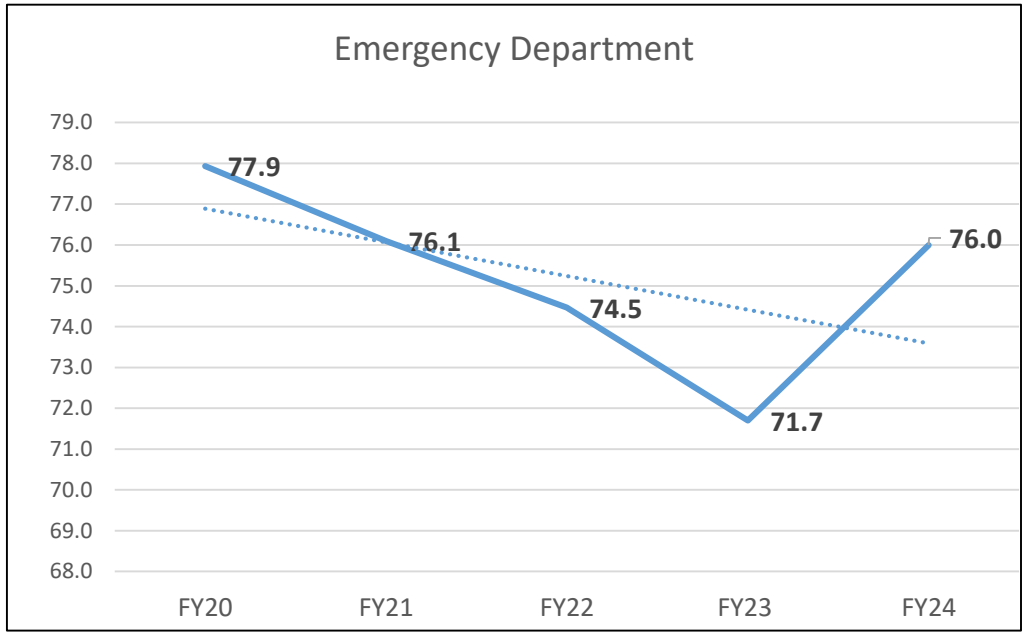
Top Key Drivers – Emergency Department

Emergency Department	
Los Gatos	**Mountain View**
Staff worked together to care for you	**Staff worked together to care for you**
Courtesy of doctors	Staff cared about you as a person
Staff cared about you as a person	**Courtesy of nurses**



Congratulations! | Patient Experience

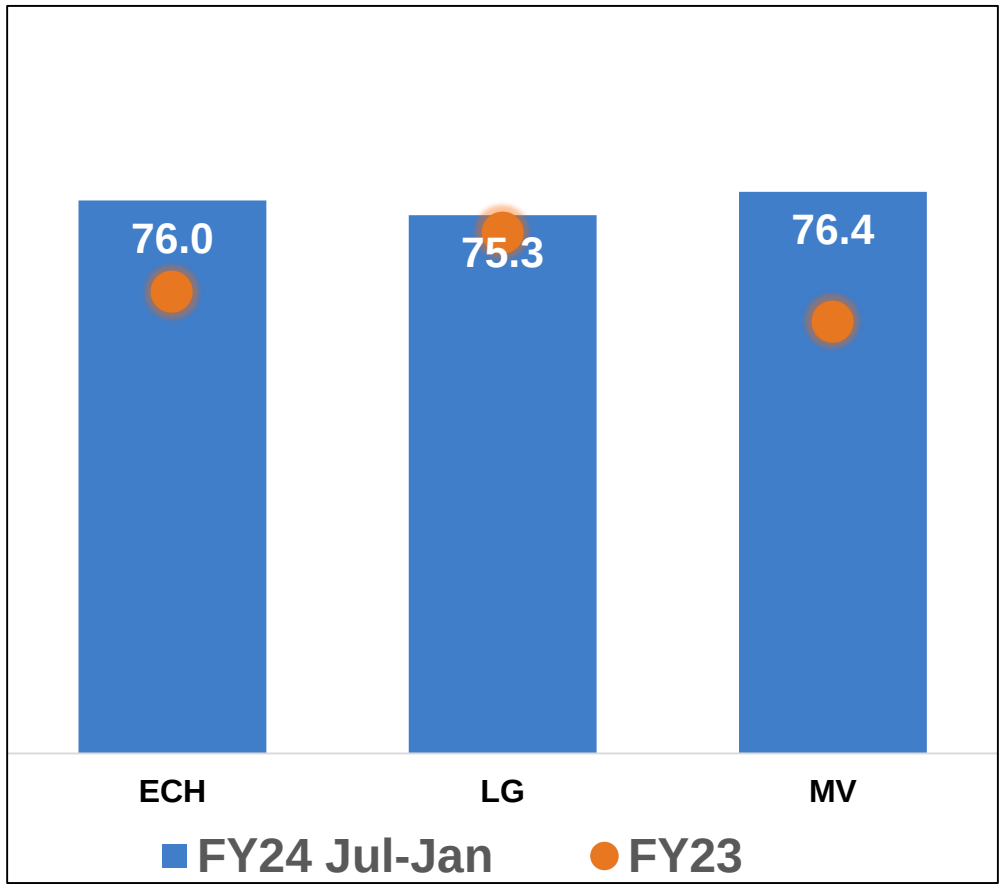
November 2023 WOW Cup Winner

Congratulations to the Emergency Department Nursing Unit for achieving a top-box score of 78.7 percent for Likelihood to Recommend in November 2023, exceeding the organizational goal of 70.3. Great Job!

ED Team Honored at Lantern Award Ceremony

El Camino Health

ED Current State



Action Plan:

- Nurse Leader Rounding
- Focus on behaviors that support perception of teamwork:
  - ✓Introducing yourself and your role.
  - ✓Informing about Delays
  - ✓ED Texting
  - ✓PEX Scribes (Vituity)
  - ✓Staff Checking on Patients
  - ✓Shift Change Hand Off/Introducing the next caregiver
  - ✓Sharing PG comments
- Reduction in Arrival to ED Departure times (Throughput)
  - ✓Increased use of discharge lounge
  - ✓Triage related tactics
- Monthly PEX ED Meetings
- Wellness cart for staff when volumes escalate
- Offering amenities to keep patients comfortable:
  - ✓ Cell phone chargers
  - ✓ Personal items
  - ✓ Activity items – adults and pediatric

El Camino Health Performance
Ambulatory Surgery

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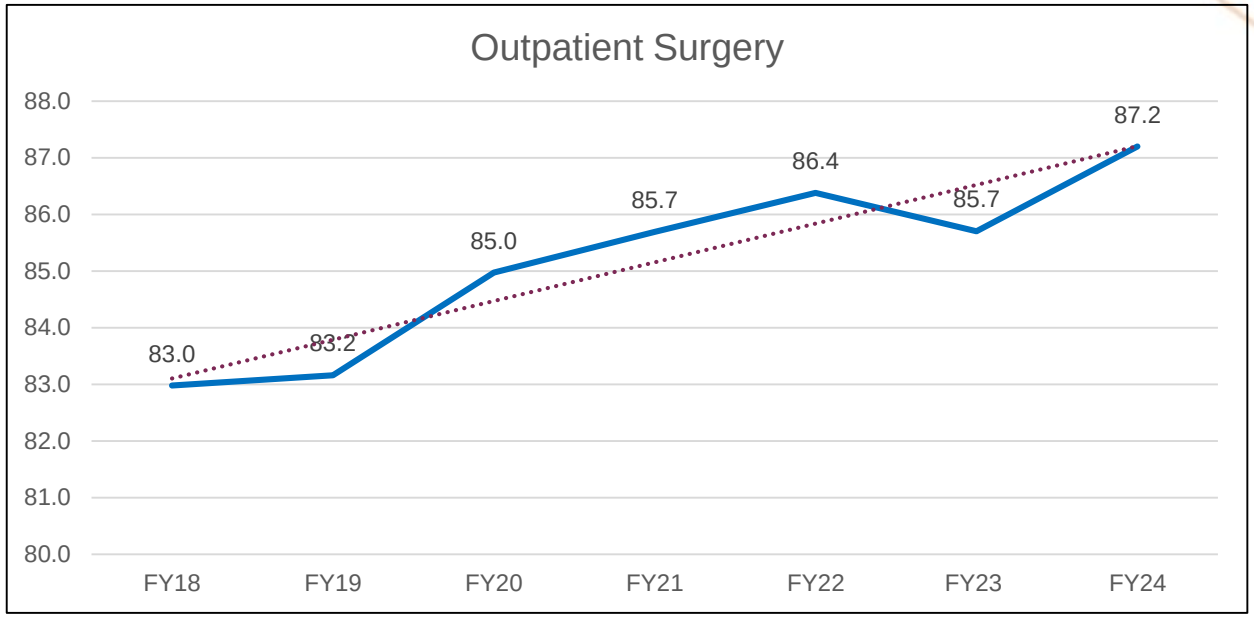
Top Key Drivers – Ambulatory Surgery

Ambulatory Surgery	
Los Gatos	**Mountain View**
How safe / secure you felt in facility	Staff treat with courtesy/respect
Facility Clean	Staff ensure you were comfortable
Information regarding pain	How safe / secure you felt in facility

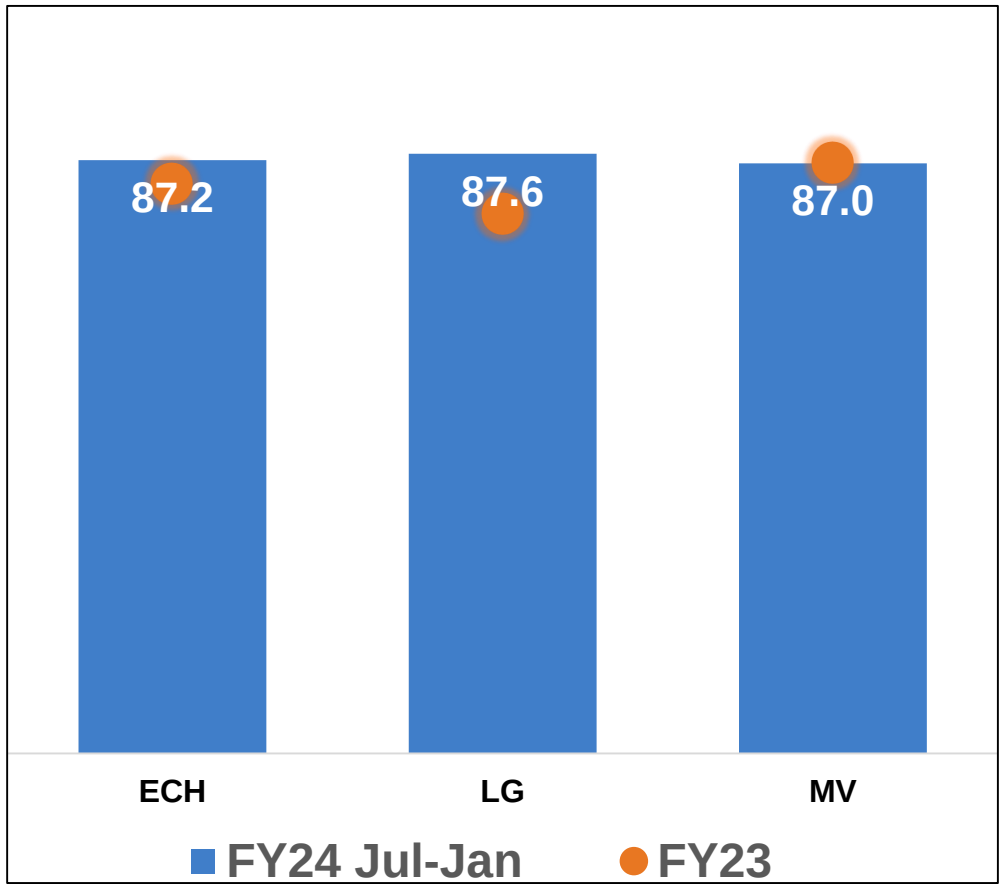


Congratulations! | Patient Experience

September 2023 WOW Cup Winner

Congratulations to the Los Gatos **OAS** team for achieving a top-box score of **87.8** percent for Likelihood to Recommend in September 2023, exceeding the organizational goal of 83.8. Great Job!

Outpatient Surgery Current State



Action Plan:

- Nurse Leader Rounding
- Post discharge calls live and automated via Cipher
- Intentional education initiatives around nausea and pain
- Service Recovery during heavy PACU boarding time periods and/or delays
- Wellness wagon for staff during high volume
- Key words at key times around safety
- ECH stuffed lions for pediatric patients

El Camino Health FY24 Plan

FY24 Plan – best practices that we will **continue** and new efforts to achieve our target

- ☆ Power of 3 (nurse leader rounding, hourly rounding, bedside shift report)
- WeCare Leader Rounding
- ☆ WeCare Behavior Standards (including service recovery and refresher trainings)
- Staff worked together (teamwork best practices)
- ☆ Nurse Communication Coaching (onboarding, huddles, UPC meetings)
- ☆ Each unit key driver analysis and plan development
- Increase recognition with paper wow cards
- Real time feedback – Forsta QR and text/email surveys (inpatient & outpatient)
- Patient Experience Literature Portal – library of resources accessible to all
- Physician with Nurse Rounds Pilot – 4B
- Language Pilot – 3C
- ☆ MD Communication Focus (MD Care Team Coaching / Shadowing, meetings)
- ☆ Hourly Rounding integration with Safety / Quality

FY24 Plan – best practices that we will **continue** and new efforts to achieve our target

- WeCare Patient Amenities Cart
- GetWell TV instant notification to unit leader on patient experience questions
- Discharge lounge utilization
- Additional language to current surveys
- New/ Refresh GWN Welcome Video
- Schwartz Rounds
- Expand and customize Cipher Discharge Phone Calls

☆ Indicates Press Ganey best practice of top performers

Questions

El Camino Health

Quality Committee Meetings
FY2025 Dates

QUALITY COMMITTEE DATES MONDAYS
Monday, August 5, 2024
Tuesday, September 3, 2024 *Moved due to the Holiday
Monday, November 4, 2024
Monday, December 2, 2024
Monday, February 3, 2025
Monday, March 3, 2025
Monday, May 5, 2025
Monday, June 2, 2025

El Camino Health

FY25 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

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

STAFF: **Holly Beeman, MD, MBA,** 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 (Enterprise Quality, Patient Care and Patient Experience dashboard, and STEEEP) are in alignment with the enterprise strategic plan.	Q4FY243 review and update which measures to include on the FY254 ~~quarterly board STEEEP~~dashboards. ~~report.~~	- ~~Enterprise quality~~ Ddashboard measures and targets - ~~STEEEP dashboard measures and targets.~~
2. Monitor Quality, Patient Care and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY243, review FY254 Incentive Goal recommendations for Quality, Safety and Patient Experience measures and targets.	- Monthly Enterprise dashboard measures with targets and performance - ~~Quarterly STEEEP dashboard with targets and performance~~
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY25.4.	- Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. ~~Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee by implementing regular feedback mechanisms, encouraging open communication, and promoting a shared sense of responsibility for achieving quality outcomes.~~	~~Using closing wrap up time, review quarterly at the end of the meeting.~~	~~- Attend a minimum of 7 meetings in person~~ ~~- Actively participate in discussions at each meeting~~ - ~~Improvement on baseline metrics for the assessment (Initial assessment to be conducted prior to the beginning of FY24)~~ (attendance guidelines to be covered in Charter, not in goals)
5. ~~Participate in the training and development of the Committee.~~		~~- Attend a conference and/or session with a subject matter expert~~ - ~~Commit to ongoing learning as needed.~~

Chair: Carol Somersille, MD
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

El Camino Health

FY25 COMMITTEE GOALS

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GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards (Enterprise Quality, Patient Care and Patient Experience dashboard, and STEEEP) are in alignment with the enterprise strategic plan.	Q4FY24 review and update which measures to include on the FY25 dashboards.	- Dashboard measures and targets -
2. Monitor Quality, Patient Care and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY24, review FY25 Incentive Goal recommendations for Quality, Safety and Patient Experience measures and targets.	- Monthly Enterprise dashboard measures with targets and performance -
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY25.	- Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve

Chair: Carol Somersille, MD
Executive Sponsor: Holly Beeman, MD, MBA, Chief Quality Officer

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

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Board STEEP Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience			✓						✓			
Health Care Equity						✓						✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Committee Member Expertise Sharing						✓						
Value Based Purchasing Report									✓			
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
Refresh STEEEP Dashboard measures for FY26												✓
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Approve Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Approve FY Committee Meeting dates											✓	
Propose Organizational Goals									✓			
Approve Organizational Goals											✓	
Propose Pacing Plan									✓			
Approve Pacing Plan											✓	
Review Charter									✓			
Approve Charter											✓	

1: Includes Approval of Minutes (Open & Closed), Current FY Enterprise Quality Dashboard, Med Staff Quality Council Minutes (Closed Session), Progress Against FY Committee goals (Quarterly), Current FY Pacing Plan (Quarterly), Patient Safety Report (Sept), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

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

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Hospital ("ECH"). ~~ealth~~. 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).

ECH ~~l Camino Health~~ management will provide the Committee with standardized quality metrics with appropriate benchmarks, when available, so that the Committee can adequately assess the quality of care being provided. ECH Management and Quality Committee members will collaborate to identify and improve opportunities for quality improvement.

Authority

The Committee is an Advisory Committee of the Board pursuant to Article VII, Sec. 7.6 of the ECH Bylaws. All governing authority for ECH ~~the Organization~~ resides with the Hospital Board for ECH. The governing authority for affiliated entities resides with ~~and with~~ the boards of the affiliated entities except that which may be lawfully delegated. Any reporting by the affiliated entities to the Committee shall be as stated in the operating and governing documents of the affiliated entities. ~~to a specific board committee~~. The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by ECH management ~~the Board~~ to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) which shall consist solely of less than a quorum of the members of the Committee. The resolution shall state the total number of members~~, the number of board members~~ to be appointed, and the specific task or assignment to be considered by the ad hoc ~~advisory~~ committee.

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

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board, and shall serve continuously unless the Chair resigns the position, is removed from the Committee, or is otherwise unable to serve. All members of the Committee shall be eligible to serve as Chair of the Committee.

- The Committee shall also include the Enterprise Chief of the Medical Staff and the Los Gatos Campus Chief of Staff as *ex officio* voting members of the Committee. The Enterprise Vice Chief of Staff or the Los Gatos Vice Chief of Staff shall serve as alternate

voting members of the Committee and replace, respectively the Enterprise Chief of Staff or the Los Gatos Chief of Staff if such person is absent from a Committee meeting.

- The Quality Committee may also include 1) no more than four~~nine~~ (4~~9~~) Community members[1] with expertise in ~~–~~assessing quality indicators, quality processes, patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) as well as other areas as needed; ~~-~~and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than four~~nine~~ Community members are recommended to serve on this Committee.

- All Committee members~~, with the exception of new Community members, *ex-officio* members and alternates,~~ shall be initially appointed by the Committee,~~Board Chair~~, subject to approval by the Board. ~~New Community members shall be appointed by the Committee, subject to approval of the Board~~. All Committee appointments shall be for a term of a minimum of 12 months ~~-~~and shall continue until such time as the ~~expiring on June 30th each year,~~ Committee member resigns, is removed by the Board, or is otherwise unable to serve. ~~renewable annually~~.

- It shall be within the discretion of the Chair of the Committee to appoint and remove a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.

Executive Support and Participation

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

General Responsibilities

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

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

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

Specific Duties

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

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

Specific duties of the Committee include the following:

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

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

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

    - ECH ~~Organization-wide~~ performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - ECH ~~Organization-wide~~ patient safety goals and hospital performance relative to patient safety targets.
    - ECH ~~Organization-wide~~ patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
    - ECH ~~Organization-wide~~ patient satisfaction and patient experience surveys.
    - ECH ~~Organization-wide~~ provider satisfaction surveys.

- Review reports from management of affiliated entities pursuant to operating and governance documents of those entities.

- Ensure ECH~~the organization~~ demonstrates proficiency through full compliance with regulatory requirements including, but not limited to The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).

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

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

- Oversee ECH ~~organizational~~ quality and safety performance improvement for both ~~the~~ ECH ~~Organization's~~ and medical staff activities.

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

Committee Effectiveness

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

Meetings and Minutes

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

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

El Camino Health

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

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Hospital ("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).

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

Authority

The Committee is an Advisory Committee of the Board pursuant to Article VII, Sec. 7.6 of the ECH Bylaws. All governing authority for ECH resides with the Hospital Board for ECH. The governing authority for affiliated entities resides with the boards of the affiliated entities except that which may be lawfully delegated. Any reporting by the affiliated entities to the Committee shall be as stated in the operating and governing documents of the affiliated entities. The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by ECH management to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) which shall consist solely of less than a quorum of the members of the Committee. The resolution shall state the total number of members to be appointed, and the specific task or assignment to be considered by the ad hoc committee.

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

Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board, and shall serve continuously unless the Chair resigns the position, is removed from the Committee, or is otherwise unable to serve. All members of the Committee shall be eligible to serve as Chair of the Committee.

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

- The Quality Committee may also include 1) no more than four (4) Community members[1] with expertise in assessing quality indicators, quality processes, patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) as well as other areas as needed; and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than four Community members are recommended to serve on this Committee.

- All Committee members shall be initially appointed by the Committee, subject to approval by the Board. All Committee appointments shall be for a term of a minimum of 12 months and shall continue until such time as the Committee member resigns, is removed by the Board, or is otherwise unable to serve.

- It shall be within the discretion of the Chair of the Committee to appoint and remove a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.

Executive Support and Participation

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

General Responsibilities

The Committee will collaborate with management to identify opportunities for quality and safety improvement. The Committee will support the implementation and monitoring of process improvement plans to address and close quality and safety gaps. Members of the Quality Committee will model behaviors, attitudes and actions consistent with the ECH tenets of a High Reliable Organization, specifically, focusing on creating strong relationships between everyone on the team to engender a culture of psychological safety which promotes our ECH mission to achieve zero patient harm. The management team shall develop dashboard metrics that will be used to measure and track quality, safety and patient experience performance for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for 1) ensuring performance metrics meet the Board's expectations; 2) aligning those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring communication to the Board and external constituents is well executed.

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

El Camino Health

Specific Duties

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

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

Specific duties of the Committee include the following:

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

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

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

    - ECH performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - ECH patient safety goals and hospital performance relative to patient safety targets.
    - ECH patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
    - ECH patient satisfaction and patient experience surveys.
    - ECH provider satisfaction surveys.

- Review reports from management of affiliated entities pursuant to operating and governance documents of those entities.

- Ensure ECH demonstrates proficiency through full compliance with regulatory requirements including, but not limited to The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).

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

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

- Oversee ECH quality and safety performance improvement for both ECH and medical staff activities.

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

Committee Effectiveness

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

Meetings and Minutes

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

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

El Camino Health

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

To: Quality, Patient Care, and Patient Experience Committee
From: Holly Beeman, MD, MBA, Chief Quality Officer
Date: March 4, 2024
Subject: Proposed Quality and Experience Goals for FY 2025

Purpose: To share management's proposal for FY 2025 Quality and Experience performance goals with the Quality, Patient Care, and Patient Experience Committee.

Quality Goal Recommendation:

	Metric	Measurement	Target	Benchmark
1.	CAUTI	Event/catheter days (rate)	% reduction from FY24 performance	NHSN/CDC
2.	C. Difficile	Event/patient days (rate)	% reduction from FY24 performance	NHSN/CDC
3.	Hand Hygiene Audits	# of Audits	# Audits in FY25	Leapfrog

Performance Scoring

Measure	Weight	Threshold	Performance	Stretch
CAUTI Rate	33%	FY24 baseline	% decrease from FY24 baseline	%% decrease from FY24 baseline
C. Difficile Rate	33%	FY24 baseline	% decrease from FY24 baseline	%% decrease from FY24 baseline
# Hand Hygiene Audits	33%	FY24 baseline	# total audits per year = 30,744 (100 audits/unit per month)	# total audits per year = 61,488 (200 audits/unit per month)

Proposed Quality and Experience Goals for FY 2025
March 4, 2024

Background: As described in the Quality Committee's charter, "the committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and the Organization's strategic goals." In the domain of "Value Proposition/Frictionless" the Board's strategic priority for Quality and Experience is to maintain Leapfrog Safety Grade of A for both campuses through FY27. To align with the Board of Director's strategic priority, management has identified three measures as a strategic quality goal, and one, for experience. All four will support the hospital's strategic quality priority to maintain Leapfrog A safety grades.

Assessment: Our most recent Leapfrog performance breakdown from Spring 2023 shows that the number of C. difficile and Catheter Associated Urinary Tract infections is deleterious to our overall performance and adversely affects our composite Leapfrog Score. Additionally, the requirements to achieve full performance in the hand hygiene domain of the Leapfrog Survey have increased substantially. To achieve full performance, we must increase the number of hand hygiene audits we perform per unit per month.

1. Current Performance:
    a. Current Performance with HAC 2.0 through January 2024.

	CAUTI	C. Diff	CLABSI
FY 23 Actual	13	35	8
FY 24 Target	≤ 12	≤ 33	≤ 7
FY 24 Actual YTD	9	23	2

    b. Leapfrog Spring 2023 Mountain View and Los Gatos Scoring:

Los Gatos Spring 2023							
Measure Domain	Measure	Enter Your Hospital's Score Here (Do NOT Leave Blanks)	Mean	Standard Deviation	Your Weight	Final Weight(N/A redistributes)	Score (Modified Z-Score x Final Weight)
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	91.702	15.443	0.113	0.057	0.030
	Bar Code Medication Administration (BCMA)	100	91.208	12.503	0.111	0.056	0.039
	ICU Physician Staffing (IPS)	50	67.492	42.212	0.141	0.071	-0.029
	Safe Practice 1: Culture of Leadership Structure	120	116.818	8.035	0.065	0.032	0.013
	Safe Practice 2: Culture Measurement, Feedba	120	115.771	15.453	0.067	0.034	0.009
	Safe Practice 9: Nursing Workforce	100	98.065	8.112	0.087	0.044	0.010
	Hand Hygiene	100	71.619	27.782	0.098	0.049	0.050
	H-COMP-1: Nurse Communication	91	89.806	2.516	0.063	0.031	0.015
	H-COMP-2: Doctor Communication	91	89.704	2.452	0.063	0.031	0.017
	H-COMP-3: Staff Responsiveness	84	81.298	4.181	0.064	0.032	0.021
	H-COMP-5: Communication about Medicines	77	74.205	3.916	0.064	0.032	0.023
	H-COMP-6: Discharge Information	87	85.068	3.777	0.064	0.032	0.016
Outcome Measures	Foreign Object Retained	0	0.015	0.056	0.094	0.047	0.013
	Air Embolism	0	0.001	0.011	0.053	0.027	0.002
	Falls and Trauma	0.119	0.437	0.463	0.109	0.055	0.038
	CLABSI	0	1.076	0.876	0.099	0.050	0.061
	CAUTI	1.592	0.861	0.722	0.100	0.050	-0.051
	SSI: Colon	1.354	0.822	0.676	0.075	0.038	-0.030
	MRSA	N/A	1.095	0.805	0.000	0.000	0.000
	C. Diff.	1.365	0.489	0.375	0.098	0.049	-0.114
	PSI 4: Death rate among surgical inpatients wit	126.6	143.224	17.464	0.043	0.022	0.021
	CMS Medicare PSI 90: Patient safety and adver	0.71	0.979	0.171	0.327	0.164	0.258
Process Measure Domain Score:		0.214					
Outcome Measure Domain Score:		0.197					
Process/Outcome Domains - Combined Score:		0.411					
Normalized Numerical Score:		3.411					

Mountain View Spring 2023							
Measure Domain	Measure	Your Hospital's Score Here	Mean	Standard Deviation	Your Weight	Final Weight (N/A redistributes)	Weighted Measure Score (Modifie
Process/Structural Measures	Computerized Physician Order Entry (CPOE)	100	91.702	15.443	0.113	0.057	0.030
	Bar Code Medication Administration (BCMA)	100	91.208	12.503	0.111	0.056	0.039
	ICU Physician Staffing (IPS)	100	67.492	42.212	0.141	0.071	0.054
	Safe Practice 1: Culture of Leadership Structures and Systems	120	116.818	8.035	0.065	0.032	0.013
	Safe Practice 2: Culture Measurement, Feedback, & Intervention	120	115.771	15.453	0.067	0.034	0.009
	Safe Practice 9: Nursing Workforce	100	98.065	8.112	0.087	0.044	0.010
	Hand Hygiene	100	71.619	27.782	0.098	0.049	0.050
	H-COMP-1: Nurse Communication	91	89.806	2.516	0.063	0.031	0.015
	H-COMP-2: Doctor Communication	91	89.704	2.452	0.063	0.031	0.017
	H-COMP-3: Staff Responsiveness	84	81.298	4.181	0.064	0.032	0.021
	H-COMP-5: Communication about Medicines	77	74.205	3.916	0.064	0.032	0.023
	H-COMP-6: Discharge Information	87	85.068	3.777	0.064	0.032	0.016
Outcome Measures	Foreign Object Retained	0	0.015	0.056	0.085	0.043	0.011
	Air Embolism	0	0.001	0.011	0.049	0.024	0.002
	Falls and Trauma	0.119	0.437	0.463	0.100	0.050	0.034
	CLABSI	0.381	1.076	0.876	0.091	0.045	0.036
	CAUTI	1.201	0.861	0.722	0.092	0.046	-0.022
	SSI: Colon	0	0.822	0.676	0.069	0.034	0.042
	MRSA	0.272	1.095	0.805	0.088	0.044	0.045
	C. Diff.	0.537	0.489	0.375	0.089	0.044	-0.006
	PSI 4: Death rate among surgical inpatients with serious treatable conditions	126.6	143.224	17.464	0.040	0.020	0.019
	CMS Medicare PSI 90: Patient safety and adverse events composite	0.71	0.979	0.171	0.299	0.149	0.236
Process Measure Domain Score:		0.298					
Outcome Measure Domain Score:		0.397					
Process/Outcome Domains - Combined Score:		0.695					
Normalized Numerical Score:		3.695					
Hospital Safety Grade (Letter Grade):							
Additional Resources:							

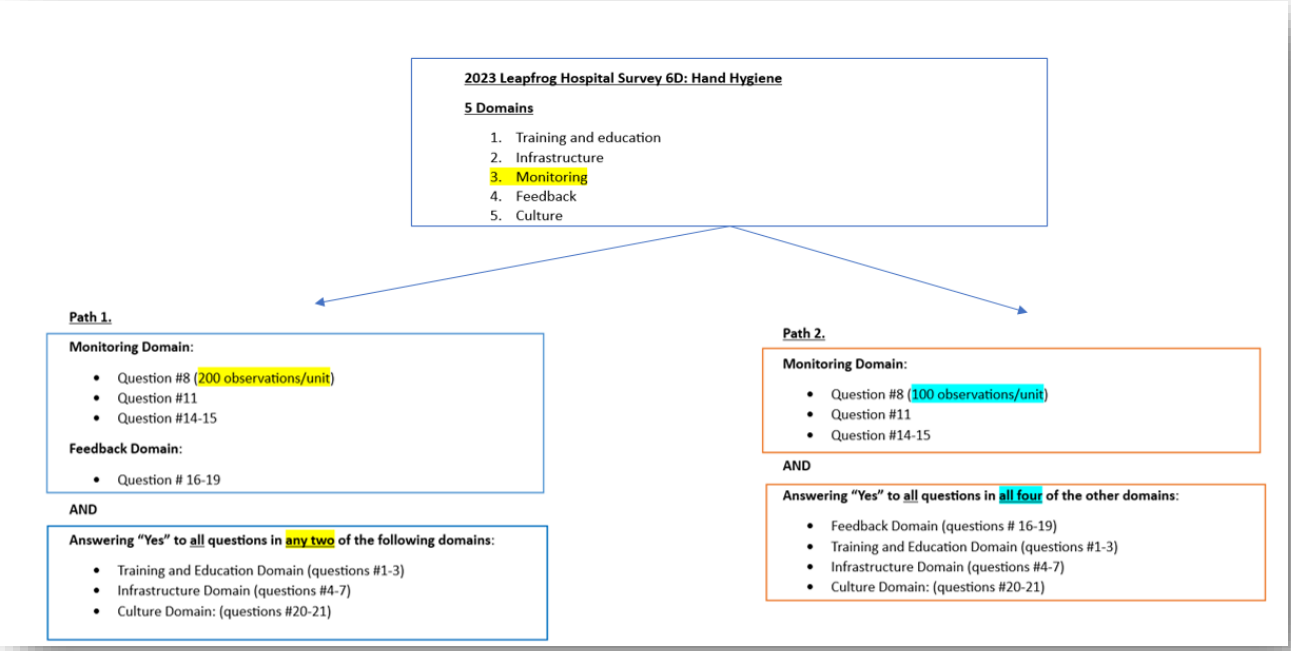
c. Hang Hygiene Audits through January 28, 2024

Unit		Audits Needed	# of Audits Completed						
			Jul 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024* (thru 1/28)
Mountain View	2C	100	130	731	583	252	745	130	451
	3B	100	0	0	0	16	236	104	34
	3C	100	122	0	0	22	113	5	265
	4A	100	300	354	218	143	760	122	0
	4B	100	416	1123	615	286	427	64	306
	CCU	100	286	144	165	366	101	45	265
	ED	100	0	0	0	0	0	0	0
	Imaging (	100	0	0	116	50	65	43	11
	Infusion (	100	104	122	114	132	112	0	0
	L&D	75	0	0	0	0	0	0	0
	MBU	100	72	6	24	16	36	0	90
	MHAS	100	0	0	0	0	0	0	0
	NICU	100	0	0	0	0	0	0	104
	OR	100	0	0	0	0	0	0	0
	PACU	100	0	0	0	0	0	0	0
	PCU	100	0	0	0	0	27	5	292
	Pulmona	50	0	0	0	0	0	0	0
	Willow	15	0	0	0	0	0	0	0
Los Gatos	ED	75	0	0	418	298	224	137	148
	ICU	8	0	0	419	317	262	16	37
	Imaging	100	0	0	0	0	26	3	0
	L&D	8	0	0	38	0	0	0	0
	MBU	23	0	0	115	35	0	0	81
	Med/Sur	100	0	76	448	572	235	205	172
	NICU	8	0	0	32	0	0	1	0
	OR	100	0	0	4	0	0	99	49
	Ortho	100	0	48	505	384	272	206	179
	Rehab IP	100	0	14	144	0	52	202	76
	Rehab O	100	0	0	2	0	6	115	14
	PACU	100	0	0	0	0	176	123	26
	Pre-Op	100	0	0	0	0	91	0	0
		2562							

There are two paths to achieve full performance on the 2024 Leapfrog hand hygiene domain. Please see appendix for Leapfrog Hand Hygiene Scoring. The # of audits required per unit is based on patient volumes. Most units are required to have 100 audits per month. Our target will be to have 100 audits/unit per month = 2,562/month x 12 months = 30,744 audits for FY25. Our stretch target will be to have 200 audits/unit per month = 5,124 audits/month x 12 months = 61,488 audits per month.

Hand Hygiene Discussion: It is important to explain that to achieve full performance in the hand hygiene domain requires a comprehensive hand hygiene program (see attachment: Leapfrog Hand Hygiene Scoring Method). Having sufficient number of audits is but one element of the program. We strive to achieve full performance on all 5 elements of the hand hygiene program requirements to maintain our Leapfrog Safety Grade A on both campuses. We are pulling out one of the many requirements, auditing hand hygiene compliance, as a strategic goal, due it's objective ease of measurement and tracking down to the unit level.

Additionally, having hand hygiene measurement as a strategic priority involves the entire ECH inpatient workforce. Although the measurements take place on nursing units. We are required to observe ALL staff members hand hygiene compliance, pharmacy, radiology techs, nutrition services, physical therapy, nursing, med staff etc.



Patient Experience Goal Recommendation:

Once again for FY25 we recommend inpatient unit likelihood to recommend as a strategic goal. The target will be based on an incremental improvement from prior performance.

Attachment: Leapfrog Hand Hygiene Scoring Method

Hand Hygiene

Hospitals are scored on their performance in five domains of hand hygiene. To meet the requirements of each domain, the hospital must respond in the affirmative to all applicable questions.

1. Monitoring: questions #8-11
    a. Electronic: questions #12-13
    b. Direct Observation: questions #14-15
2. Feedback*: questions #16-19
3. Training and Education: questions #1-3
4. Infrastructure: questions #4-7
5. Culture: questions #20-21

*Hospitals must respond "yes" to question #8, #9, or #10 in the Monitoring Domain in order to access the questions in the Feedback Domain.

Hand Hygiene Score (Performance Category)	**Meaning that…**

Achieved the Standard	The hospital responded "yes" to **all** applicable questions in the Monitoring and Feedback Domains and meets the **monthly** sample size of **200** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2023 Hospital Survey (measure specifications, Section 6), for monitoring hand hygiene opportunities, **each month in each patient care unit:**
	
	• **Monitoring Domain**:
	  ○ Question #8:
	  Hospital collects hand hygiene compliance data on at least **200** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit**
	  ○ Question #11:
	  Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene
	  ○ The hospital responded "yes" to all questions pertaining to the monitoring method used (as indicated in question #8):
	  ▪ *Electronic Compliance Monitoring*: questions #12-13
	  ▪ *Direct Observation:* questions #14-15
	• **Feedback Domain:** questions #16-19
	
	AND
	
	The hospital responded "yes" to **all** questions in any **two** of the following domains:
	• **Training and Education Domain:** questions #1-3
	• **Infrastructure Domain:** questions #4-7
	• **Culture Domain:** questions #20-21

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Hand Hygiene Score (Performance Category)	**Meaning that…**

Achieved the Standard (alternative)	Hospitals that collect hand hygiene compliance data on a **monthly** sample size of **100** hand hygiene opportunities per unit per month, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2023 Hospital Survey (measure specifications, Section 6), can achieve the standard if they meet the following:
	
	• **Monitoring Domain**:
	  ○ Question #9:
	  Hospital collects hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit**
	  ○ Question #11:
	  Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene
	  ○ The hospital responded "yes" to all questions pertaining to the monitoring method used (as indicated in question #9):
	  ▪ *Electronic Compliance Monitoring*: questions #12-13
	  ▪ *Direct Observation:* questions #14-15
	
	AND
	
	The hospital responded "yes" to **all** questions in the other four domains:
	• **Feedback Domain:** questions #16-19
	• **Training and Education Domain:** questions #1-3
	• **Infrastructure Domain:** questions #4-7
	• **Culture Domain:** questions #20-21

Considerable Achievement	The hospital responded "yes" to **all** applicable questions in the Monitoring and Feedback Domains and meets the **monthly or quarterly** sample size of **100** for monitoring hand hygiene opportunities, **each month or quarter in each patient care unit**:
	
	• **Monitoring Domain**:
	  ○ Question #9 or #10:
	  ▪ Hospital collects hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit**
	  ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities **each quarter in each patient care unit**
	  ○ Question #11:
	  Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will

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Hand Hygiene Score (Performance Category)	**Meaning that…**
	be used by patients with feedback on both when they are and are not compliant with performing hand hygiene ○ The hospital responded "yes" to all questions pertaining to the monitoring method used (as indicated in question #10): ▪ *Electronic Compliance Monitoring*: questions #12-13 ▪ *Direct Observation:* questions #14-15 • **Feedback Domain:** questions #16-19 ***AND*** The hospital responded "yes" to **all** questions in any **two** of the following domains: • **Training and Education Domain:** questions #1-3 • **Infrastructure Domain:** questions #4-7 • **Culture Domain:** questions #20-21
Some Achievement	The hospital responded "yes" to **all** applicable questions in any **two** of the following domains: • **Monitoring Domain:** ○ Question #8, #9, or #10: ▪ Hospital collects hand hygiene compliance data on at least **200** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit** ▪ Hospital collects hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit** ▪ Hospital collects hand hygiene compliance data on at least 100 hand hygiene opportunities **each quarter in each patient care unit** ○ Question #11: Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene ○ The hospital responded "yes" to all questions pertaining to the monitoring method used (as indicated in question #8, #9, or #10): ▪ *Electronic Compliance Monitoring*: questions #12-13 ▪ *Direct Observation:* questions #14-15 • **Feedback Domain:** questions #16-19 • **Training and Education Domain:** questions #1-3 • **Infrastructure Domain:** questions #4-7 • **Culture Domain:** questions #20-21

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Hand Hygiene Score (Performance Category)	**Meaning that…**

Limited Achievement	The hospital responded "yes" to **all** applicable questions in any **one** of the following domains:
	
	• **Monitoring Domain:**
	  ○ Question #8, #9, or #10:
	  ▪ Hospital collects hand hygiene compliance data on at least **200** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 1-3 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit**
	  ▪ Hospital collects hand hygiene compliance data on at least **100** hand hygiene opportunities, or at least the number of hand hygiene opportunities outlined based on the unit type in Tables 4-6 of the 2023 Hospital Survey (measure specifications, Section 6), **each month in each patient care unit**
	  ▪ Hospital collects hand hygiene compliance data on at least **100** hand hygiene opportunities **each quarter in each patient care unit**
	  ○ Question #11:
	Hospital uses hand hygiene coaches or compliance observers to provide individuals who touch patients or who touch items that will be used by patients with feedback on both when they are and are not compliant with performing hand hygiene
	  ○ The hospital responded "yes" to all questions pertaining to the monitoring method used (as indicated in question #8, #9, or #10):
	  ▪ *Electronic Compliance Monitoring*: questions #12-13
	  ▪ *Direct Observation:* questions #14-15
	• **Feedback Domain:** questions #16-19
	• **Training and Education Domain:** questions #1-3
	• **Infrastructure Domain:** questions #4-7
	• **Culture Domain:** questions #20-21
	
	OR
	
	The hospital met **0** domains.

Declined to Respond	The hospital did not submit a Survey.
Pending Leapfrog Verification	The hospital's responses are undergoing Leapfrog's standard verification process.

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