El Camino Health

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

Monday, March 6, 2023 – 5:30 pm
El Camino Hospital | 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: 921 3536 7215#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	*public comment*	**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**	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	*public comment*	**motion required 5:37 – 5:47**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (2/06/2023) ***Information*** b. Report on Board Actions c. Progress Against FY 2023 Committee Goals d. QC Follow-Up Items			
6.	**CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair		**information 5:47 – 5:52**
7.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:52 – 6:02**
8.	**FY23 ENTERPRISE QUALITY DASHBOARD**	Mark Adams, MD, Chief Medical Officer		**discussion 6:02 – 6:17**
9.	**PROPOSED FY24 COMMITTEE PLANNING ITEMS** a. FY24 Committee Goals b. QC Charter	Mark Adams, MD, Chief Medical Officer		**discussion 6:17 – 6:47**

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		ESTIMATED TIMES
	c. FY24 Pacing Plan d. FY24 QC Dates			
10.	**ADJOURN TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 6:47 – 6:48**
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair		**information 6:48 – 6:49**
12.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (02/06/2023) b. Medical Staff Bylaw Revisions ***Information*** *Health and Safety Code Section 32155* c. Quality Council Minutes (02/01/2023)	Carol Somersille, MD Quality Committee Chair		**motion required 6:49 – 6:54**
13.	*Health and Safety Code Section 32155* **CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer		**motion required 6:54 – 7:04**
14.	*Health and Safety Code Section 32155* **SERIOUS SAFETY/RED ALERT EVENT**	Mark Adams, MD, Chief Medical Officer		**discussion 7:04 – 7:09**
15.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		**motion required 7:09 - 7:10**
16.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair		**information 7:10 – 7:11**
17.	**ROUNDTABLE**	Carol Somersille, MD Quality Committee Chair		**discussion 7:11 – 7:14**
18.	**ADJOURNMENT**	Carol Somersille, MD Quality Committee Chair	*public comment*	**motion required 7:14– 7:15 pm**

Next Meeting: April 3, 2023, May 1, 2023, June 5, 2023

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, February 6, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Carol Somersille, MD	**Melora Simon**	**Holly Beeman,** MD, MBA, CQO
Philip Ho, MD		**Dan Woods,** CEO
Prithvi Legha, MD**		**Meenesh Bhimani,** MD, COO
Jack Po, MD		**Mark Adams,** MD, CMO
Krutica Sharma, MD**		**Cheryl Reinking,** DNP, RN, CNO
John Zoglin		**Deb Muro,** CIO**
		Shahab Dadjou, President, ECHMN
		Shreyas Mallur, MD, ACMO
		Steven Xanthopoulos, MD**
		Ute Burness, RN, VP of Quality and Payer Relations
		Lyn Garrett, Senior Director, Quality
		Daniel Shih, MD**
		Tracy Fowler, Director, Governance Services
	**via teleconference	**Nicole Hartley,** Executive Assistant II

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 Hospital (the "Committee") was called to order at 5:30 pm by Chair Carol Somersille. A verbal roll call was taken. Dr. Legha joined at 5:32 pm. Ms. Simon was absent. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. PUBLIC COMMUNICATION	There were no comments from the public.	
4. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. Dr. Sharma and Mr. Zoglin pulled item 4d – FY23 Enterprise Quality Dashboard and Chair Somersille requested to pull item 4c – FY23 Pacing Plan. Chair Somersille addressed item 4c – FY23 Pacing Plan stating that Patient Experience is only on the Pacing Plan one time for the fiscal year. Could we add an additional date to	***Consent Calendar Approved***

	discuss additional topics like Press Ganey and Global Experience? Dr. Beeman shared that we do discuss Patient Experience at every meeting via Enterprise Quality Dashboard patient experience measures but we currently only have one time on the pacing plan that Christine Cunningham presents to the Committee. Mr. Zoglin added it would be good to consider for next year's pacing plan. Chair Somersille recommends that the Committee consider adding an additional date. Dr. Sharma addressed 4d – Enterprise Quality Dashboard and asked that we add our monthly threshold or target line to the trend chart for the HAC measures. Dr. Beeman thanked Dr. Sharma for the suggestion and stated that will be added. Mr. Zoglin asked staff how they feel about the data presented on the Enterprise Dashboard and being behind on 15 of the 17 items listed. Chair Somersille asked if they are concerned. Dr. Adams stated that yes, we are extremely concerned, staff lives and breathes this every day, and we have outlined a vast array of interventions instituted to improve. Dan shared that we are all hands on deck and presented this at the All Leaders Meeting regarding achieving these goals together. A discussion continued within the Committee regarding the Enterprise Dashboard, the initiatives in place, and the All Hands on Deck mentality about the results. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (12/12/2022); For information: (b) Report on Board Actions, (c) FY23 Pacing Plan, (d) FY23 Enterprise Quality Dashboard, (e) QC Follow-Up items **Movant**: Somersille **Second**: Po **Ayes**: Somersille, Ho, Po, Legha, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	*Action: Dr. Beeman to add a monthly threshold or target line to the trend chart on the Enterprise Dashboard*
5. PATIENT STORY	Cheryl Reinking, CNO, shared a patient story that was shared with ECH via the Press Ganey survey. The patient had an outpatient surgical procedure. The patient commented that they would like more options and information for managing nausea post procedure. Cheryl shared that the periop team has developed a new nausea management protocol. The protocol includes pre-procedure/post-procedure information on nausea management so the patients know what to expect. One example of nausea reduction intervention Cheryl shared was an aromatherapy device (QueaseEASE) provided to patients to	

	prevent nausea. Cheryl provided a sample of QueaseEASE to the Committee Members. QueaseEASE is a new aromatherapy device that has been used with our cancer patients and has been successful. It is now being offered in other areas such as inpatient and outpatient surgery. A nurse anesthetist invented this product and it is a great option for patients who would like an alternative to medication.	
6. Q2 FY23 STEEEP DASHBOARD REVIEW	Dr. Holly Beeman, CQO provided an overview to supplement the memo describing the Q2 FY23 STEEEP Dashboard performance: • Surgical Site Infections – The team is going back 5 years to look for trends. They are looking for surgeon specific patterns. In addition, a current focus is compliance with Enhanced Recovery After Surgery (ERAS) protocol. • Patient Falls – We are rolling out the Hopkins Mobility Initiative which will help ECH toe the fine line between increasing patient mobility to keep patient's 'conditioned' during their hospital stay to decrease falls. • Stroke measures-- Both door to needle and door to groin times are meeting/exceeding targets. Dr. Adams highlighted the new Director of stroke, Dr. Bhalla who is elevating the performance of our stroke program. • Imaging Turnaround Time – This measure is improving. The staffing and connectivity issues with the Night Radiology Reading team (night hawk) have been the root cause of the prolonged reading times overnight. To address this issue, the Radiologists have worked with management to create a simple to use on-call triage system so docs waiting for radiology results in the ED can contact an ECH radiologist to jump in and read the study if we learn the Night Hawk service is unable to meet the demand. Risk Adjusted Readmission Index – Progress is being made and we have a new data scientist that helped create a dashboard to view the readmission rate by Skilled Nursing Facilities (SNFs). Our sepsis coordinator has been to each of our partner SNFs to provide education, tools, and build relationships with the SNF staff to optimize collaboration between acute and post-acute settings. • Sepsis Mortality Index – In the month of December, there was an anomalous increase in the index (unfavorable). A deep dive review by our Sepsis Program Manager revealed that patients admitted to the floor while they were half way through the 3 hours sepsis bundle, was creating a hand-off problem .The receiving physician and rn on the floor were not able to track where in the 3 hour bundle the sepsis patient was. This resulted in steps of the bundle not being	

	completely timely. With lower bundle compliance, the mortality increases. There is an opportunity with the handoff in communication to ensure the team on the floor accepting the patient from the ED is aware of where the patient is on the 'bundle' so that steps and interventions are deployed timely. • ED Arrival to ED Departure – We have added four treatment chairs to help with treat to street. This began last Monday. • Health Equity measures categories – the dashboard items are the beginning stages of tackling health equity. We will have more meaningful metrics for FY24. At Quality Council, when departments present their annual performance improvement report, Dr. Beeman has asked presenters to use a lens of health equity as they review their data and performance opportunities. • Patient Experience – Meenesh and Cheryl have implemented an Executive Rounding program to help support the power of 3 rounding. The Executives participating are rounding on patients with a dyad nurse manager. Dr. Sharma asked do you anticipate The Joint Commission evaluating organizations differently now that Health Equity will be a national patient safety goal beginning July 1st. goal. Dr. Beeman shared yes, due to it being a patient safety standard, it triggers our regulatory team to proactively articulate a detailed action plan around our efforts to address health disparities. Dr. Sharma suggested sharing this with the Committee once it comes together.	*Action: Dr. Beeman to share with the Committee the action plan for complying with the new Joint Commission patient safety goal regarding Health Equity at a future meeting.*
7. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Ute Burness, RN, VP of Quality and Payer Relations provided an overview to supplement the materials in the packet for the El Camino Health Medical Network Report and highlighted the following: • Quality Infrastructure Enhancements – reconstituted the Quality Committee, have representation from PCP and all major specialties; defined the charter and what their focus is and understand what this goal is of the Committee • Recruited and onboarded a Quality Nurse who recently passed her 120 days with ECHMN • Dashboard Review – Blood Pressure, Diabetes management, Breast care screening, colon cancer screening, annual flu vaccination, and medical reconciliation	

	A discussion continued within the Committee regarding the Dashboard, the timing of the data, and how physicians receive the data for the quality measures. Additionally, Ute shared that they have amended provider schedules to increase appointment availability and they are piloting a RN triage at one site to assist with administrative tasks and free the physician's time to see more patients.	
8. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:58 pm. **Movant**: Zoglin **Second**: Ho **Ayes**: Somersille, Ho, Po, Legha, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Simon **Recused**: None	***Adjourned to closed session at 6:58 pm***
9. AGENDA ITEM 16: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at 7:18 pm. Agenda items 9-15 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (12/12/2022), the Quality Council Minutes (12/07/2022), the Quality Council Minutes (1/04/2023), and the Credentialing and Privileges Report by unanimous vote by all committee members present.	
10. AGENDA ITEM 17: ROUNDTABLE	No additional comments.	
11. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 7:19 pm **Movant**: Po **Second**: Zoglin **Ayes**: Somersille, Ho, Po, Legha, Sharma, Zoglin **Noes**: None **Abstain**: None **Absent**: Simon **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:

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Nicole Hartley, Executive Assistant, II

Prepared by: Nicole Hartley, Executive Assistant, II
Reviewed by: Stephanie Iljin, Manager of Administration

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY, PATIENT CARE, PATIENT EXPERIENCE COMMITTEE MEETING MEMO

To: Quality, Patient Care, Patient Experience Committee
From: Tracy Fowler, Director Governance Services
Date: March 6, 2023
Subject: Report on Board Actions

Purpose: To keep the Committee informed regarding actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

Since the last time we provided this report to the Quality Committee, the Hospital Board met once and the District met once. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report for any meetings since the last Quality Committee

Board/Committee	Meeting Date	**Actions** (Approvals unless otherwise noted)
ECH Board	February 15, 2023	- Surplus Cash – Reserve Fund Investment Policy - Credentialing and Privileges Report - Psychiatric Telehealth Services Renewal Agreement (Enterprise) - Capital Project Request: MV & LG Pharmacy Upgrades - Board and Advisory Committee Education Policy - Investment Committee Charter - Quality Committee Member Appointments - Scope of Service – Imaging Services - Human Resources Division Scope of Service
ECHD Board	February 8, 2023	- Ad Hoc Committee Recommendations for ECHB Director Reappointment
Compliance and Audit Committee	February 22, 2023	- Physician Financial Arrangement Reports
Executive Compensation Committee	No meetings	- No approvals to report
Finance Committee	February 27, 2023	- No approvals to report

El Camino Health

FY23 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods, and assuring appropriate resource allocation to achieve this purpose.

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: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large. The

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY22 Achievement and Metrics for FY22 (Q1 FY23) - Review FY23 Incentive Goal recommendations for Quality, Safety and Patient Experience measures	Review management proposals; provide feedback and make recommendations to the Board
2. Review the milestones and outcome metrics of the ECH High Reliability implementation.	HRO Journey in process currently with classes underway April 2022 with plans for ongoing education throughout FY22 and FY23.	HRO: Serious Safety Event Rate and Culture of Safety Survey.
3. Reducing health care disparities is a quality priority for the enterprise	Biannual report to Quality Committee FY23	Monitor the effectiveness of ECH activities to reduce health care disparities in the individuals we serve
4. Review Quality, Patient Care and Patient Experience reports and dashboards	- Review reports per Pacing Plan timeline.	Explanation of measure methodology and benchmarks included with each report.
5. Review Board Quality STEEEP Dashboard and propose changes as appropriate	Quarterly	Review Dashboard and Recommend Changes to the Board
6. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Using closing wrap up time, review quarterly at the end of the meeting	- Attend 2/3 of all meetings in person - Actively participate in discussions at each meeting

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

As of: 2/6/23

Quality Committee Follow-Up Items

Item	Date Requested	Committee Member Name	Item Requested	Individual to complete the follow up	Completion Date
	FY23				
1	9/6/2022	Carol Somersille, MD	4d – Progress Against FY23 Committee Goals. She noted to correct the Chair name to her name and remove Julie Kliger's name.	Nicole Hartley	9/7/2022
2	9/6/2022	Carol Somersille, MD	on the item dated 06/06/2022 to her name and remove Holly Beeman's name under Committee Member.	Nicole Hartley	9/7/2022
3	11/7/2022	John Zoglin	Agenda Item 7. Follow up items are: Present a 5-year analysis to the Committee and a status update on the deciles.	Nicole Hartley/Christine Cunningham	12/12/2022
4	11/7/2022	Alyson Falwell	time for stroke patients evaluated and discharged from ED) performance as shared in Core Measure report during the Nov 2022 Quality Committee	Dr. Holly Beeman	12/12/2022
5	11/7/2022	Melora Simon	Requests to display both the fiscal year to date and rolling 12 month performance results in future ECHMN quality reports.	Ute Burness	2/6/2023
6	2/6/2023	Krutica Sharma, MD	Requested that we add a monthly threshold or target line to the trend chart on the Enterprise Dashboard	Dr. Holly Beeman	3/6/2023
7	2/6/2023	Krutica Sharma, MD	Request the action plan for complying with the new Joint Commission patient safety goal regarding Health Equity be shared with the committee at a future meeting.	Dr. Holly Beeman	

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 6, 2023
Subject: Patient Experience feedback from Press Ganey Survey Comments

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

Summary:

1. Situation: These comments are from a patient who received a Press Ganey survey following treatment and discharge from the emergency department.

2. Authority: To provide insight into one patient's experience and the importance of managing patient flow and capacity in the ED and throughout the organization.

3. Background: This patient found the staff "nice". However, with the 30% increase in ED patient volumes, the ED staff have been required to care for patients in less conventional environments in order to triage and treat patients in a timely manner. This patient commented that her care was completed in a hallway chair. Recent changes have assisted with space constraints in providing additional private areas for quick rapid medical evaluation, treatment, and discharge which promotes patient flow.

4. Assessment: While treating patients in the hallway is not ideal, sometimes it is necessary in order to provide care timely when the emergency department is at capacity. Due to lack of privacy and patient concerns, the staff came forward with an idea to convert some office space to patient care space adding 4 additional recliner chairs for low acuity patients. These chairs were activated in January and are able to provide additional privacy while also promoting a timely turn around in triage, care, treatment and discharge. In addition, process improvements are continuing to improve including a change to expedite the discharge function for patients leaving from the ED.

5. Other Reviews: None

6. Outcomes: We have seen our patient experience scores increase recently with an LTR score of 77.2 (Target 77) in January. In addition, the arrival to discharge time continues to improve. The January metric was 191 minutes at MV with a target of 190.

List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do we continue to address capacity issues which is a national phenomenon in healthcare systems?

2. What do patients care about most when they go to the Emergency Department?

Press Ganey Survey Comment

Emergency Department: Most nurses were nice, the only problem was that there were no beds or private areas so I had to sit in a hallway chair with my IV for 2 hours while I waited for my results. But that was not the staff's fault. It was just uncomfortable but I survived.

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 6, 2023
Subject: Enterprise Quality, Safety and Experience Dashboard through October 2022

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on quality, safety and experience metrics and performance through January 2023 (unless otherwise noted) as demonstrated on the FY23 Enterprise Quality, Safety and Experience Dashboard.

Summary:

1. Situation: The Fiscal Year 2023 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. These key metrics were selected based on a review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization. This memo and the attached dashboard provide the Committee with a snapshot of the FY 2023 metrics monthly with trends over time and compared to the actual results from FY2022 and the FY 2023 targets.

2. Authority: The Quality, Patient Care and Patient Experience Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on key quality metrics.

3. Background: At the beginning of each fiscal year, an assessment is completed to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added.

4. Assessment: Of the hundreds of performance measures tracked and actively managed, 17 measures are reported on the FY23 Enterprise Quality Dashboard. Of the 16 measures with targets, 9 measures are at or exceeding target.

    i. Hospital Acquired Condition Index. This metric is a composite of monthly weighted rates of 5 component measures. During January, the index was 0.59 which is lower (favorable) than target of 0.986. Year to date the HAC Index is 0.983 (favorable) the FY23 target of 0.986. Lower is better.

        1. C. Difficile Infections. Unfavorable. We have not yet reduced C. Diff infections to our satisfaction. Three patients had hospital onset C. Diff in January. Year to date, 24 patients have had C. Diff infections whilst our goal for all of FY23 is to have <=34 infections. We are currently in the midst of our enterprise wide C. Diff education module for nurses and certified nurse assistants. This has revealed previous education around C. Diff has been insufficient. Current education is

being provided to correct this deficit. Simultaneously, we continue to have suboptimal compliance with hand-hygiene. We are launching our aggressive and lively hand hygiene campaign at this time.

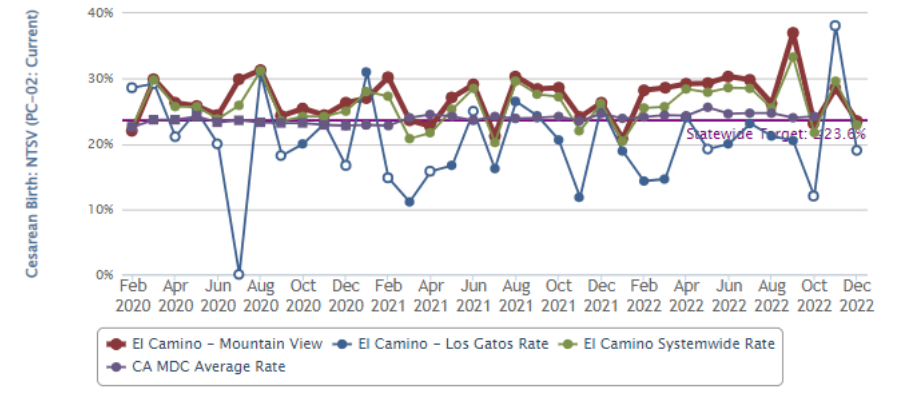
2. Surgical site infection. It is too early to determine if there will be any surgical site infections in January. To date there have been none identified. The trend year to date is slightly above where we want to be. Areas of focus are on compliance with Enhanced Recovery After Surgery and ensuring hair clipping of patients is performed in the pre-op area, not in the operating room.

3. Non-ventilator Pneumonia. Favorable with only 3 events in January, lower than target of < 9 events per month. The focus on re-education on the importance of oral care, and having patients sit up for meals, both designed to prevent patients from micro-aspiration of mouth bacteria into the lungs, has been successful.

4. Falls and Pressure Injury performance are both favorable.

ii. Sepsis Mortality Index. Favorable. The anomalous HIGH index (unfavorable) in October was transient. The January Sepsis Mortality Index of 0.92 is consistent with our typical (excellent) performance.

iii. PC-02: Cesarean Birth Core Measure. Unfavorable (**very**). Data for PCO2 core measure lags by more than a quarter due to how, who and when the data is extracted and validated by IBM who generates the data for this Core Measure. What is reflected in the Enterprise Quality dashboard shows an all-time HIGH c/s rate of 37% in Mountain View in the month of September and a year to date enterprise rate through Q1 of 28.8%. This is not close to target of 23.9%. Since the spike in September 2022, C/S rates have reduced favorably as is evident in data the Maternal Child Health team has access to on the California Maternal Quality Care Collaborative (CMQCC) website.



Period	El Camino - Mountain View	El Camino - Los Gatos Rate	El Camino Systemwide Rate	CA MDC Average Rate
Dec 2022	23.5%	19.0%	22.9%	N/A

The September uptick may be related to volume pressures and resulting lower threshold to perform a C-section. The patient acuity in Fall 2022 was higher than average.

Primary cesarean sections are grouped into three categories for purposes of identifying trends and opportunities for improvement.

- Primary elective (patient's request)
- Spontaneous labor
- Induced labor

Compared to other California (CA) hospitals, our c/s rate for primary elective and spontaneous labor groups are similar. ECH has a higher c/s rate for induction patients compared to other CA hospitals. A detailed review of the c/s's demonstrates that of all NTSV's (nulliparous, term, singleton, vertex) 47.5% of these patients had been induced. Of the inductions, 80% were for medical reasons. These findings have helped the team focus on patients whose labor is being induced. We need to improve our performance in this group of patients. The team is reviewing current literature to re-evaluate the medications and processes being used to induce labor. Nurses and physicians are collaborating to identify and implement a standard to optimize the chance of a vaginal delivery for those patients whose labor is induced.

A NTSV taskforce began meeting weekly in January. This group is comparing current processes and protocols compared to current medical literature and will be making recommendations for revisions to how patients are being induced.

B. Patient Experience Measures.

Maternal Child Health and ED likelihood to recommend (LTR) are both exceeding target for January 2023 (favorable). ECHMN LTR performance has improved and is just shy of target. Inpatient LTR continues to lag below target. Executive patient rounding on each nursing unit began in February. This intervention has been shown to be a key driver in high patient satisfaction. We are hopeful this intervention will result in positive improvement in data from late February and ongoing.

List of Attachments

Attachment 1-- Enterprise Quality, Safety, and Experience Dashboard January 2023

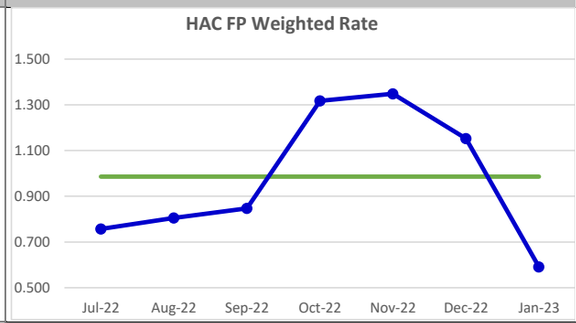
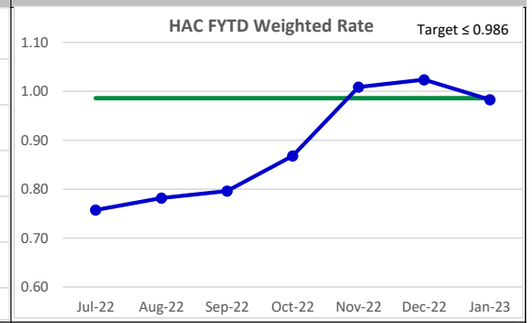
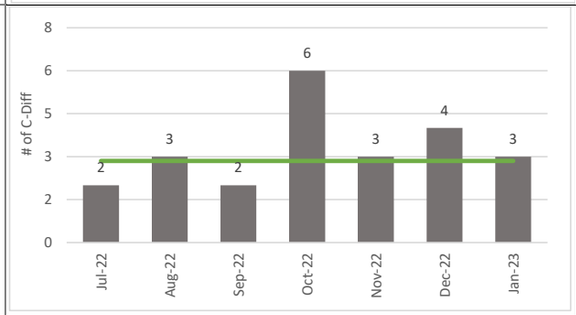
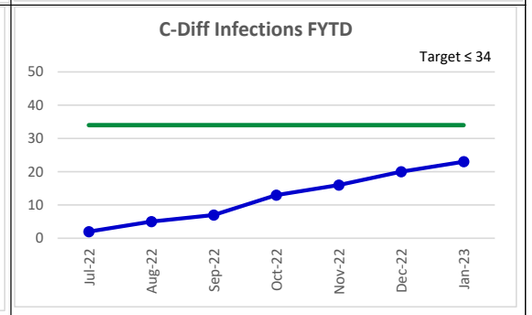
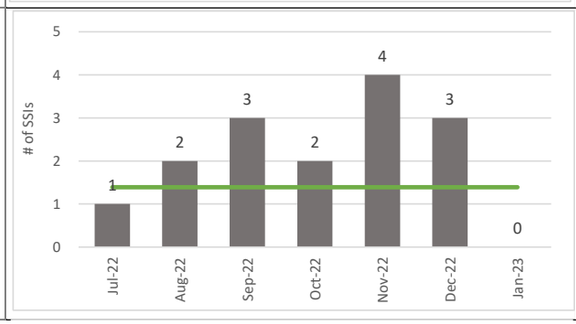
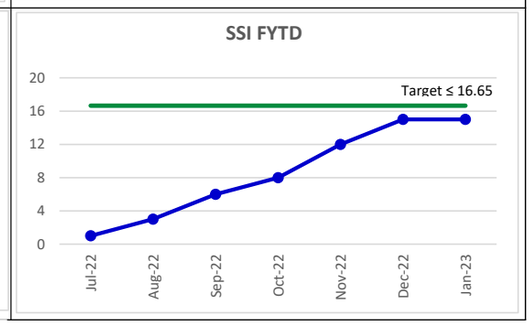
El Camino Health

FY23 Enterprise Quality, Safety, and Experience Dashboard

January 2023 (unless otherwise specified)

Month to Board Quality Committee:

March, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **HAC Index** *Latest data month: Jan, 23*	0.591	0.983	1.066	0.986 (7.5% ↓)		
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Jan, 23*	3	3.29 / month	3.08 / month	2.85 / month		
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Jan, 23*	0	2.14 / month	1.50 / month	1.39 / month		

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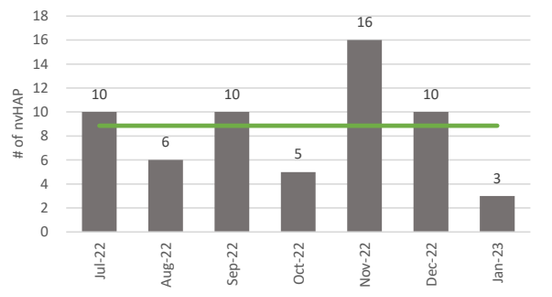
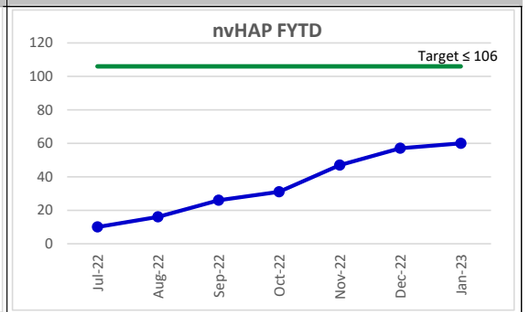
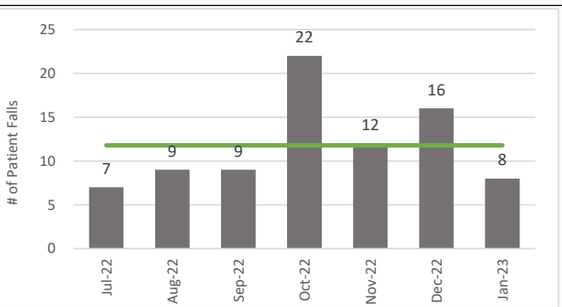
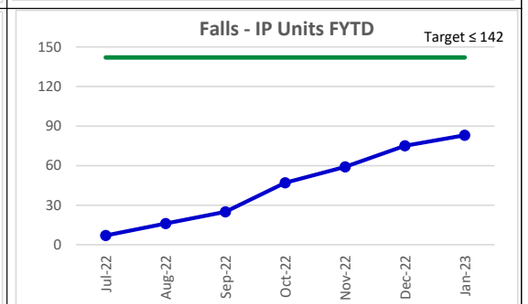
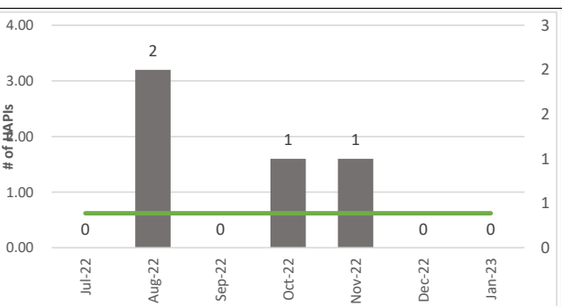
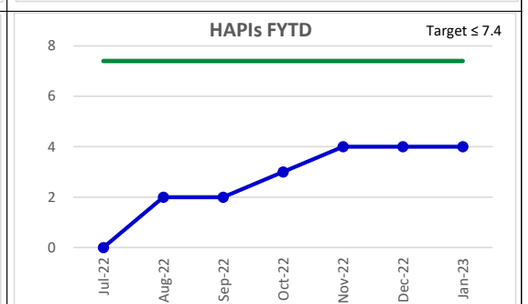
March, 2023

		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Jan, 23*	3	8.57 / month	9.58 / month	8.86 / month		
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Jan, 23*	8	11.86 / month	12.75 / month	11.79 / month		
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Jan, 23*	0	0.57 / month	0.67 / month	0.62 / month		

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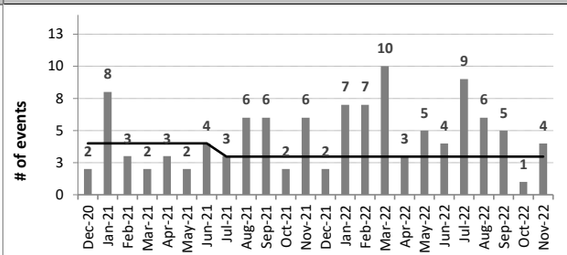
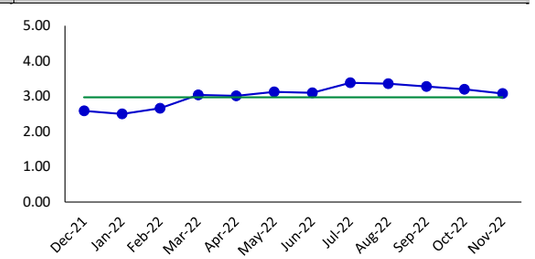
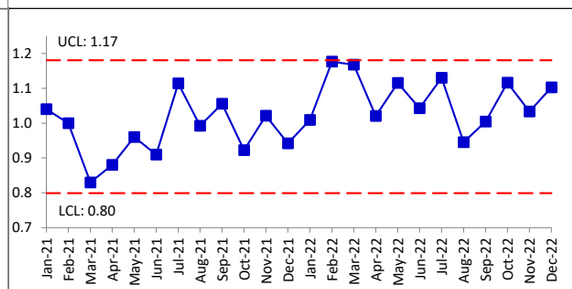
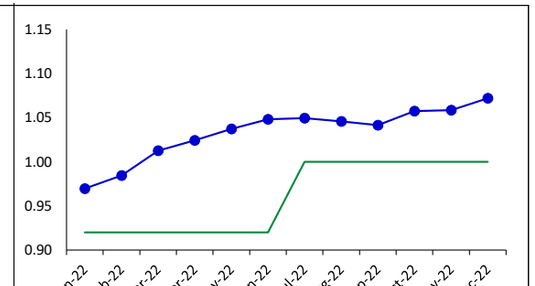
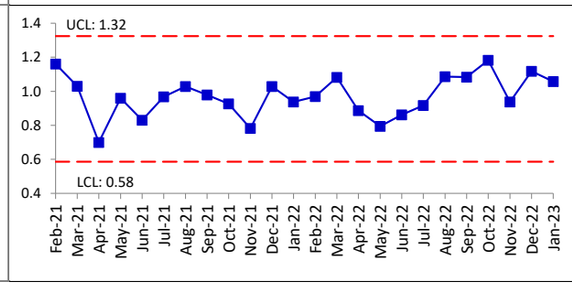
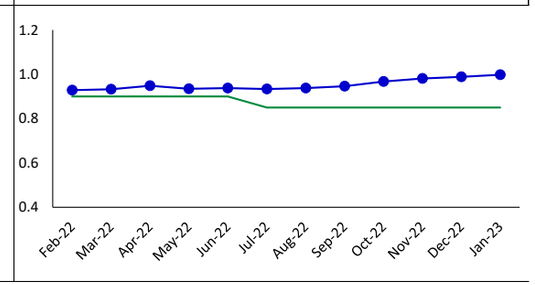
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
7	**Serious Safety Event Rate (SSER)** **Latest data month: Nov, 22*	4	3.08 (63/204828)	3.10 (Jul, 21 - Jun, 22)	n/a		
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** ** Latest data month: Dec, 22*	1.10 (9.97%/9.04%)	1.06 (9.24%/8.76%)	1.05	1.00		
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*	1.06 (2.67%/2.53%)	1.06 (2.10%/1.98%)	0.94	0.85		

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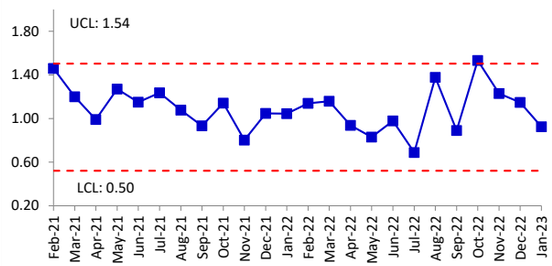
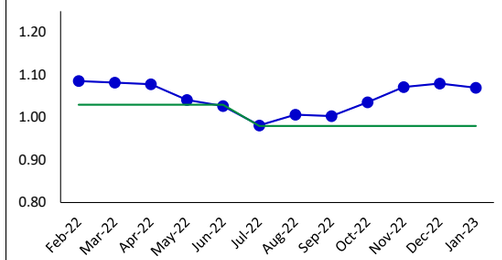
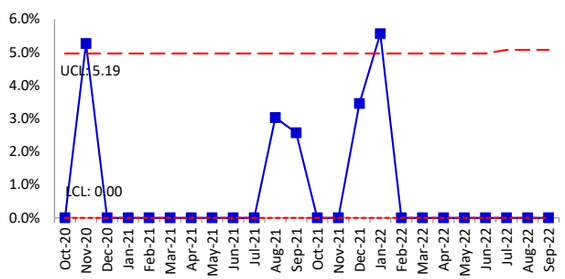
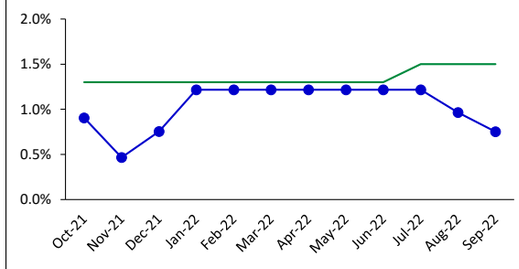
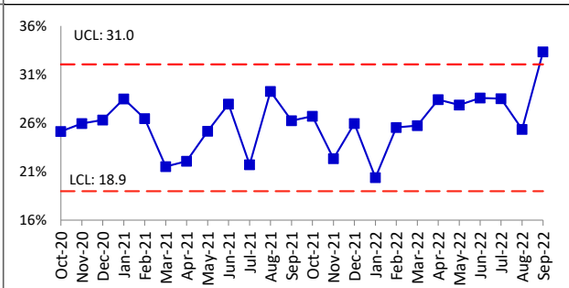
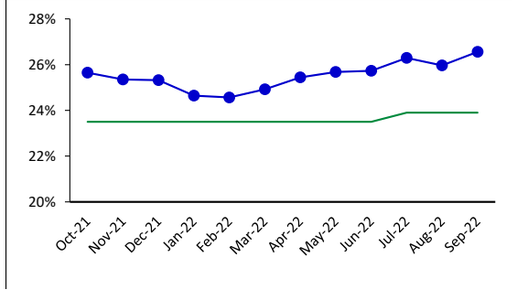
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*	0.92 (13.29%/14.37%)	1.11 (13.11%/11.82%)	1.03	0.98		
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) **Latest data quarter: Sept, 22*	MV: 0.0% (0/24) LG: 0.0% (0/9) ENT: 0.0% (0/33)	MV: 0.0% (0/77) LG: 0.0% (0/27) ENT: 0.0% (0/104)	MV: 0.4% (1/271) LG: 3.5% (3/83) ENT: 1.1% (4/356)	1.5% (FY23 Target)		
12	**PC-02: Cesarean Birth** (reported quarterly) **Latest data quarter: Sept, 22*	MV: 37.0% (50/135) LG: 20.5% (8/39) ENT: 33.3% (58/174)	MV: 30.5% (146/479) LG: 21.4% (24/112) ENT: 28.8% (170/591)	MV: 27.1% (503/1,857) LG: 19.9% (83/147) ENT: 25.8% (586/2,274)	23.9% (FY23 Target)		

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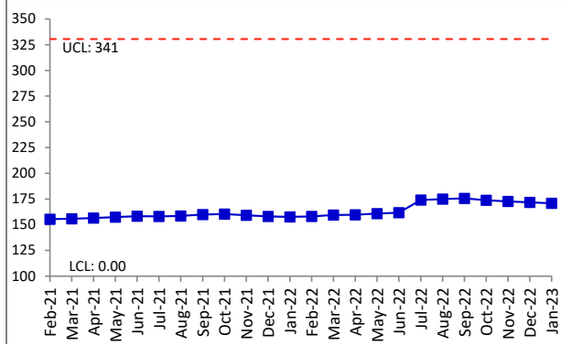
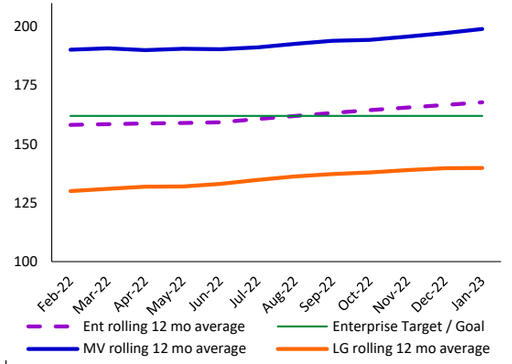
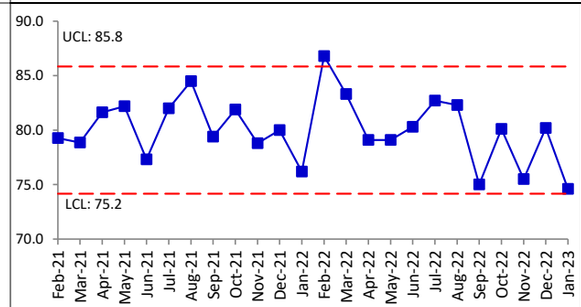
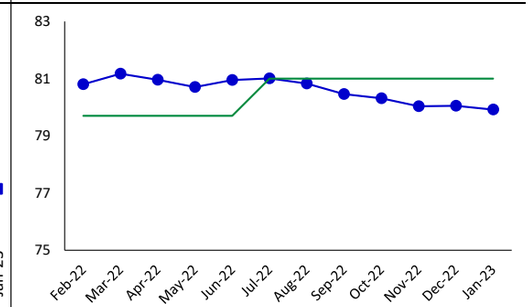
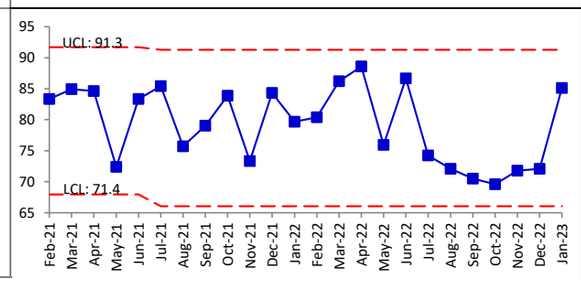
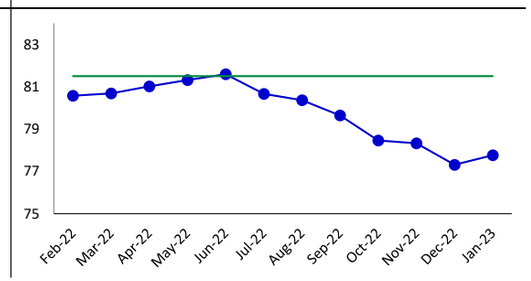
		Latest month	FYTD				
13	**OP18b: Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Jan, '23*	MV: 191 mins LG: 140 mins ENT: 166 mins	MV: 200 mins LG: 142 mins ENT: 171 mins	MV: 190 mins LG: 133 mins Ent: 162 mins	MV: 190 mins LG: 133 mins Ent: 162 mins		
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*	74.6	78.7	80.8	81.0		
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*	85.1	73.5	81.3	81.5		

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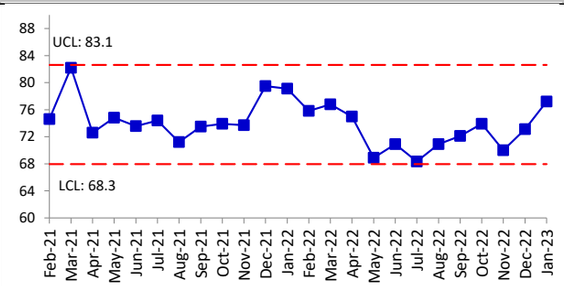
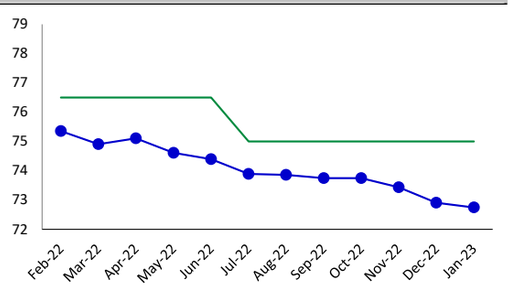
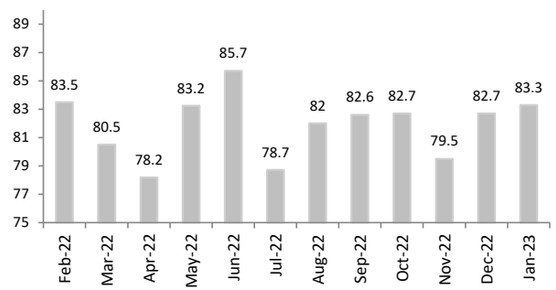
		FY23 Performance		Baseline FY22 Actual	FY 23 Target	Trend	FYTD or Rolling 12 Month Average
		Latest month	FYTD				
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Jan, 23*	77.2	72.1	74.5	75.0		
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Jan, 23*	83.3	81.7	83.2	83.4		NA

Notes:

1) SSER through Nov, 22
2) Readmissions through Dec, '22
3) PC-01 & PC-02 FY23Q1 (July - Sept 2022) results available
4) ECHMN: reflect new vendor (PG) survey results
5) Updated 2/21/23

El Camino Health

Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
1	*Organizational Goal **HAC Index** *Latest data month: Jan, 23*		H. Beeman, MD	New for FY23, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (5) key inpatient safety events. The elements of the composite are weighted as noted: Falls 20%, hospital-acquired Pressure Injuries (HAPIs) 25%, non-ventilator hospital-acquired pneumonia (nvHAP) 20%, Clostridium difficile infections (C-Diff) 10%, and surgical site infections (SSIs) 25%.	See below
2	HAC component **Clostridium Difficile Infections (C-Diff)** *Latest data month: Jan, 23*		C. Nalesnik	1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.	Numerator: Infection control Dept. Denominator: EPIC Report
3	HAC component **Surgical Site Infections (SSI)** *Latest data month: Jan, 23*		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

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Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
4	**HAC component** **non-ventilator Hospital-Acquired Pneumonia (nvHAP)** *Latest data month: Jan, 23*		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 5) Latency: periodic; corrections may change previously reported results.	EPIC Clarity data warehouse; Numerator identified by nvHAP workgroup; Denominator: EPSi patient days
5	**HAC component** **NDNQI: IP Units Patient Falls** *Latest data month: Jan, 23*		Nursing	1) NDNQI metric: In or outpatient falls on an inpatient nursing unit. "Falls" in a nursery are 'drops'. 2) Numerator inclusions: Patient falls as determined by a monthly evaluation & validation of iSAFE incident reports. 3) Numerator exclusions: L&D, intentional falls. 4) Denominator: EPSi acute patient days excluding: 6900 Pre-OP/SSU, 7400 L&D, 7427 PACU 5) Formula: (# falls/patient days) * 1,000 6) Latency: rare; corrections may change previously reported results.	Numerator: Incident Reports and Staff Validation/iSafe Denominator: EPSi patient days
6	**HAC component** **HAPIs (Stage 3, 4 & Unstageable Hospital Acquired Pressure Injury** *Latest data month: Jan, 23*		A. Aquino	1) Internal metric: Inpatient Stage 3, Stage 4 & Unstageable hospital-acquired pressure injuries 2) Numerator exclusions: Expirations, "skin failure/ Kennedy Pressure Ulcer" & proned Covid-19 patients 3) Denominator: EPSi acute patient days excluding 6070 NICU/Nursery Lvl 2, 6900 Pre-Op SSU,7400 L&D, 7427 PACU 4) Latency: periodic; corrections may change previously reported results.	Numerator: EPIC Report and staff validation Denominator: EPSi patient days

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Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
7	**Serious Safety Event Rate (SSER)** **Latest data month: Nov, 22*		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.	HPI Systems
8	**Readmission Index** **(All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Care Sciences Standard RA*** * Latest data month: Dec, 22		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. 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
9	**Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*		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

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Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
10	**Sepsis Mortality Index** ***Observed/Expected*** ***Premier Care Sciences Standard RA*** *Latest data month: Jan, 23*		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
11	**PC-01: Elective Delivery Prior to 39 weeks gestation** (reported quarterly) *****Latest data quarter: Sept, 22*		H. Beeman, MD	1) Numerator: Patients with elective deliveries 2) Denominator: Delivered newborns with gestation weeks >/= 37 to 39 weeks For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): The FY23 target for PC-01 1.5% (top 25th %ile for MDC). MCH needs to retain some ability to do medically indicated, yet not meeting criteria, early deliveries.	IBM CareDiscovery Quality Measures
12	**PC-02: Cesarean Birth** (reported quarterly) *****Latest data quarter: Sept, 22*		H. Beeman, MD	1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation For the trended graph: UCL & LCL are 2+/- the Standard Deviation from the average. LCL is set to '0' if value ,/= zero. 9/16/22 (per H. Freeman): FY23 target for PC-02 NTSV is 23.9%. Given our population (Asian average in CA was 25.2% from 07/2021-06/2022 for same nursery level CA MDC, + have significantly older population than CA), we think this is pretty aggressive.	IBM CareDiscovery Quality Measures

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Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
13	**OP18b: Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)** *Latest Data Month: Jan, '23*		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
14	***Organizational Goal** **IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*		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
15	**IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: Jan, 23*		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

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Definitions and Additional Information

		Comments	Definition Owner	Definition	Source
16	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: Jan, 23*		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
17	*** Organizational Goal** **ECHMN (El Camino Health Medical Network) : Likelihood to Recommend Care Provider** **Top Box Rating of 'Yes, Definitely Likely to Recommend ' %, Unadjusted** *Latest data month: Jan, 23*		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

Notes:

1) SSER through Nov, 22
2) Readmissions through Dec, '22
3) PC-01 & PC-02 FY23Q1 (July - Sept 2022) r
4) ECHMN: reflect new vendor (PG) survey
5) Updated 2/21/23

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 (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

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: the 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. All committee members regularly attend and are engaged in committee meeting preparation and discussions	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

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

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 Health. 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).

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

Authority

All governing authority for the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated 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 the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

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

Membership

- 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. 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 nine (9) Community members[1] with expertise in ~~in~~ assessing quality indicators, quality processes ~~(*e.g.*, LEAN)~~, patient

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

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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 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 appointed by the 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 expiring on June 30th each year, renewable annually.

- It shall be within the discretion of the Chair of the Committee to appoint 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 Medical Officer (CMO)~~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 ~~CMO~~ 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 ~~culture of safety~~mission to achieve zero patient harm.

The principles of Whole System Quality as described by the Institute for Healthcare Improvement will inform this Committees approach to enable the pursuit of quality excellence through a commitment to continuous learning. (Sampath B, 2021). The specific behaviors of committee participants (members and management) ~~will~~that align with ECH leadership principles designed to foster a culture of learning and improving are;

1. Build a shared sense of purpose—The co-production of a cohesive and unified vision for a future state of the organization to cultivate a shared sense of purpose.
2. Practice systems thinking—The ability to see the interconnected elements of the system, and to distinguish patterns instead of conceptualizing change as isolated events.
3. Engage in collective learning and dialogue—The process of collective inquiry, dialogue and co-production to advance the organization toward the shared vision and goals.

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4. Practice personal inquiry and reflection—The discipline of self-reflection, unearthing deeply held belief structures and understanding how they dramatically influence behaviors. (Sampath B, 2021)

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With input from the Committee and other key stakeholders including annual performance improvement reports reviewed at the monthly Quality Council meeting, the management team shall develop dashboard metrics that will be used to measure and track quality, safety and patient experience performance. ~~of care and outcomes, and patient satisfaction~~ 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 ~~that~~ 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 ~~that~~ communication to the Board and external constituents is well executed.

Specific Duties

"Senior leaders (board and committee members) set the tone for organizational learning through their positional and symbolic power. By modeling the behaviors they seek to cultivate, executives and department leaders encourage, support, and normalize learning practices, ensuring psychological safety to acknowledge and help resolve individual and system issues." ~~The~~

In the setting of these behavioral expectations, ~~specific~~ general ~~duties of the Committee include the following:~~

1. Quality Planning—Ensure the enterprise strategy plan is quality-centric.
2. Quality Control—Review quality 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:

- ~~Oversee management's development of a multi-year strategic quality plan (PaCT).~~

- Oversee management's development of the Organization's goals encompassing the measurement and improvement of ~~safety, risk, efficiency, patient-centeredness, patient satisfaction~~quality, safety and patient experience~~, and the scope of continuum of care services~~ as tracked on the Enterprise Quality, Patient Care and Patient Experience Dashboard~~.~~

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

    - Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
    - Organization-wide patient safety goals and hospital performance relative to patient safety targets.

- ~~Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.~~
- Organization-wide patient satisfaction and patient experience surveys.
- Organization-wide ~~physician~~ provider satisfaction surveys.

- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements~~, to including, but limited to,~~ 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 ~~Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts~~annual report on actions taken to improve patient safety as per the ~~hospital and boa~~Safety Event Reporting~~rd~~ policy that is maintained in PolicyStat.

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

- ~~Ensure that the Organization's scope of service and community activities and resources are responsive to community need.~~

Committee Effectiveness

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

Meetings and Minutes

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

DRAFT

Quality, Patient Care, and Patient Experience Committee
FY24 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			✓									
Patient Experience (HCAHPS)			✓									
Patient Experience									✓			
Health Care Equity						✓						✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Sepsis Review						✓						
Value Based Purchasing Report										✓		
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
Refresh STEEEP Dashboard measures for FY25												✓
Special Topic (Placeholder)			✓							✓		
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Approve Committee Goals										✓		
Propose FY Committee Meeting dates									✓			
Approve FY Committee Meeting dates										✓		
Propose Organizational Goals										✓		
Approve FY23 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), Report on Board Actions, QC Follow Up Items, Patient Safety Report (Sept), CDI Dashboard (Semi-Annual), Core Measures (Semi-Annual), Leapfrog (June)

El Camino Health

Quality Committee Meetings
Proposed FY2024 Dates

RECOMMENDED QC DATE MONDAYS
Monday, August 21, 2023
Monday, September 18, 2023
Monday, November 20, 2023
Monday, December 18, 2023
Monday, February 26, 2024 *4th week due to Presidents Day*
Monday, March 18, 2024
Monday, April 15, 2024
Monday, May 20, 2024
Monday, June 17, 2024