El Camino Health

AGENDA

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

Monday, June 7, 2021 – 5:30 pm

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

PURSUANT TO STATE OF CALIFORNIA EXECUTIVE ORDER N-29-20 DATED MARCH 18, 2020, El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 960 0622 7228. 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 ensuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (05/03/2021) ***Information*** b. Progress Against FY21 Committee Goals c. FY21 Enterprise Quality Dashboard d. Report on Board Actions e. Quality Committee Follow-Up Tracking f. Article of Interest	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:43**
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:43 – 5:46**
5.	**PATIENT STORY**	Cheryl Reinking, RN, CNO		**discussion 5:46 – 5:51**
6.	**READMISSION DASHBOARD**	Mark Adams, MD, CMO		**discussion 5:51 – 6:01**
7.	**PSI REPORT**	Mark Adams, MD, CMO		**discussion 6:01 – 6:11**
8.	**QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN**	Mark Adams, MD, CMO		**discussion 6:11 – 6:31**
9.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information 6:31 – 6:33**
10.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:33 – 6:34**

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) 988-8254 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
11.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:34 – 6:35**
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 (5/03/2021) ***Information*** b. Quality Council Minutes	Julie Kliger, Quality Committee Chair		**motion required 6:35 – 6:37**
13.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:37 – 6:47**
14.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**discussion 6:47 – 6:52**
15.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 6:52 – 6:53**
16.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**information 6:53 – 6:54**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
17.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 6:54 – 6:59**
18.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:59 – 7:00**

El Camino Health

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, May 3, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Julie Kliger, Chair**
George O. Ting, MD, Vice Chair**
Melora Simon**
Krutica Sharma, MD**
Michael Kan, MD**
Apurva Marfatia, MD**
Jack Po, MD**
Alyson Falwell**

Members Absent
Terrigal Burn, MD

****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 Hospital (the "Committee") was called to order at 5:30 pm by Chair Kliger. A verbal roll call was taken. Terrigal Burn, MD, was absent. Dr. Ting and Dr. Kan were not present during roll call. All other members were present at roll call and participated telephonically. A quorum was present according 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 Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any Committee or public member would like to remove an item from the consent calendar. **Motion:** To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (04/05/2021); For information: (b) Progress Against FY 2021 Committee Goals, (c) FY 2021 Enterprise Quality Dashboard, (d) Report on Board Actions, (e) Quality Committee Follow-Up Tracking, (f) Pacing Plan, and (g) Article of Interest. **Movant:** Sharma **Second:** Simon **Ayes:** Falwell, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** Burn & Kan **Recused:** None	***Consent Calendar approved***
4. CHAIR'S REPORT	Chair Kliger did not report on the Chair's Report beyond what was submitted in the materials.	
5. PATIENT STORY	Cheryl Reinking, DNP, RN, NCA-BC, CNO, presented a patient's story from the Press Ganey survey and noted the this was regarding a mother who gave birth. The patients' expectations were not met as she experienced many issues and concerns, specifically a problem with the epidural. Overall, communication was the core of the patient's concerns. Ms. Reinking stated that the physicians' followed up with the patient to address her concerns.	

	In response to a committee member's question, the service provided for new mothers includes a pre-education program that some new mothers do not take advantage of attending. **Dr. Kan joined the meeting during the Patient Story.*	
6. PROPOSED FY22 STRATEGIC GOALS	Mark Adams, MD, CMO, presented the FY 2022 Strategic Goals and stated there had been more iterations to the goals presented in the packet. Dr. Adams requested the Committee to recommend the FY 2022 goals for board approval. He further noted that he would be taking the SEPSIS as a personal goal and would not be included in the strategic goals. In response to committee members' questions, Dr. Adams stated that the SEPSIS goal would be one of his incentive goals. Ms. Reinking noted that she would be taking the Responsiveness domain as her incentive goal. **Motion:** To approve the Proposed FY 2022 Strategic Goals and recommend to the Board for approval. **Movant:** Sharma **Second:** Falwell **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***FY22 Strategic Goals approved for Board Recommend ation***
7. PROPOSED FY22 PACING PLAN	Mark Adams, MD, CMO, presented the FY22 Pacing Plan and suggested deferring some of the items to the consent calendar to allow additional discussion topics paced throughout the year. Chair Kliger agreed with Dr. Adams' recommendation. **Motion:** To approve the Proposed FY 2022 Pacing Plan and to recommend to the Board. **Movant:** Ting **Second:** Sharma **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***FY22 Pacing Plan approved***
8. EL CAMINO HEALTH MEDICAL NETWORK REPORT	Vince Manoogian, ECHMN Interim President, presented the El Camino Medical Network Report and highlighted the following: • The results show a slight decrease but still a score well above the target. Management has been on top of this report to make sure that the score is on target. • CMS would do the final MIPS calculation. Mr. Manoogian predicts a score of 85%, which would put ECH at the exceptional bonus level. • The quality committee and credentialing Committee at ECHMN have grown with one representative from each site. In response to committee members' questions, Dr. Adams stated that HEDIS was based on the internal measure for all patients and all payors for this report. Mr. Manoogian noted that most of the targets are set on a national level and are assessed at where ECHMN would want to be with each target.	

	Dr. Ting suggested that the Committee should get more than a quarterly ECHMN report. In response to Mr. Ting's suggestion, Ms. Kliger stated that there are levels of governance required to be followed, and requests like this need board-level approval. Chair Kliger suggested additional data quarterly to see high and low-performance months and the variations of those months.	
9. QUARTERLY BOARD QUALITY DASHBOARD REPORT	Dr. Adams presented the Quarterly Board Quality Dashboard Report and noted that patients continue to delay care and are coming in later on during their concerns. Nevertheless, all patients are tested before being admitted to the ED, and the data has improved since the last report.	
10. PUBLIC COMMUNICATION	There was no public communication.	
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:01 pm. **Movant:** Ting **Second:** Po **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Adjourned to closed session at 7:01 pm***
12. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:31 pm. Agenda items 12-17 were covered in the closed session. During the closed session, the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (04/05/2021), Quality Council Minutes, and Medical Staff Credentialing and Privileges Report.	
13. AGENDA ITEM 19: CLOSING WRAP UP	None.	
14. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:32 pm. **Movant:** Sharma **Second:** Simon **Ayes:** Falwell, Kan, Kliger, Marfatia, Po, Sharma, Simon, & Ting **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Meeting adjourned at 7:32 pm***

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

_____

Julie Kliger, MPA, BSN
Chair, Quality Committee

El Camino Health

FY21 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: **Mark Adams, MD**, Chief Medical Officer (Executive Sponsor)

The CMO shall serve as the primary staff to support the Committee and is 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. 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	- FY20 Achievement and Metrics for FY21 (Q1 FY21) - FY22 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY22) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per Pacing Plan timeline –
4. Review Effectiveness of Board Dashboard using STEEEP Methodology and propose changes if appropriate	Semi – Annually Q2 and Q4	Review Dashboard and Recommend Changes
5. 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

SUBMITTED BY: **Chair**: Julie Kliger, MPA, BSN
Executive Sponsor: Mark Adams, MD, CMO

Approved by the El Camino Hospital Board of Directors 6/10/2020

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Mark Adams MD CMO
Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: June 7, 2021
Subject: FY21 Enterprise Quality, Safety, and Experience Dashboard

Summary:

1. Situation: The 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 are selected based on a careful 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.

- **A.** Provide the Committee with a snapshot of the FY 2021 metrics monthly with trends over time and compared to the actual results from FY2020 and the FY 2021 goals.
- **B.** Annotation is provided to explain each metric.

2. Authority: The Quality 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. These twelve (12) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2021 Quality, Efficiency and Service Goals.

4. Assessment:

- **A.** Readmission Index decreased a second month to 0.80 with a reduction in the # of readmits and zero COVID-19 readmissions.
- **B.** Three SSEs assigned by team review for February: 2 reportable HAPIs, 1 procedural error related to IV fluid administration
- **C.** Mortality Index decreased again to 0.69 with fewer deaths and zero COVID deaths.
- **D.** HCAHPS Likelihood to Recommend increased slightly with somewhat relaxed visitor restrictions.
- **E.** Only 1 C.Diff HAIs for April, maintaining metric below target.
- **F.** Zero SSIs in April.
- **G.** Sepsis mortality Index dropped over the last 3 months.
- **H.** PC-01 at zero, sustained now for 4 months.
- **I.** PC-02, Cesarean Birth below target in March for the first month since September 2020.
- **J.** Patient Throughput down for the first time in months with continued efforts to move patients out of ED.

5. Other Reviews: None

6. Outcomes: None

Suggested Committee Discussion Questions: None

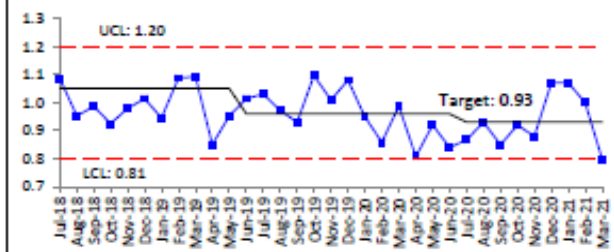
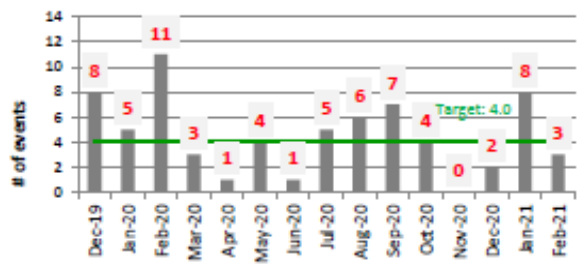
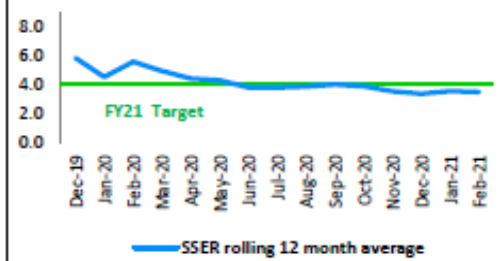
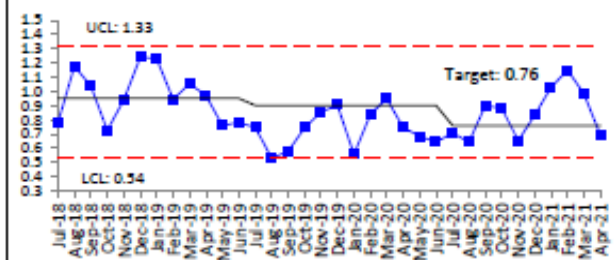
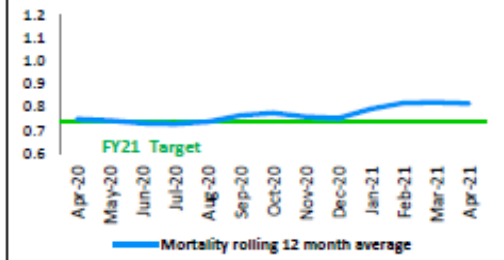
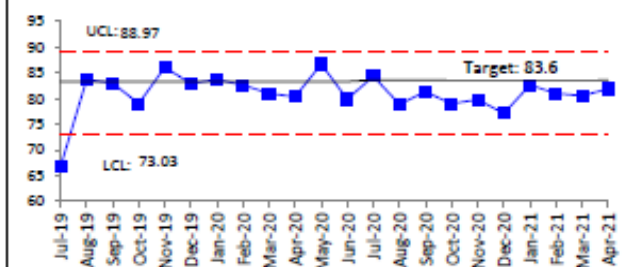
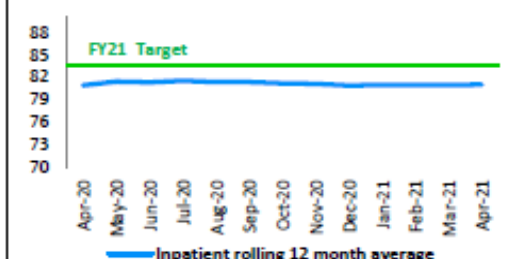
List of Attachments: June 2021 Enterprise Quality, Safety, and Experience Dashboard, April data unless otherwise specified - final results

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2021 (unless otherwise specified)

Month to Board Quality Committee: June, 2021

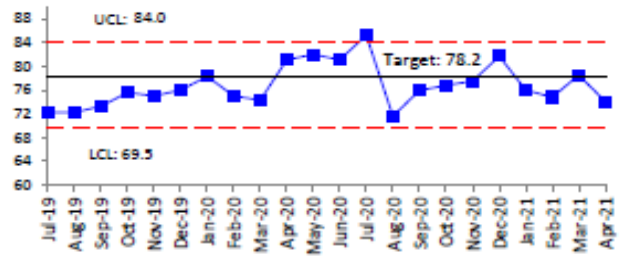
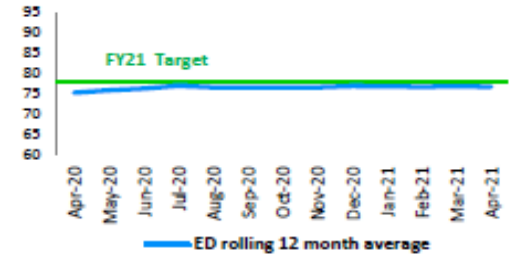
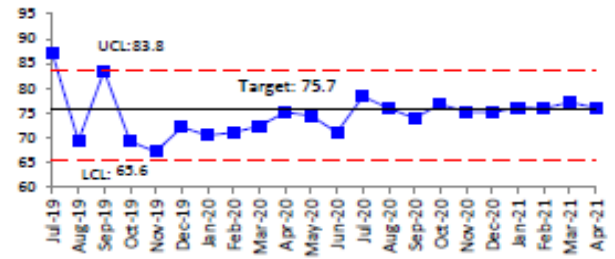
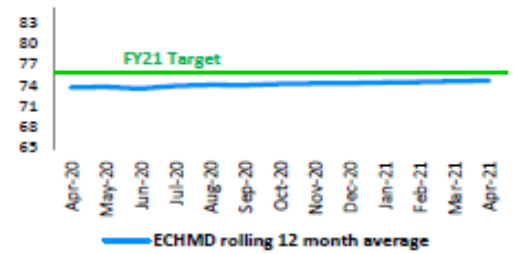
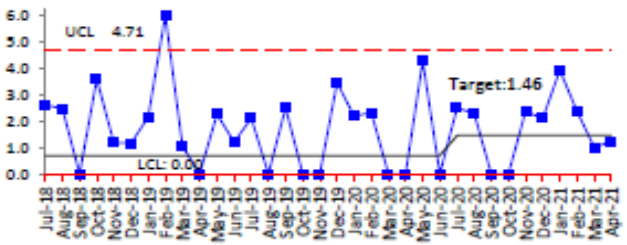
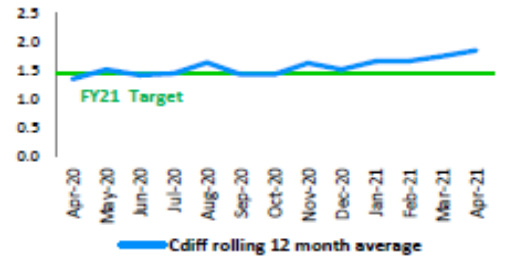
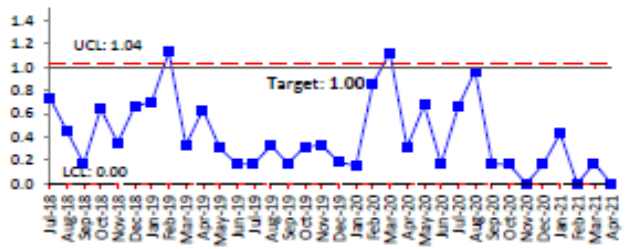
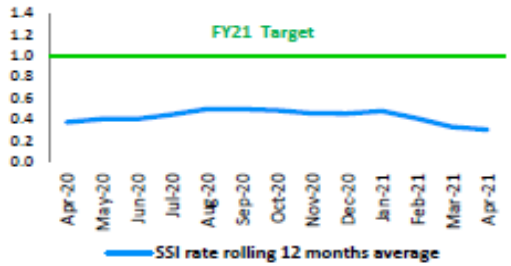
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index** (All Patient All Cause Readmit) ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: March 2021	0.80 (6.95%/8.70%)	0.93 (7.73%/8.29%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** # of events/ (FYTD Rate per 10,000 Acute Adjusted Patient Days) ***Latest data month: February 2021	3	3.47 (68/195946)	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: April 2021*	0.69 (1.24%/1.79%)	0.86 (1.96%/2.28%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: April 2021*	81.9	80.4	83.1	83.6		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2021 (unless otherwise specified)

Month to Board Quality Committee: June, 2021

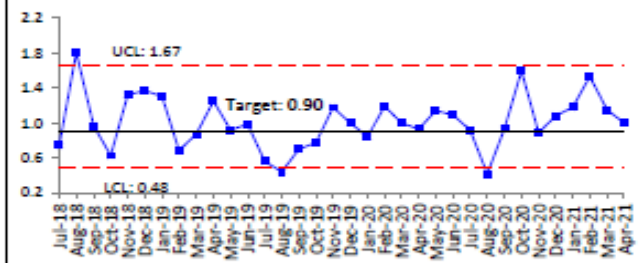
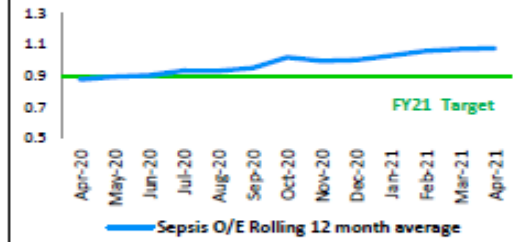
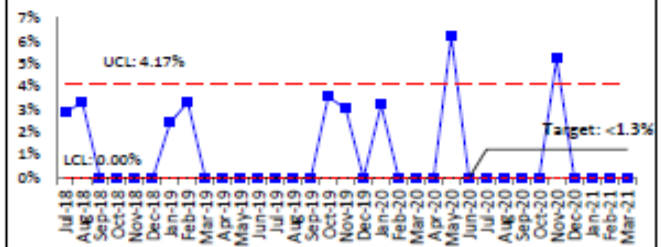
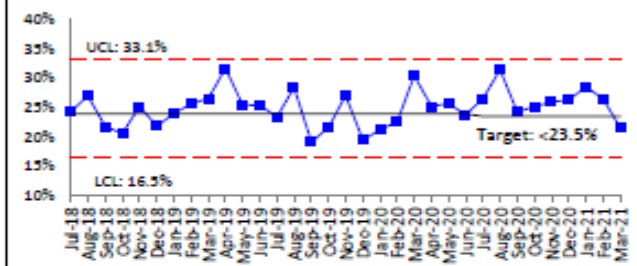
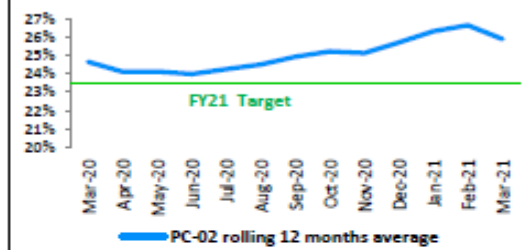
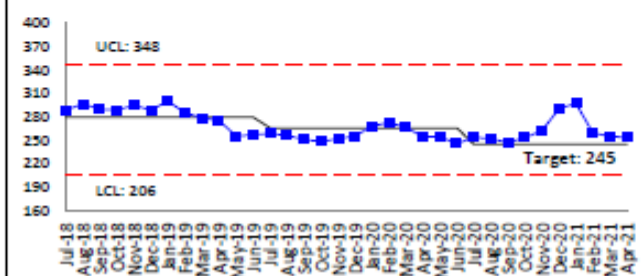
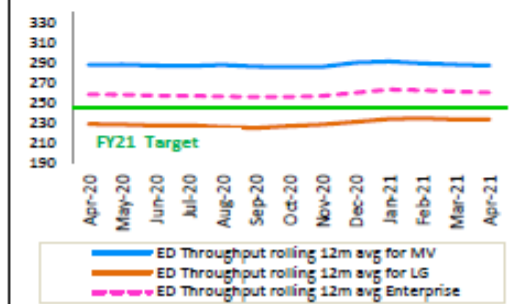
		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal ED Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted *Latest data month: April 2021*	74.1	76.2	75.7	78.2		
6	* Organizational Goal ECH MD : Likelihood to Recommend Care Provider (SVMD only) **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: April 2021*	76.0	76.1	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: April 2021*	1.23 (1/8160)	1.79 (16/89329)	1.46	<= 1.46 (MV: 10/ LG: 3)		
8	*Organizational Goal Surgical Site Infections (SSI)- Enterprise SSI Rate = Number of SSI / Total surgical procedures x 100 *Latest data month: April 2021*	0.00 (0/659)	0.28 (16/5775)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

April 2021 (unless otherwise specified)

Month to Board Quality Committee: June, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: April 2021*	1.00 (14.67%/12.71%)	1.07 (13.24%/12.34%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: March 2021*	MV: 0.0% (0/24) LG: 0.0% (0/8) ENT: 0.0% (0/32)	MV: 0.5% (1/194) LG: 0.0% (0/53) ENT: 0.40% (1/247)	MV: 1.47% (5/341) LG: 0.00% (0/48) ENT: 1.29% (5/389)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: March 2021*	MV: 24.0% (29/121) LG: 13.5% (5/37) **ENT: 21.5%** (34/158)	MV: 27.5% (319/1159) LG: 21.2% (58/273) **ENT: 26.3%** (377/1432)	MV: 24.7% (412/1665) LG: 18.9% (48/253) **ENT: 23.9%** (460/1918)	23.5%		
12	*Strategic Goal **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED, Newborns, and excludes transfer between sites)* *Latest data month: April 2021*	MV: 273 min LG: 234 min **Ent: 254 min**	MV: 287 min LG: 239 min **Ent: 263 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Stephanie Iljin, Supervisor of Executive Administration
Date: June 7, 2021
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:

1. Situation: It is essential to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive; still, it includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

2. Authority: This is being brought to the Committees at the request of the Board and the Committees.

3. Background: Since the last time we provided this report to the Quality Committee, the Hospital Board has met twice, and the District Board has 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.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	May 24, 2021	- FY22 Operating & Capital Budget
	May 12, 2021	- Board Officer Nomination and Selection Procedures - Medical Staff Credentials and Privileges Report - Quality Council Minutes - FY21 Period 8 Financials - Medical Staff Report
ECHD Board	May 18, 2021	- FY22 Community Benefit Plan Study Session - Confirm Process: June District Board Officer Elections
Executive Compensation Committee	May 27, 2021	- Progress against FY21 Committee Goals - Proposed FY22 Committee Goals - Proposed FY22 Committee Dates - Appointment of Ad Hoc Search Committee - Proposed FY22 Executive Performance Incentive Plan Goals - Executive Performance Incentive Plan Policy - Executive Benefits Plan Policy - Proposed Amendment to CEO's Employment Agreement - Committee Charter

Report on Board Actions
May 27, 2021

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
Compliance Committee	N/A	
Finance Committee	May 24, 2021	– FY21 Pacing Plan – FY21 Period 10 Financials – Capital Funding Request – MV Wireless Upgrade – FY22 Goals – FY22 Pacing Plan – FY22 Proposed Dates – FY22 ECH Community Benefits Grant Program – Appointment of Ad Hoc Search Committee – Los Gatos Associate Chief Medical Officer Renewal Agreement – Enterprise Control Medical Director Renewal Agreement

List of Attachments: None.

Suggested Committee Discussion Questions: None.

Quality Committee Follow up Item Tracking Sheet (07/23/2020)

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing
5	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	Ongoing
6	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	Ongoing
7	Add Review of Lean Projects to Pacing Plan for FY21	3/2/2020	JG	Added to March 2021 Meeting	

Harvard Business Review

Strategic Planning

Demystifying Strategy: The What, Who, How, and Why

by
- Michael D. Watkins

September 10, 2007

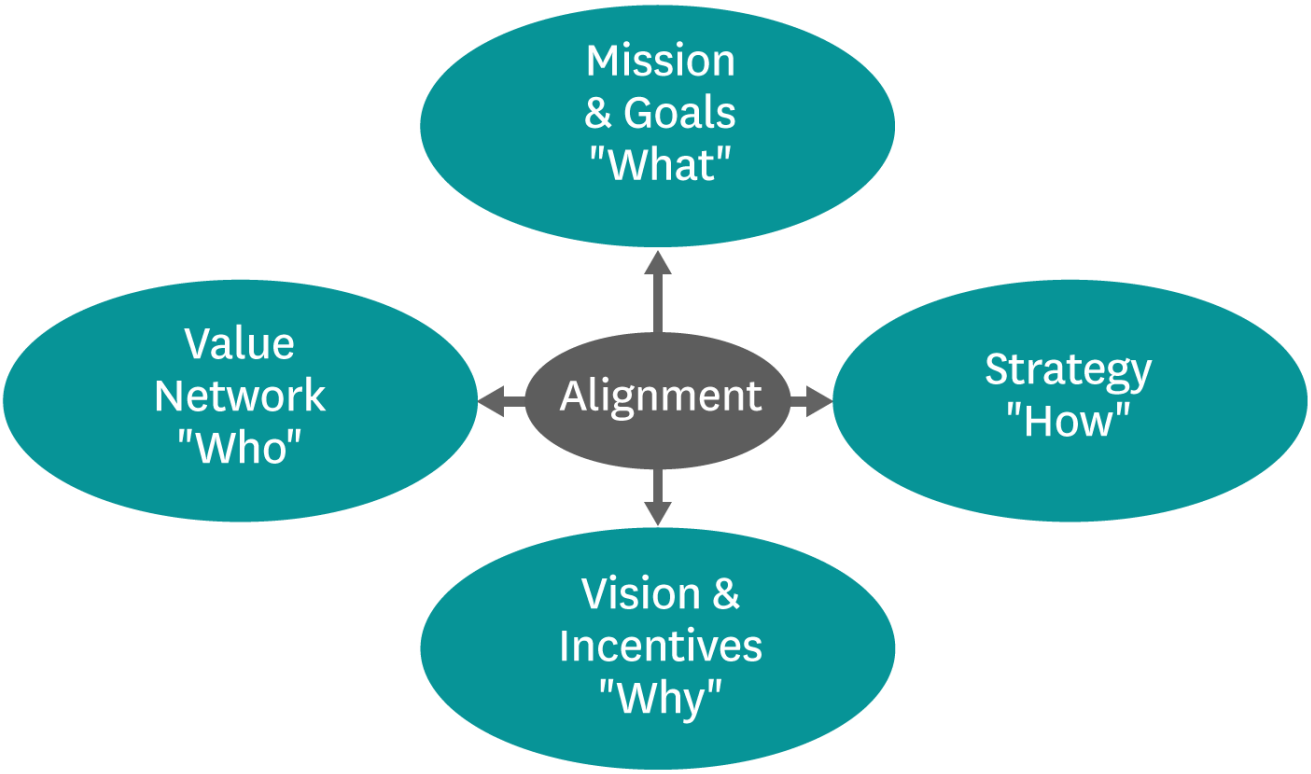
Many leaders I work with struggle with strategy. They know it's important to have strategies in order to align decision making in their businesses. They understand that they can't observe and control everything in their organizations (much as many of them would like to). They earnestly want to develop good strategies and they get the theory. But when it comes down to the nitty-gritty of crafting strategy, they rapidly get bogged down.

This is unfortunate, but it's not that surprising. It's a direct consequence of confusion about what a "business strategy" is… and is not. Here's my definition: A business strategy is a set of guiding principles that, when communicated and adopted in the organization, generates a desired pattern of decision making. A strategy is therefore about how people throughout the organization should make decisions and allocate resources in order accomplish key objectives. A good strategy provides a clear roadmap, consisting of a set of guiding principles or rules, that defines the actions people in the business should take (and not take) and the things they should prioritize (and not prioritize) to achieve desired goals.

As such, a strategy is just one element of the overall strategic direction that leaders must define for their organizations. A strategy is *not* a mission, which is what the organization's leaders want it to accomplish; missions get elaborated into specific goals and performance metrics. A strategy also is *not* the value network — the web of relationships with suppliers, customers, employees, and investors within which the business co-creates and captures economic value. Finally, a strategy is *not* a vision, which is an inspiring portrait of what it will look and feel like to pursue and achieve the organization's mission and goals. Visioning is part (along with incentives) of what leaders do to motivate people in the organization to engage in above average effort.

In a nutshell, as illustrated below, mission is about **what** will be achieved; the value network is about with **whom** value will be created and captured; strategy is about **how** resources should be allocated to accomplish the mission in the context of the value network; and vision and incentives is about **why** people in the organization should feel motivated to perform at a high level. Together, the mission, network, strategy, and vision define the strategic direction for a business. They

provide the what, who, how, and why necessary to powerfully align action in complex organizations.



One straightforward implication is that you can't develop a strategy for your business without first thinking through mission and goals. Likewise, you can't develop a coherent strategy in isolation from decisions concerning the network of partners with whom the business will co-create and capture value. By focusing on all four elements, and sequencing them in the right way, the process of crafting strategy can be demystified.

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
Date: June 7, 2021
Subject: Patient Experience E-Mail/Letter

Purpose: To provide the Committee with written patient feedback received via an e-mail/letter from a patient who had recently experienced care at ECH.

Summary:

1. Situation: These comments are regarding a patient with experience having surgery at ECH MV recently. The patient expressed concern about her waiting in patient registration and her diabetic management during her stay. The patient also had very positive comments about her experience as well saying it was "awesome."

2. Authority: To provide insight into one patient's experience.

3. Background: This patient was here for surgery and was kind enough to write ECH an e-mail/letter following her stay to point out her concerns following her surgery. We are fortunate to be connected with this patient and will be meeting with her to more deeply understand her concerns related to diabetic management and her wait in patient registration/admitting.

4. Assessment: The diabetic management committee is reviewing the chart and meeting with this patient to more greatly understand her concerns so a performance improvement plan can be established, including protocol review and revision as needed.

5. Other Reviews: None

6. Outcomes: The Diabetic Resource Committee will be reporting back on changes that may be needed relating to this case. The Patient Registration department will ensure they have staffing plans to accommodate these situations to reduce wait times.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What is the mechanism for identifying performance improvement needs in a clinical situation described by this patient?

2. How do we involve patients in understanding their concerns more deeply to be able to address the gaps in care completely?

Patient Letter sent to Patient Experience on May 6, 2021

“I wanted to give some feedback since I have been back to work for a few weeks regarding my surgery and my stay here.

Overall the care that I received was awesome. I even had one nurse who is a traveler that stated that “El Camino is the best hospital that she has worked at and that she would love to be hired here someday.” Unfortunately, I do not remember her name.

One item that I think may need a little work was the admission process. When I showed up (a little earlier than I needed to), there was only one person at admissions. A staff person was ahead of me in line asking about a patients referral. I understand that the staff needed help, but it was a little frustrating that I had to wait 10 minutes for their conversation to be over. After their 10 minute conversation, the admission staff had to get their manager. When the manager came, instead of taking her aside, I had to continue to wait until they were finished. I think it would have been best for the manager to take the person aside to the have the conversation.

Another item that I am not sure is that critical and I am not sure of the protocols had to do with my management of my Type 1 diabetes. I have been diabetic for almost 34 years now. After surgery I knew my sugar was going to be high. I told the nurses that I had been without my long acting insulin which helps stabilize my sugar and it just did not seem important to them. They just told me that they needed to check on it. My sugar the entire stay was 300+ which made me feel even worse.

I filled out the press ganey survey at my house.

I really appreciated the flowers and blanket I received as well.

I was so impressed with this hospital and would come back here as a patient in a heartbeat. I have also been telling everyone that I can about my experiences”

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director of Quality
Date: June 7, 2021
Subject: YTD FY2021, to end of Q3, 30 day All Cause, Unplanned Readmission Dashboard

Purpose:

- To provide comparison observed over expected (O/E) data on the 7 diagnoses measured as part of the HRRP Readmission Penalty program. Readmissions Index all payor/all cause for FY 2017, FY 2018, FY 2019, FY 2020 and through end of Q3 2021. HRRP penalizes hospitals up to 3% of their inpatient Medicare revenue based for having worse-than-expected readmissions rates of ***any*** of the 6 conditions listed. At risk are those diagnoses with O/E above 1.0.

Summary:

1. Situation: ECH Organizational goal: Readmission Index. Hospitals incur a penalty under ACA of up to 3% of DRG payments for Readmission rates that are above CMS calculated expected for 7 diagnoses and procedures. Readmission Teams are focusing on readmissions in each category. A penalty is assigned to the hospital if any of the 7 categories are above the Expected rate.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: Readmission rates provided the 7 diagnosis groups for FY2017, FY 2018, FY2019, FY2020 and Q1 FY2021.

4. Assessment: This report provides the detail behind the Readmission Index Organizational goal and shows improvement in the overall 7 diagnosis to 0.67 in Q3 FY21 to 0.86 from 1.0 in FY20. The O/E ratio is greater than 1.0 for Diagnosis/procedure for 3 diagnoses: CABG to 1.55, Stroke to 1.13 and THA/TKA to 1.55. The other 4 diagnosis are below 1.
Readmission Patient details are being analyzed by the Stroke team including 17 readmissions, by the Orthopedics team including 4 readmissions, and by the Heart and Vascular Institute including five readmissions after CABG.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Q3 FY2021 30 day All Cause, Unplanned Readmission Dashboard

Suggested Committee Discussion Questions:

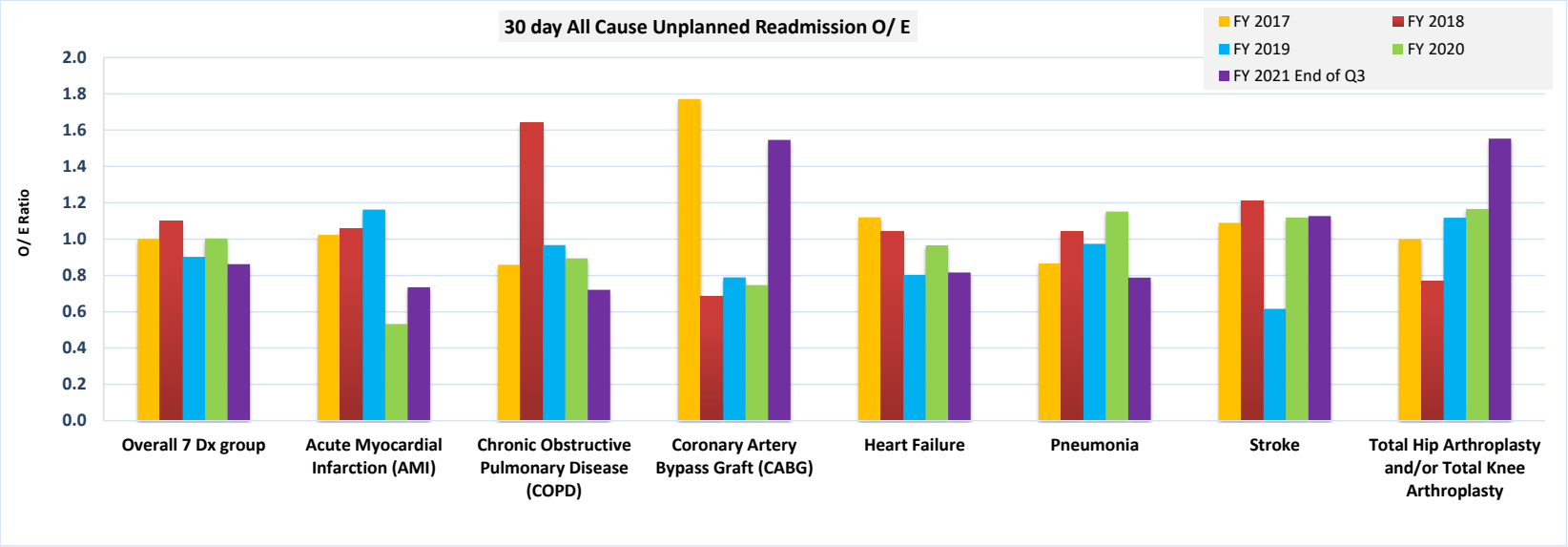
1. None

El Camino Health

FY 2021 End of Q3, 30 Day All-Cause Readmission Dashboard - ACA Dx.

Premier Risk Adjusted, All Payer, All Cause, Unplanned Readmits
Patient Type: Inpatient

	FY 2017			FY 2018			FY 2019			FY 2020			FY 2021 End of Q3		
	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio	Observed Rate	Expected Rate	O/E Ratio
Overall 7 Dx group	**9.08%**	**9.08%**	**1.00**	**10.02%**	**9.11%**	**1.10**	**8.95%**	**9.92%**	**0.90**	**10.64%**	**10.60%**	**1.00**	**10.17%**	**11.81%**	**0.86**
Acute Myocardial Infarction (AMI)	7.69%	7.51%	1.02	7.72%	7.30%	1.06	8.75%	7.53%	1.16	3.92%	7.36%	0.53	6.08%	8.27%	0.74
Chronic Obstructive Pulmonary Disease (COPD)	14.14%	16.48%	0.86	26.97%	16.41%	1.64	14.88%	15.40%	0.97	14.97%	16.75%	0.89	12.99%	18.01%	0.72
Coronary Artery Bypass Graft (CABG)	11.24%	6.34%	1.77	4.63%	6.76%	0.69	5.38%	6.81%	0.79	5.33%	7.15%	0.75	10.53%	6.81%	1.55
Heart Failure	17.79%	15.89%	1.12	16.17%	15.52%	1.04	13.39%	16.67%	0.80	16.44%	17.03%	0.97	13.77%	16.88%	0.82
Pneumonia	10.31%	11.92%	0.87	12.82%	12.30%	1.04	12.50%	12.84%	0.97	14.41%	12.51%	1.15	10.20%	12.94%	0.79
Stroke	7.17%	6.58%	1.09	8.20%	6.77%	1.21	4.56%	7.41%	0.62	8.15%	7.29%	1.12	8.30%	7.36%	1.13
Total Hip Arthroplasty and/or Total Knee Arthroplasty	2.06%	2.08%	1.00	1.63%	1.99%	0.77	2.54%	2.27%	1.12	2.83%	2.42%	1.17	3.91%	2.52%	1.55



Report updated: 5/20/21

Source: Premier Quality Advisor, Standard CareScience Risk Calculation, All-Cause Hospital-Wide 30-Day Readmissions

El Camino Health

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director Quality
Date: June 7, 2021
Subject: Patient Safety Indicator (PSI) Scores FY20 compared to Q1-Q3 FY21

Purpose:

To provide an update on the AHRQ Patient Safety Indicators for Q1-Q3 FY21.

Summary:

1. Situation: The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events for all patients following surgeries, procedures, and childbirth. These events are amenable to changes in the health care system or provider. The PSIs were developed after a comprehensive literature review, analysis of ICD-10-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses.

2. Authority: Quality Committee of the Board is responsible for oversight of quality & safety.

3. Background: The PSIs can be used to help hospitals identify potential adverse events that might need further study; provide the opportunity to assess the incidence of adverse events and in- hospital complications using administrative data found in the typical discharge record; include indicators for complications occurring in the hospital that may represent patient safety events; and, indicators also have area level analogs designed to detect patient safety events on a regional level.

4. Assessment: Each of the PSI are first reviewed and validated by the CDI manager and Coding manager, and are then sent through the Medical Staff's Peer review process for trending by physician. In this report PSI rates that are better than the Premier Mean are highlighted in green.

- **A.** PSI-03 Pressure Ulcer – 6 in Q1-3; each has had a root cause analysis. Several of these involve COVID pts, with proning and general debility being contributing factors
- **B.** PSI-09 Perioperative hemorrhage or hematoma – 5 occurrences, no trends just sporadic instances
- **C.** PSI-06 Iatrogenic Pneumothorax – 2 occurrences in one patient
- **D.** PSI-18 and PSI-19 OB Vaginal trauma with & without instrument – both being addressed by Maternal Child Health Medical Leadership with case review and education on documentation of injury as well as newer techniques to avoid vaginal trauma. Nonetheless, the rate has remained above Premier Mean and effectively unchanged from FY20. The high proportion of Asian and South Asian births continue to be a significant driver of these results.

5. Other Reviews: None

6. Outcomes: None.

List of Attachments:

1. Patient Safety Indicator (PSI) Scores Q1-3 FY21.

Suggested Committee Discussion Questions: None

Patient Safety Indicator Report (AHRQ) all patients FY20 compared to FY21 (Q1-3)

Rate Measures

Patient Safety Indicator		Numerator (FY21 Q1-3)	Denominator (FY21 Q1-3)	Rate/1000 (FY21 Q1-3)	Premier Mean* (FY21 Q1-3)	Numerator (FY20, Q1-4)	Denominator (FY20, Q1-4)	Rate/1000 (FY20, Q1-4)	Premier Mean* (FY20, Q1-4)
PSI-02	Death in Low Mortality DRGs	0	305	0.00	1.18	0	674	0.00	0.54
PSI-03	Pressure Ulcer	6	5,295	1.13	0.44	5	6,924	0.72	0.46
PSI-04	Death in Surgical Pts w Treatable Complications	9	75	120.00	121.71	17	104	163.46	120.99
PSI-06	Iatrogenic Pneumothorax	2	8,527	0.23	0.12	2	11,594	0.17	0.14
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	7,285	0.00	0.10	0	10,136	0.00	0.10
PSI-08	In Hospital Fall with Hip Fracture	0	7,254	0.00	0.11	2	9,781	0.20	0.10
PSI-09	Perioperative Hemorrhage or Hematoma	5	2,637	1.90	1.68	3	3,911	0.77	1.84
PSI-10	Postoperative Acute Kidney Injury Requiring Dialysis	0	1,457	0.00	0.76	1	2,317	0.43	0.75
PSI-11	Postop Respiratory Failure	4	1,156	3.46	5.20	2	1,894	1.06	4.18
PSI-12	Perioperative PE or DVT	6	2,793	2.15	2.48	7	4,091	1.71	2.61
PSI-13	Postop Sepsis	4	1,454	2.75	4.21	4	2,289	1.75	3.46
PSI-14	Postop Wound Dehiscence	0	930	0.00	0.79	0	1,252	0.00	0.65
PSI-15	Unrecognized Abdominopelvic Accidental Puncture or Laceration	1	2,471	0.40	0.71	6	3,177	1.89	0.82
PSI-17	Birth Trauma Injury to Neonate	9	3,082	2.92	3.78	17	4,332	3.92	4.02
PSI-18	OB Trauma Vaginal Delivery with Instrument	31	158	196.20	103.67	45	237	189.87	107.66
PSI-19	OB Trauma Vaginal Delivery without Instrument	74	2,037	36.33	17.55	83	2,822	29.41	15.45

Count

Patient Safety Indicator		Cases (FY21 Q1-3)	Premier Mean Cases*	Cases (FY220, Q1-4)	Premier Mean Cases*
PSI-05	Retained Surgical Item or Unretrieved Device Fragment	0	0.07	0	0.16

Green = better than Premier comparative mean

El Camino Health

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Mark Adams MD CMO
Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director of Quality
Date: June 7, 2021
Subject: Revised Quality Improvement and Patient Safety Plan for 2021

Recommendation(s): Approve revised QAPI Plan for 2021

Summary:

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

2. Background: The Quality Improvement and Patient Safety Plan provides the blueprint for quality and safety improvement at El Camino Hospital and is required as the "QAPI Plan" in CMS Conditions of Participation and Joint Commission Standards. CDPH also requires hospitals to have a Patient Safety Plan. This plan defines the structure, function, and processes utilized to accomplish the overall quality and safety strategy of the organization. The progress and success of the plan is measured by the many quality and safety metrics that are tracked and trended. With the Joint Commission triennial survey due in 2021 and the California General Acute Care Survey also due in 2021, this updated plan needs to be approved and distributed across the organization.

3. Assessment: The changes in this plan for 2021 include:

- Title changed to include QAPI which is recognized by surveyors universally
- Focus changed from performance improvement to quality improvement to alleviate confusion with the Performance Improvement Department which is not part of the Quality Department
- Medical Staff statistics updated with new categories of medical staff
- High Reliability section updated by the CMO to include new safety logo and iSAFE adverse event reporting
- Medical Staff Departments updated with Bylaws changes and Executive Committee meetings
- Performance Improvement and Operating System section updated by the Executive Director
- Organizational Goals updated for 2021
- Attachments revised as needed and new attachments included such as the Quality Board Dashboard, expanded to 6 attachments

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

5. Outcomes: None.

Suggested Committee Discussion Questions:

Revised Quality Improvement and Patient Safety Plan for 2021
June 7, 2021

Are there any missing elements?
Are committee members familiar with the El Camino Health Operating System?
Does the committee appreciate how lean has been incorporated into the QAPI?

List of Attachments: Quality Improvement and Patient Safety Plan (QAPI) plus addendums

El Camino Health

Origination:	*05/2018*
Effective:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Catherine Carson: Senior Director Quality*
Area:	*Quality, Risk & Patient Safety*
Document Types:	*Plan*

Quality Improvement & Patient Safety Plan (QAPI)

PURPOSE

The quality improvement & Patient Safety Plan (QAPI) describes the multidisciplinary, systematic quality improvement framework utilized by El Camino Hospital (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

ORGANIZATION OVERVIEW

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

The ECH Medical Staff includes 1217 active, provisional and consultant, and 228 affiliate physicians/ independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

EI CAMINO HEALTH MISSION

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

EI CAMINO HEALTH VISION

To lead the transformation of healthcare delivery in Silicon Valley.

EI CAMINO HOSPITAL VALUES

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

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

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

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

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

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

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

HIGH RELIABILITY

El Camino's 2021 vision for quality includes a continuation of the high reliability journey initiated in 2020 leading to zero preventable harm. Safety is a well-defined science and can be improved through attention to reliability culture (expectations, behaviors, teamwork, etc.) and processes (intuitive design, mistake proofing, etc.). A High Reliability Steering Committee provides guidance and direction toward the implementation of high reliability practices. Implementation includes training and case-based learning, multi-disciplinary interactions to improve communication, tools, job aids and newsletters. The HRO brand, SAFETY FIRST MISSION ZERO has been adopted and will be used to enhance communication and understanding of high reliability. Real-time change management will include simulations, moments for safety before meetings, red "no interruption zones," and a cascade of safety huddles that focus on patient and team member risk assessment and mitigation. Additional support for cultural transformation will include leader rounding, safety coaches on each unit, policy changes, tools, on-line resources, and rewards/recognition.

El Camino will develop a tool kit for all executive and medical staff leaders, provide training, and monitor use. The toolkit will include techniques to lead the safety journey (e.g., how to encourage reporting, educating for safety, having a moment for safety in each meeting, sharing lessons learned), build accountability (e.g., rounding to influence, 5:1 feedback, red rules, fair and just culture), and finding and fixing problems (e.g., stop the line, top 10 work list, action planning). Leader performance evaluations will incorporate measures of safety leadership.

El Camino physician and executive leaders will work to decrease power gradients and improve interpersonal communication. In addition to the daily Safety Huddle, El Camino will develop a series of communication tools to allow for immediate frontline communication and education to decrease the risk of preventable harm. This will include internal dashboards that show the SSER (including Faces of Safety) to better personalize otherwise impersonal data.

Using the newly implemented iSAFE incident reporting system data, all safety events are now classified by a team of experts trained in the HPI classification system. The classified events are then subjected to a Pareto analysis. This allows for identification of recurrent safety events so that interdisciplinary teams can be formed to address the gaps in generally accepted performance standards.

DEFINITIONS:

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

- **Safe:** Avoiding harm to patients from the care that is intended to help them

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

SERVICES/PROGRAMS

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

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

OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).

2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.
6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

A. Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility for implementing the quality improvement & Patient Safety Plan to the medical staff and hospital administration.

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

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

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

B. Medical Executive Committee (MEC)

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

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

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

C. Medical Staff Departments and Divisions

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

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

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

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

D. Leadership and Support

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

1. Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure,

assess, and improve the hospital's governance, management, clinical, and support activities

2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for quality improvement and safety giving priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and re-prioritize these activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's quality performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff are trained in quality and safety improvement approaches and methods and receives education that focuses on safety, quality, and high reliability
7. Continuously measure and assess the effectiveness of quality and safety improvement activities, and implement improvements for these activities

E. Medical Staff, Employees, and Contracted Services

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

F. Enterprise Quality & Patient Safety Committees: Enterprise Quality Council and Patient and Employee Safety Committees

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. The Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization’s quality and safety goals and is reviewed monthly. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY 21 Quality Council report schedule.

The Enterprise **Patient and Employee Safety Committee** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Medication Errors, Employee Injures, and the Grievance Committee. (See Attachment C: Patient and Employee Safety Dashboard). The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital

administration to develop action plans in response to the results. The Director of Risk Management also conducts risk assessments regarding the safety of patient care including Failure Mode Effects Analysis (FMEA) for new or changed hospital services. The Director of Risk Management/Patient Safety Officer provides data on incident reports (iSafe – ECH's Online System for– adverse event reporting) the adequacy of the reporting process, including updates on the number and type of iSafe reports, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Adverse Events/Sentinel Events Procedure to outline the process for categorizing patient safety events, including serious safety events, performance of a root cause analysis for sentinel events, compliance with regulatory requirements for mandated reporting of adverse events and process of notification of ECH leadership of sentinel and adverse events.

The **Enterprise Patient Safety Oversight Committee (PSOC)** is also a subcommittee of the Quality Council Committee and is described in the *Management of Adverse Events/Sentinel Events Procedure* (Administrative). The Patient Safety Oversight Committee is a committee that meets weekly to review and categorize iSafe Reports, serious patient safety events, behavior, safety and operational issues. The Committee is comprised of the Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Medical Director for Quality Assurance, Associate Chief Medical Officer, Sr. Director Quality, Director of Risk Management/Patient Safety Officer, Director of Accreditation/Public Reporting, Director of Medical Staff Services and a representative of the Medical Staff. These leaders provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

The Root Cause Analysis (RCA) Steering Committee is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). The RCA Steering Committee focuses on events that an RCA has completed and thus has the senior leadership with the involved departments reporting on actions taken and the continuous improvement until the process change has been sustained. This process also includes the SSE's and investigation process.

G. Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality Department staff serves as internal resources for the development and evaluation of quality improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including the teams addressing the organizational quality, ERAS Team and the HAP (hospital-acquired pneumonia)Team. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments D and E
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements

4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment F for Data Registries in use)
5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
6. Collaborates with the Director of Risk Management on efforts to manage and reduce risk through Root Cause Analyses and Intense Analyses as responses to adverse events and near misses
7. Collaborates to facilitate failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting
8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital – acquired infections and conditions
10. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
11. Providing data as requested to external organizations, see data provided in Appendix B
12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list
13. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data
14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health to improve the quality of care and safety of care provided to our patients

H. Improving Organizational Performance

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

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

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of quality improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)

4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.

I. Performance Processes

Design

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

1. **Patient Safety**
   ECH strives to prevent errors and adverse effects to patients that are associated with complex patient care. While patient safety events may not be completely eliminated, harm to patients can be reduced and our goal is always zero harm. To promote the goal of zero harm, ECH adopted a new logo and phrase: “Safety First Mission Zero” in 2020. To learn from and to make changes to reduce harm, all hospital-acquired conditions, infections and complications of care are reviewed and results shared with involved departments and providers. Root cause analyses and intense analyses are conducted to more clearly understand the factors involved in a near miss or untoward event. The purpose is to develop and sustain a culture of safety. The leadership, risk management and quality staff work to promote a "just culture" that focuses on the systems involved in care and to create a trust-report-improve cycle to promote reporting of all event and near misses.

safety firstmission zero

   a. iSafe reports, surgical site infections, MRSA infections, evidenced-based bundle failures and other events that result in patient harm are reported and evaluated weekly by the Safety Event Classification Team. This team determines if there were defects in care or deviations from generally

accepted performance standards (GACPS) and the level and type of patient harm. This information is translated and reported as the Serious Safety Event Rate.

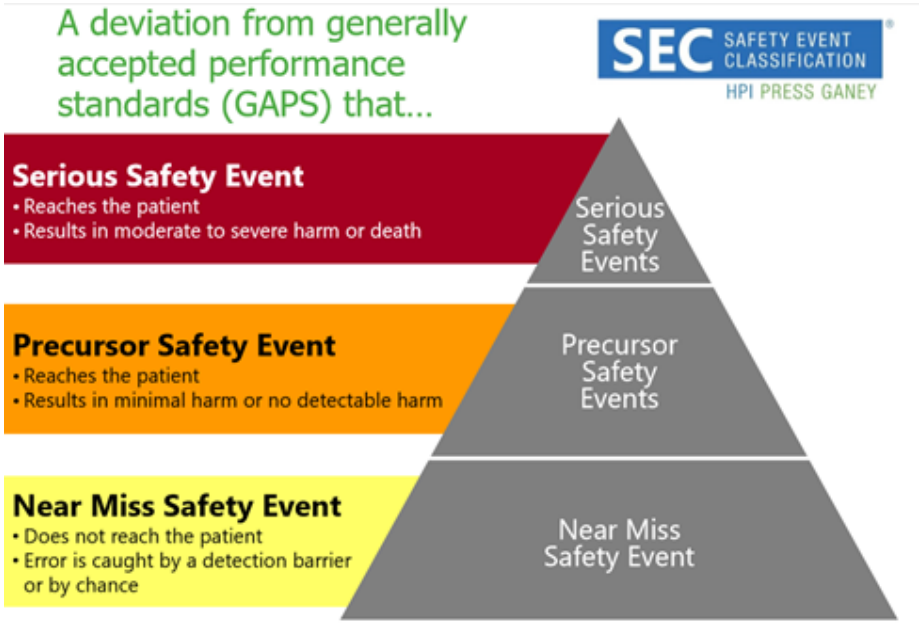
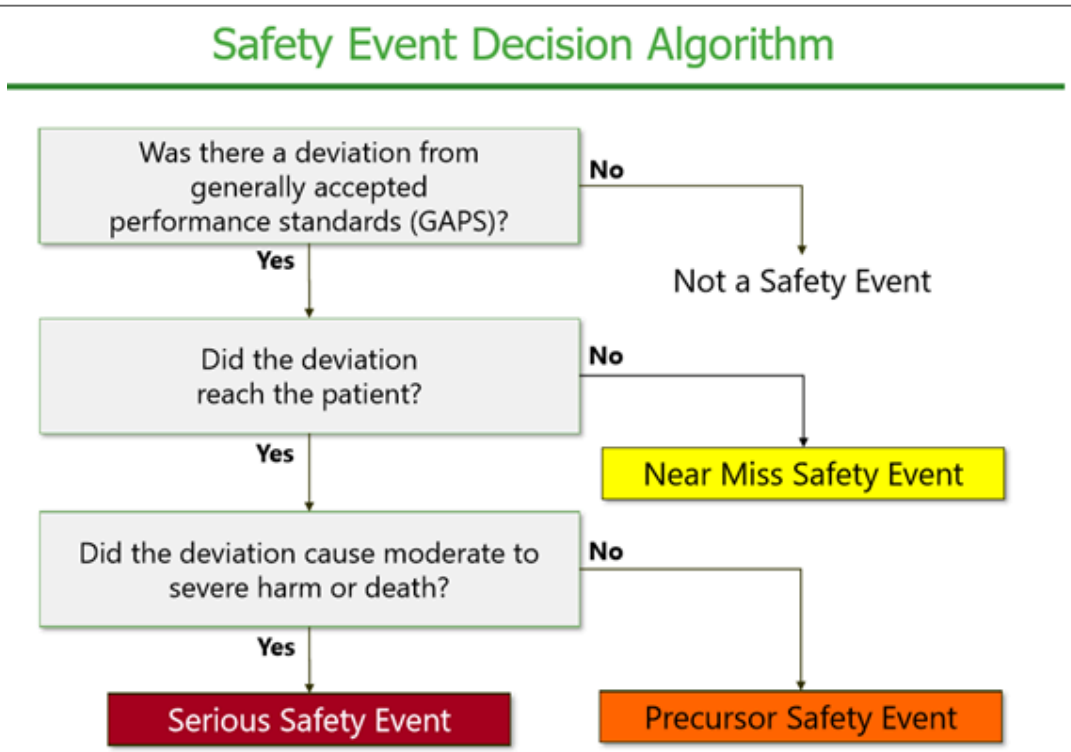


Table 1. HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch



2. **Measurement**
   ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and finance. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.

   Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

   a. Consistent with the organization's mission, vision, goals, objectives, and plans;
   b. Meeting the needs of individuals served, staff and others;
   c. Clinically sound and current;
   d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
   e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
   f. Incorporated into the results of performance improvement activities.

   Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data

collection is systematic and is used to:

a. Establish a performance baseline;
b. Describe process performance or stability;
c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
d. Identify areas for more focused data collection to achieve and sustain improvement.

3. **Analysis**
Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.

When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.

ECH requires an intense analysis of undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;
d. Blood Utilization to include confirmed transfusion reactions;
e. Significant adverse events and drug reactions;
f. Significant medication errors, close calls, and hazardous conditions;
g. Significant adverse events related to using moderate or deep sedation or anesthesia;

J. Improvement Model And Methodology

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

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

The model has two parts:

1. ***Three fundamental questions, which can be addressed in any order.***
    - What are we trying to accomplish?

- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

2. ***The Plan-Do-Study-Act (PDSA) Cycle***

The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

Step 1: Plan

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

Step 2: Do

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

Step 3: Study

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

Summarize and reflect on what was learned.

Step 4: Act

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

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

3. ***Goal Setting and Auditing Methodology***

   a. S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part

of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
The acronym stands for:

S – Specific

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

M – Measurable

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

A – Achievable

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

R – Relevant

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

T – Time-Bound

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

b. Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample

size to ensure the auditing has encompassed the correct % of needed audit to be statically valid. Measure of Success (MOS) auditing process has specified the following minimums:

- Sample all cases for a population size of fewer than 30 cases
- Sample 30 cases for a population size of 30–100 cases
- Sample 50 cases for a population size of 101–500 cases
- Sample 70 cases for a population size of more than 500 cases
- Sample 100 cases for a population greater than 500 cases
  To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

K. Performance Improvement and the El Camino Health Operating System

The Performance Improvement department has adopted the use of Lean methodology and principles as the foundation for interventions used. Tools from Six Sigma, Change Management, and PDCA are used to support the journey to a High Reliability Organization. This is accomplished through a focus on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the base.

The Performance Improvement department provides resources to the organization for problem solving, as well as deploying ECHOS, our El Camino Health Operating System. The dedicated team is comprised of Program Managers with both clinical and industry expertise. The work is aligned to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and collaborating with all levels of the organization.

Systems critical to the success of Performance Improvement include reward and recognition, education and training, idea generation, communication, and engagement. These behaviors encourage and support everyone to be a problem-solver, and to engage in continuous improvement. The process makes visible the abnormal conditions and areas for improvement, while celebrating the incremental wins and positive changes.

ECHOS: El Camino Health Operating System

The ECH Operating System is the way that we lead and conduct performance improvement at EL Camino Health. It is the processes and tools that are used to run the various functions of our work. At the top is our True North; our mission, vision and values, as well as our True North pillars. The foundation represents our Operating system, which consists of all the process improvement concepts, methods and tools.

The Management System, with our patients as the focus, has three components which define how ECH:

1. **Aligns** the goals of the organization from the Executives to the Front Line with annual *Strategy Deployment*
2. **Engages** our people in daily front line problem solving daily through the *Daily Management System* using Tiered Huddles, Linked Visual Systems, Gemba, Standard Calendar, and Leader Standard Work
3. **Continuously Improve** our processes across departments, using structure and tools that enable both

local and large cross-functional processes to be improved and even transformed

L. Quality improvement Link With Organizational Goals

ECH's quality improvement & Patient Safety Plan focuses on specific quality measures in three areas: quality/ safety, service and finance. See below for the Fiscal Year 2021 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the Quality goal Readmission Index, ECH formed five new teams to address issues with Readmissions at the beginning of the fiscal year and who meet bi-weekly: Cancer team, Post-Acute Care Management team, Weekly Readmission Review team, Social Determinants of Health team, and the Surgical Complications team. Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal. (Attachment H.)

True North Pillar	OBJECTIVES/OUTCOMES	Measurement Defined		
		Minimum	Target	Stretch
Threshold	Return to, and maintain positive EBIDA	≥ 3% EBIDA		
Quality and Safety	Serious Safety Event (SSEs) Rate	5.0	4.0	3.6
	Readmission Index	0.96	0.93	0.915
	Medical Network: HEDIS Composite Score	2.75	3.0	3.2
Service	Likelihood to Recommend (LTR) – Inpatient	83.1	83.6	85.2
	LTR – Emergency Department	76.4	78.2	80.7
	LTR – El Camino Health Medical Network	72.9	75.9	78.9
Finance	Operating EBIDA margin	90% of Budget	100% of Budget	110% of Budget

M. Commitment to Patient Experience

ECH has embraced the concept of an excellent Patient Experience as foundational and believes that our goal is to create partnerships among health care practitioners, patients and families that will lead to the best outcomes and enhance the quality, safety and experience of patients and the health care team. As a result, ECH collects feedback from a myriad of sources to ensure that the Patient/Family voice is embedded in all that we do. In addition, a Patient and Family Advisory Council has been established as a mechanism for involving patients and families in performance improvement efforts, policy and program decision-making. The patient and family advisors act as champions of the ideal patient experience, and ensure its implementation across ECH. They are involved in reviewing communication to patients and families to ensure that it builds on patient and family strengths, engages them in a partnership with health care services, and serve as members of some hospital committees. They act as advisors with a focus on collaborating and co-designing and will often make recommendations for improvements in service and quality.

N. Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee,

Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

O. Confidentiality

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

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

P. Annual Evaluation

The Sr. Director of Quality Services, shall coordinate the annual evaluation of the program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address the program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.

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

Cross References:

1. Management of Adverse Events and Sentinel Events Procedure
2. Medical Staff Peer Review Policy

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

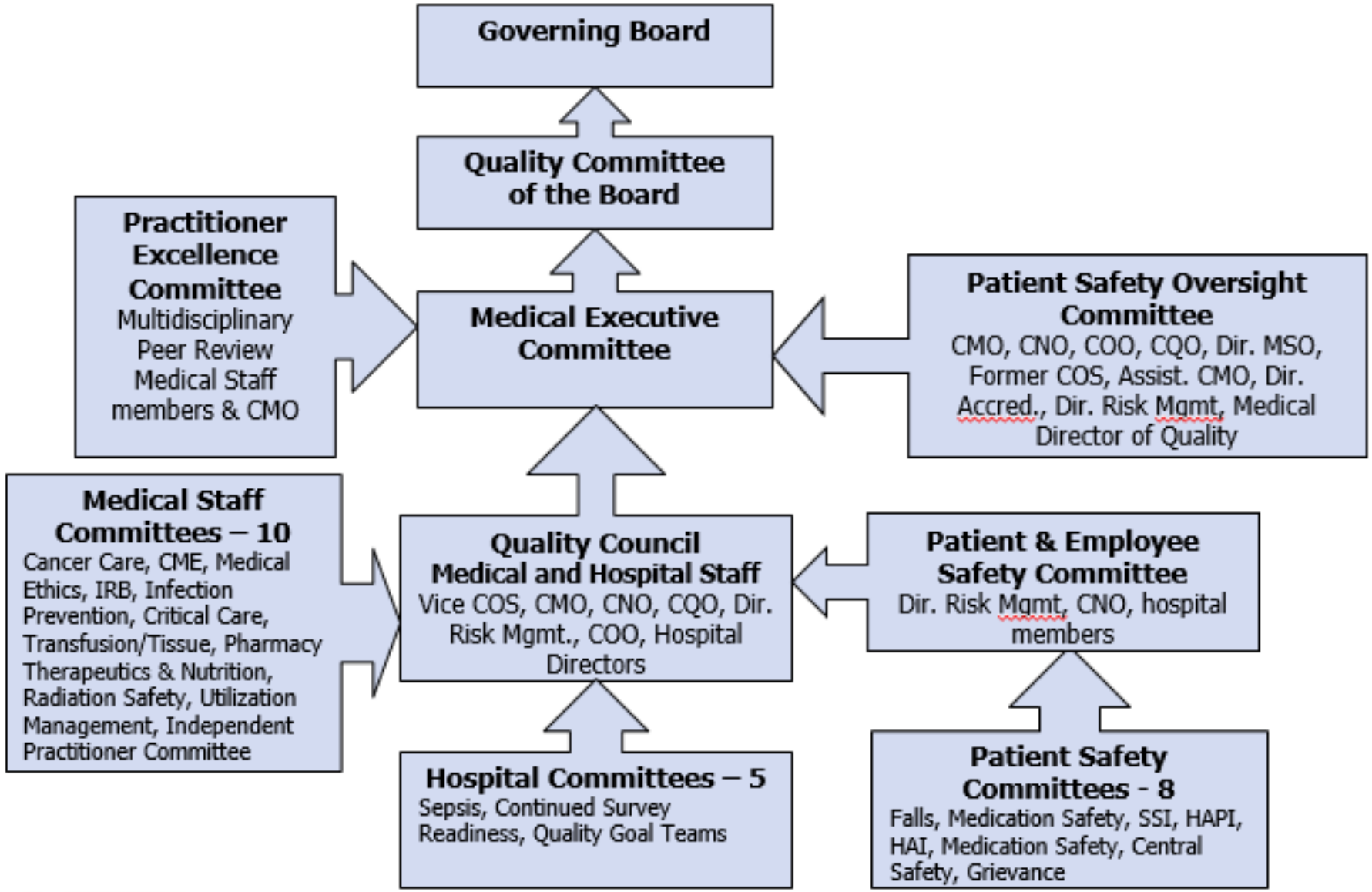
Attachments

Attachment G: External Regulatory Complicance Indicators 2021
Attachment F: Registries List for PI-PS

Attachment E: Quarterly Board Quality Dashboard STEEEP 2.2021
Attachment D: Org Goals and Quality FY21
Attachment A: Information Flow QA-PI-PS Plan 2021
Attachment B: Combined Quality Council Reporting Calendar FY21
Attachment C: Patient and Employee Safety Dashboard FY21

Quality Improvement & Patient Safety Plan

Attachment A: Flow of Information



El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY 21 Quality Council

Annual Performance Improvement Reporting Calendar for Hospital Departments/Programs/Service Lines*

1st Wednesday – 7:00 am to 9:00 am

2020	**July 1, 2020 Cancelled**	**August 5, 2020**	**September 2, 2020**
		▪ MV Emergency Dept. ▪ LG Emergency Dept. ▪ Information Services	▪ Antibiotic Stewardship ▪ Health Information Management ▪ Orthopedics Service Line ▪ Patient Experience (HCAHPS)
	October 7, 2020	**November 4, 2020**	**December 5, 2020**
	▪ Nutrition Services ▪ Pharmacy ▪ Heart/Vascular Institute ▪ Care Coordination	▪ Cancer Service Line ▪ Human Resources ▪ Maternal Child Health Service Line	▪ Urology Service Line ▪ Sleep Center ▪ Respiratory Care Services ▪ Spine Service Line
	January 6, 2021	**February 3, 2021**	**March 3, 2021**
2021	▪ Rehab Service Line ▪ Mental Health & Addiction Service Line ▪ Environmental Services	▪ Infection Prevention ▪ Acute Dialysis ▪ Critical Care ▪ Patient Blood Management	▪ Sepsis ▪ Acute Rehab ▪ Sterile Processing ▪ Value Base Purchasing
	April 7, 2021	**May 5, 2021**	**June 2, 2021**
	▪ Imaging Services / Radiology ▪ Contract Services ▪ Quality/Performance Improvement /Patient Safety Plan	▪ Core Measures ▪ CPR ▪ Laboratory & Pathology	▪ Palliative Care ▪ MV Peri-Operative Services ▪ LG Peri-Operative Services ▪ Stroke Program

Revised 1/5/2021

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

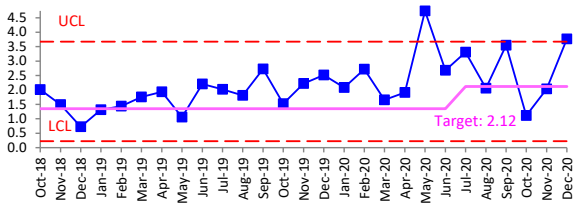
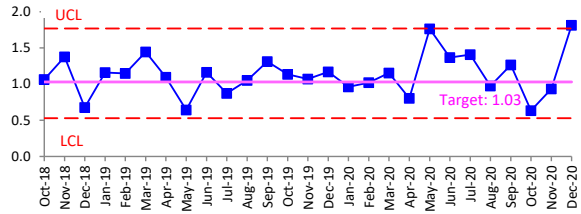
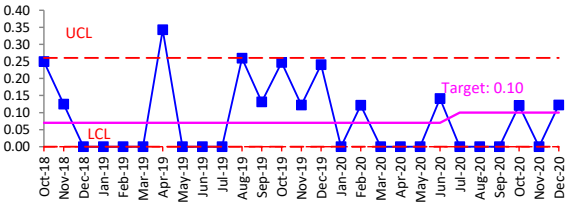
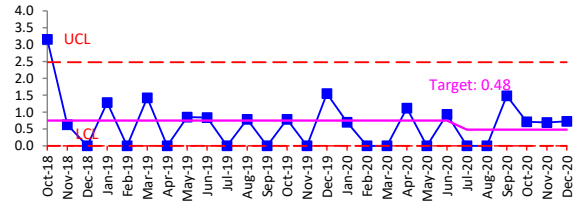
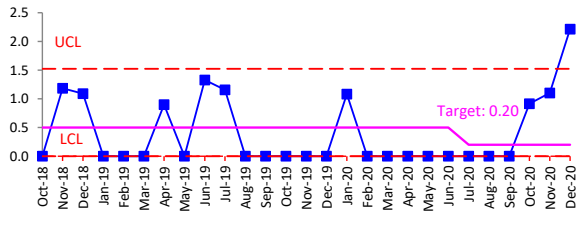
Annual (A) Reports		Standing Items (As Appropriate)
▪ Acute Inpatient Dialysis ▪ Acute Rehab ▪ Antibiotic Stewardship ▪ Cancer Service Line ▪ Care Coordination ▪ Contracted Services ▪ Core Measures ▪ Critical Care ▪ CPR ▪ Emergency Dept.(MV & LG) ▪ Environmental Services ▪ Health Information Management (HIM) ▪ Human Resources ▪ Heart/Vascular Institute ▪ Imaging Services/Radiology ▪ Infection Prevention ▪ Information Services ▪ Laboratory & Pathology ▪ Maternal Child Health Service Line ▪ Mental Health & Addiction Service Line ▪ Nutrition Services	▪ Orthopedic Service Line ▪ Palliative Care ▪ Patient Blood Management ▪ Patient Experience (HCAHPS) ▪ Peri-Operative Services MV & LG ▪ Pharmacy ▪ Quality/Performance Improvement/ Patient Safety Plan ▪ Rehab Services ▪ Respiratory Care Services ▪ Sepsis ▪ Sleep Center ▪ Spine Service Line ▪ Sterile Processing (separate from Peri-Op Svs) ▪ Stroke Program ▪ Urology Service Line ▪ Value Based Purchasing	▪ Regulatory Update

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY21 End of Q2**

Report updated: 1/26/2020

	SAFETY EVENTS	Performance FY21, Q2	Performance FYTD 21	Baseline FY20 Actual	Target FY21 Target/ Goal	Trend *Displaying at least the last 24 months of available data*	Comments
1	**Patient Falls reported to CALNOC/ NDNQI *without ED*** *Med / Surg /CC / MBU/L&D/LD* *per 1000 CALNOC (NDNQI) patient days* *Reporting period: Oct - Dec 2020*	2.34 (39/78577)	2.63 (84/31885)	2.35 (142/60369)	<=2.12 (10% reduction from FY20 performance) (128)		Falls Committee leadership transition in Q1 of FY21. Significant improvement in front line staff representation and new format of meetings in which each manager provides summary of falls and prevention opportunities. Goals: Enhance education on Fall Risk Screening Tool--Healthstream module pending; each unit to reduce falls by > or equal to 10%; increased supply of chair alarms and use of visual monitoring; present case study in falls that occurred as learning opportunities; improve post fall Huddle frequency.
2	**All Patient Fall Rate** *All patient falls per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	1.13 (52/46187)	1.17 (107/91511)	1.14 (196/172435)	<=1.03 (10% reduction from FY20 performance) (176)		Work to enhance VM capabilities to ED for Q2. Taube--visual staircase improvements to be done. F/U with visitor falls in L&D. 28 total patient falls in December. 2 visitor fall at external ground excluded from rate calculation. 2 Moderate and 4 mild hard. 14 Imaging done for 9 patients that all came negative.
3	**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (HAPI) Rate** *per 1000 Total Patient days* *Reporting period: Oct - Dec 2020*	0.08 (2/24481)	0.04 (2/48658)	0.11 (10/92714)	<=0.10 (10% reduction from FY20 performance) (9)		2 HAPIs for Q2 FY21: 1. Pt admitted on 10/12 to CCU to PCU then to 4A, HAPI discovered in 10/24 2. DOA 12/10, date of discovery 12/27, mild upper mouth mucosal injury. Pt prone intubated. Unstageable on the left cheek RCA done for both '0' HAPIs for Q1 FY21
4	**HAI- Catheter Associated Urinary Tract Infection (CAUTI)** *per 1000 Urinary Catheter days* *Reporting period: Oct - Dec 2020*	0.71 (3/4229)	0.60 (5/8290)	0.47 (7/14859)	<= 0.48 MV: 6 LG: 1		CAUTI – themes identified : 1. Timeliness of specimen collection 2. Cloudy, foul smelling urine – collect specimen for UA 3. Hygiene 4. NO SPECIMEN COLLECTED FROM PUREWICK Intense review were done and action items are monitored
5	**HAI- Central Line Associated Blood Stream Infection (CLABSI)** *per 1000 Central Line Days* *Reporting period: Oct - Dec 2020*	1.38 (4/2904)	0.66 (4/6091)	0.15 (2/13639)	<= 0.20 MV: 3 LG: 0		CLABSI - Theme Identified: 1. Timeliness of blood draw 2. Blood draw technique – need re-education and review 3. Hygiene – better hand-off between shifts 4. Knowledge gap – identifying second source of infection Intense review were done and action items are monitored.

El Camino Health

Definitions and Additional Information

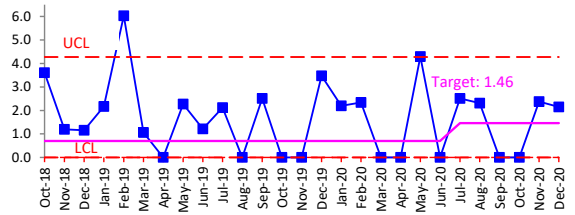
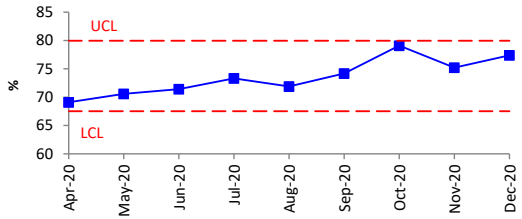
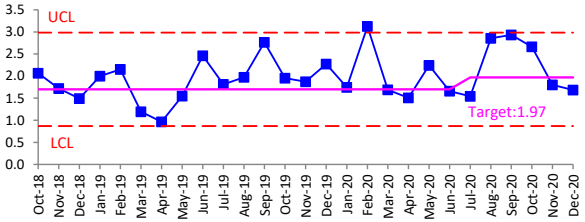
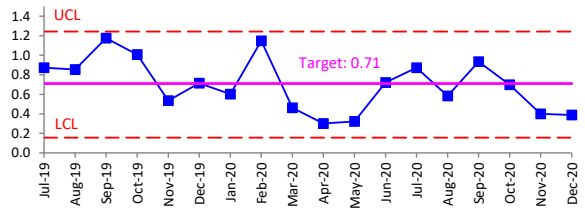
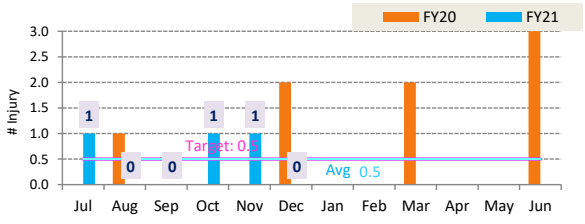
		Data Owner	Work Group	Definition	Data Source
SAFETY EVENTS					
1	**Patient Falls reported to CALNOC/ NDNQI *without ED*** *Med / Surg /CC / MBU/L&D/LD* *per 1000 CALNOC (NDNQI) patient days* *Reporting period: Oct - Dec 2020*	Jane Truscott/ Andria Mills/ Alex Tungol	Falls Committee/PESC Committee	All Med/Surg/CC falls reported to NDNQI per 1,000 CALNOC (NDNQI) (Med/Surg/CC) patient days from EPSI report, excludes ED falls. CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Includes Assisted Falls (when staff attempts to minimize the impact of the fall). Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included in CALNOC fall. Target: Minimum 10% reduction from FY20, decided by fall benchmark meeting on 8/11/20 *Upper Control Limit (UCL) and Lower Control Limit(LCL) are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports and Staff Validation
2	**All Patient Fall Rate** *All patient falls per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	Jane Truscott/ Andria Mills/ Alex Tungol	Falls Committee/PESC Committee	All reported falls in hospital and outpatient departments. Fall Rate calculated per 1000 Adjusted Patient Days (EPSI) starting FY21. Target: Minimum 10% reduction from FY20, decided by fall benchmark meeting on 8/11/20 *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports and Staff Validation
3	**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (HAPI) Rate** *per 1000 Total Patient days* *Reporting period: Oct - Dec 2020*	Anna Aquino / Franz Encisa	PIPSC Committee	Stage 3, Stage 4 and Unstageable Hospital Acquired Reportable Pressure Injury Rate per 1000 patient days. Data reported by date of discovery, excludes expired patients. Reportable HAPIs is defined as Stage 3, Stage 4 and Unstageable. We report all "reportable HAPIs" to CDPH but for the purposes of our Quality dashboard reporting, we exclude patients who developed reportable HAPIs that qualify as "Skin Failure or Kennedy Pressure Ulcer". Exclusion: Patients diagnosed with Skin Failure (Formerly know as Kennedy Pressure Ulcer). Data verification and comments received from Anna A. Target: 10% reduction from FY20, decided by Target setting meeting in July 2020 (Anna A.) *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Regulatory/PIPSC
4	**HAI- Catheter Associated Urinary Tract Infection (CAUTI)** *per 1000 Urinary Catheter days* *Reporting period: Oct - Dec 2020*	Catherine Nalesnik	HAI Committee/ Anna Aquino	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP *Target data received from Catherine N. on 9/1/20 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero.*	NHSN
5	**HAI- Central Line Associated Blood Stream Infection (CLABSI)** *per 1000 Central Line Days* *Reporting period: Oct - Dec 2020*	Catherine Nalesnik	HAI Committee/ Anna Aquino	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP *Target data received from Catherine N. on 9/1/20 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero.*	NHSN

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY21 End of Q2**

Report updated: 1/26/2020

		Performance		Baseline	Target	Trend	Comments
SAFETY EVENTS		FY21, Q2	FYTD 21	FY20 Actual	FY21 Target/ Goal	*Displaying at least the last 24 months of available data*	
6	**HAI- Clostridium Difficile Infection (C.diff)** *per 10,000 Patient Days* *Reporting period: Oct - Dec 2020*	1.44 (8/52654)	1.52 (8/52654)	1.46 (14/95698)	<= 1.46 MV: 10 LG: 3		C-DIFF – themes identified: 1. Timeliness of specimen collection 2. Stool descriptor not being used 3. Hygiene – inconsistent documentation Intense review were done and action items are monitored
7	**Documentation of Vital Signs within 10-20min of Transfusion Initiation** *Reporting period: Oct - Dec 2020*	77.2%	75.2%	70.4% (New measure, Q4 FY20 data only)	>=90%		Each Nursing Department Manager were asked to address the non-compliance rate and provide the corrective action plan The average rate of compliance has been steadily improved since July 2020. The ongoing efforts to improve the outcome include ongoing education/in-service, sending the checklist/reminder with each blood product, iCare prompt for nurses to document vitals signs, and sharing unit and nurse specific monthly report. It is expected to reach 80% compliance rate, which is 10% increase from the baseline, in coming months
8	**Medication Errors that Reached Patient** *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	2.06 (95/46187)	2.25 (206/91511)	2.07 (357/172435)	<=1.97 (5% reduction from FY20 performance) (339)		Major error categories for Q2 include Incorrect time, Omitted medication, Incorrect dose & Duplicate dose. The CFs include – 5 rights not followed (Incorrect IV flow rate, Meds given too late), Vancomycin, Roller clamp not opened & PCA issues. Taskforce team has implemented a BPA to alert nurses for Vanco trough levels. Pilot study measures on Roller clamp were implemented enterprise wide & each fallout is being investigated. Observed a downward trend. PCA fallouts were investigated and presented to med safety and discussed action items
9	**Omitted Medication Errors that Reached Patient** *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	0.50 (23/46187)	0.64 (59/91511)	0.75 (129/172435)	<=0.71 (5% reduction from FY20 performance) (123)		Major CFs for omitted meds are roller clamp issues. Other reasons include not following the MAR for med admiration, Potassium & Magnesium replacements
10	**Employee Injury due to Assisted Falls** *# of injury* *Reporting period: Oct - Dec 2020*	2 (0.67/mo)	3 (0.50/mo)	8 (0.67/mo)	<=6 (0.50/mo)		Q2: 2 1 non-OSHA in Oct: fall prevention: pt using urinal, felt dizzy and fainted. Staff held him up and got him into a chair 1 OSHA in Nov: fall recovery: pt fainted in bathroom and was assisted to the floor Q1 FY21: 1 (July)

El Camino Health

Definitions and Additional Information

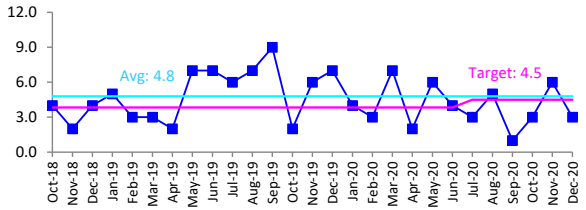
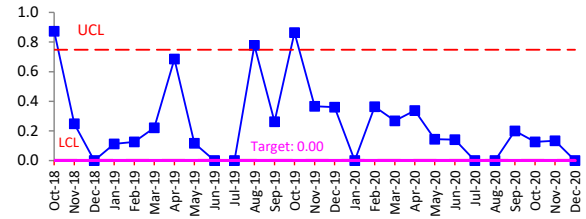
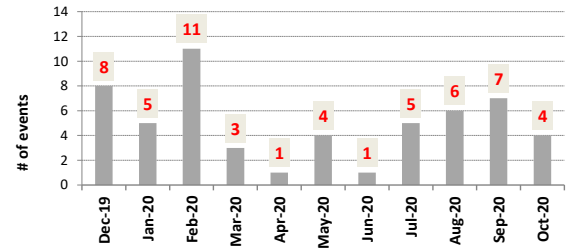
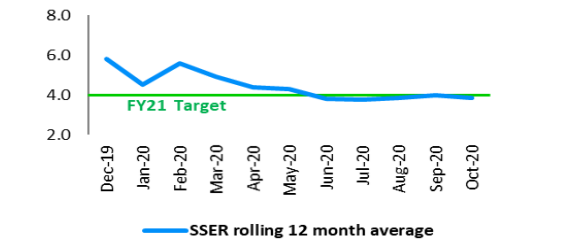
		Data Owner	Work Group	Definition	Data Source
SAFETY EVENTS					
6	**HAI- Clostridium Difficile Infection (C.diff)** *per 10,000 Patient Days* *Reporting period: Oct - Dec 2020*	Catherine Nalesnik	HAI Committee/ Anna Aquino	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only 1. Based on NHSN defined criteria 2. ALL positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization. Exclusion criteria: 1. Out-patients and ED patients *Target data received from Catherine N. on 9/1/20 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	NHSN
7	**Documentation of Vital Signs within 10-20min of Transfusion Initiation** *Reporting period: Oct - Dec 2020*	Jeong Chae	Transfusion Safety Committee	Definition: During the first 15 minutes, nurse is required to remain at the patient's bedside as most transfusion reactions occur during the first 15 minutes of transfusion. This measure will assess nursing staff's compliance in checking and recording patient's vital signs within 10-20min of initiation. The measure value is the average value of 4 required elements of vital signs – blood pressure, temperature, respiratory rate, and pulse. Target: 90% of compliance rate *Baseline and Target data received from Jeong on 7/27/20 via email* Baseline data Q4 FY20 *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.*	EPIC Report and Staff Validation
8	**Medication Errors that Reached Patient** *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	Deep Mattapally	Medication Safety Committee	Incidents for Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Route, Incorrect Dose, Incorrect Time, Incorrect Medication order, Medication Reconciliation that Reached the Patient. EPSI report used for Patient days and # of events provided by Deep M. *Target data received from Deep on 7/27/20 via email* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports / EPSI Report
9	**Omitted Medication Errors that Reached Patient** *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	Deep Mattapally	Medication Safety Committee	An omitted medication error is a medication/dose that is not administered to patient before the next scheduled dose. They are a subset of All med errors that reached patient. No exclusions and Inclusion: both medication and dose. EPSI report used for Patient days and # of events provided by Deep M. New measure added to the dashboard in FY 21 July. *Baseline and Target data received from Deep on 7/27/20 via email*	Incident Reports / EPSI Report
10	**Employee Injury due to Assisted Falls** *# of injury* *Reporting period: Oct - Dec 2020*	Mari Numanlia-Wone	Central Safety Committee	The definition of an employee injury due to Patient Fall/Prevention includes a musculoskeletal injury to an employee as a result of preventing a patient from falling, assisting a patient fall to the floor, and fall recovery of a patient from the floor/ground after a fall. *Target and Baseline data received from Mari on 8/24/20 via email*	EWHS Systems- Employee enter data in this system. EMR System Agility- EWHS data are entered in Agility after staff review.

El Camino Health

Patient and Employee Safety Dashboard

Reporting Period: **FY21 End of Q2**

Report updated: 1/26/2020

		Performance		Baseline	Target	Trend	Comments
SAFETY EVENTS		FY21, Q2	FYTD 21	FY20 Actual	FY21 Target/ Goal	*Displaying at least the last 24 months of available data*	
11	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* *Reporting period: Oct - Dec 2020*	12 (4/mo)	21 (3.5/mo)	63 (5.25/ mo) MV: 55 LG: 8	<=54 (15% reduction from FY20 performance) (4.5/ mo)		5 incidents related to dementia or other disorder. 2 related to substance abuse, 3 were behavioral health patients and the other 2 were agitated and confused patients. 7 of the incidents resulted in minor injuries to staff WPV committee is continuing to investigate the contributing factors for the incidents.
12	**Never Events Reported to CDPH Rate** *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	0.09 (4/46187)	0.08 (7/91511)	0.32 (30/92714)	0		Oct: 2 HAPI • Unstageable = 1 (LG-ICU, Right Buttock) • Stage 3 = 1 (MV-4A, Coccyx) Nov: 2 1 RFO, MV-OR, retained Mako tracking pins 1 Assault • MV-3C, pt non-sexual physical altercation with hospital staff resulted in minor injury Dec: 0
13	**Serious Safety Event Rate (SSER)** # of events ** Reporting period: Oct - Dec 2020*	4 (Oct only)	3.87 (55/142274)	4.28	4.0		October: 4 SSE, Nov and Dec data are not processed as of 1/26/21 7 SSE in September 2 Sepsis Management Concerns 2 Falls 1 SSI 1 Wrong Body Party Removed 1 Reportable HAPI Our trend is increasing from July
	Serious Safety Event Rate (SSER) Rolling 12 month average *Reporting period: Dec 2019 - Oct 2020*	NA	3.87 (55/142274) (Dec '19 - Oct '20 rolling avg)	4.28	4.0		The graph displays Rolling 12 month average for the reporting period December 2019 to October 2020

** SSE data are up to October 2020 only*

El Camino Health

Definitions and Additional Information

		Data Owner	Work Group	Definition	Data Source
SAFETY EVENTS					
11	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* *Reporting period: Oct - Dec 2020*	Steve Weirauch/ Matthew	Safety/ Security	Every general acute care hospital, shall report any incident involving the use of physical force against an employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury. This includes any incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury. -Cal/OSHA - Title 8, § 3342. Violence Prevention in Health Care. *Target data received from Steve and Matthew S.on 7/2/20 via email*	WPV Reporting Log, data based on reported incidents
12	**Never Events Reported to CDPH Rate** *per 1000 Adjusted Patient Days* *Reporting period: Oct - Dec 2020*	Franz Encisa	PESC Committee	Never Events is Identified patient incident as defined in and pursuant to Health and Safety Code Section 1279.1 as well as Title 22, California Code of Regulations, Section 70737 (the "unusual occurrence" reporting requirement). Data collected by CDPH reported date. Includes expired patients. *Target received from Sheetal via email, 8/3/20* *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is set to '0' if value is less than or equal to zero*	Incident Reports and Staff Validation
13	**Serious Safety Event Rate (SSER)** # of events ** Reporting period: Oct - Dec 2020*	Sheetal Shah	PESC Committee	Serious Safety Event (SSE) is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient Inclusion is events determined to be serious safety events per Safety Event Classification team. Denominator is Acute Adjusted Patient Days which defines as 'Acute Patient Days adjusted by factor to adjust IP activity to include OP activity' (per EPSI definition, email Mary W. 9/14/20) New measure added to the dashboard in FY 21 July. Started monitoring in December 2019. *Target received from Sheetal via email 8/24.* *Baseline data received from Sheetal on 7/24/20 by email.*	HPI Systems
	Serious Safety Event Rate (SSER) Rolling 12 month average *Reporting period: Dec 2019 - Oct 2020*	Sheetal Shah	PESC Committee	Serious Safety Event (SSE) is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient Inclusion is events determined to be serious safety events per Safety Event Classification team. Denominator is Acute Adjusted Patient Days which defines as 'Acute Patient Days adjusted by factor to adjust IP activity to include OP activity' (per EPSI definition, email Mary W. 9/14/20) New measure added to the dashboard in FY 21 July. Started monitoring in December 2019. *Target received from Sheetal via email 8/24.* *Baseline data received from Sheetal on 7/24/20 by email.*	HPI Systems

** SSE data are up to October 2020 only*

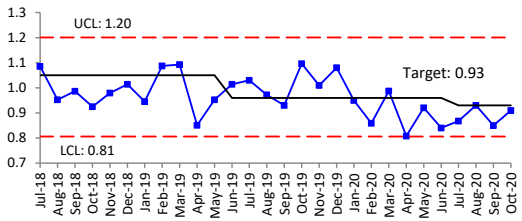
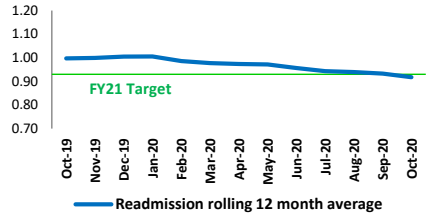
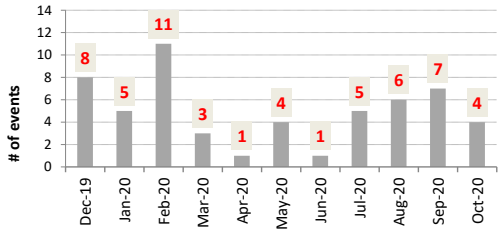
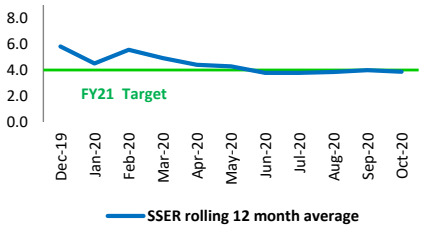
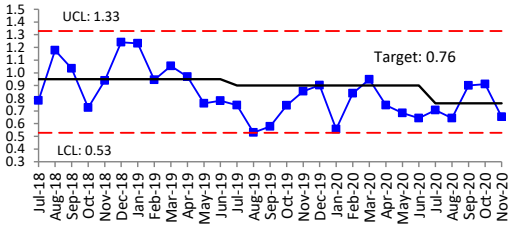
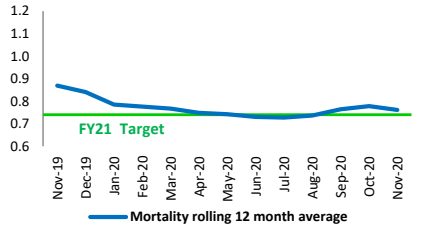
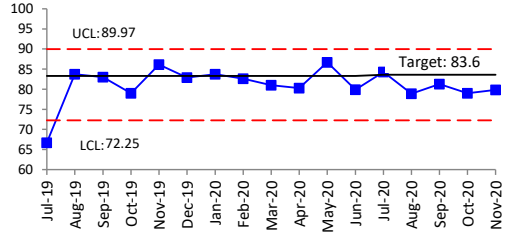
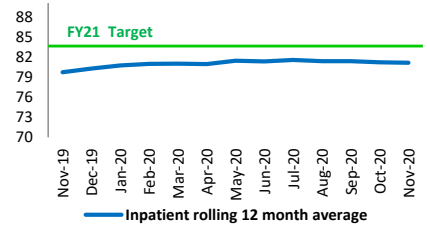
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

November 2020 (unless otherwise specified)

Month to Board Quality Committee:

January, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: October 2020*	0.91 (8.03%/8.82%)	0.89 (7.32%/8.22%)	0.96	0.93		
2	*Organizational Goal **Serious Safety Event Rate (SSER)** # of events/ (FYTD Rate) ***Latest data month: October 2020*	4	3.87 (55/142274)	4.28	4.0		
3	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: November 2020*	0.65 (1.45%/2.22%)	0.76 (1.46%/1.93%)	0.74	0.76		
4	*Organizational Goal **IP Enterprise - HCAHPS Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: November 2020*	79.8	80.1	83.1	83.6		

Definitions and Additional Information

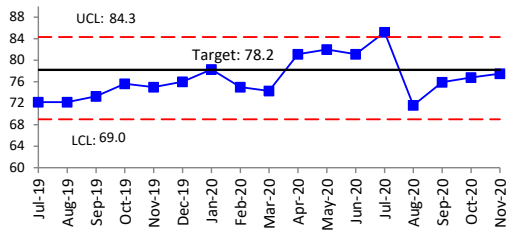
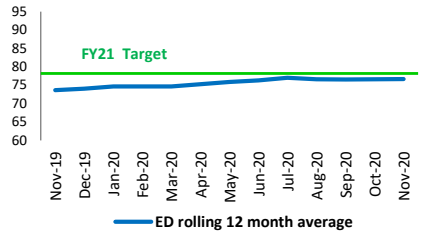
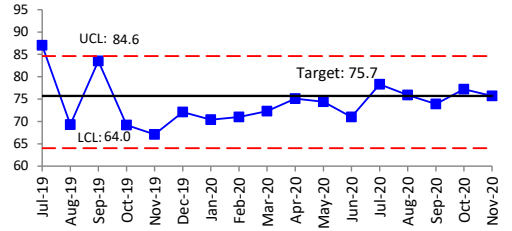
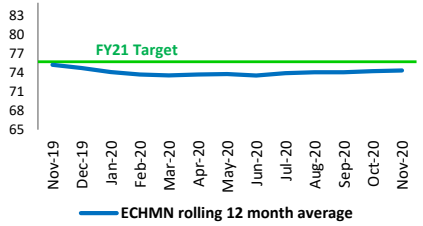
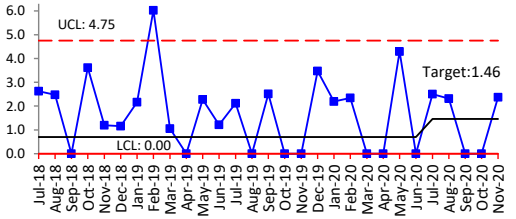
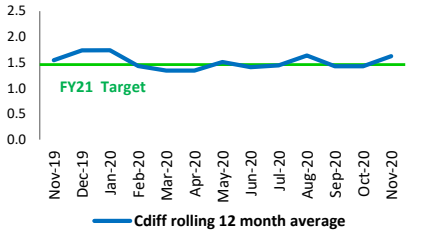
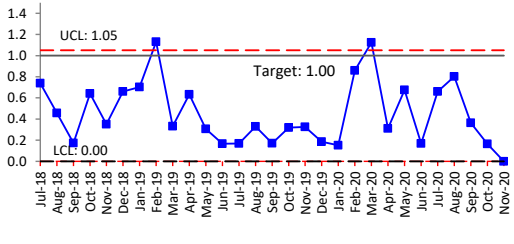
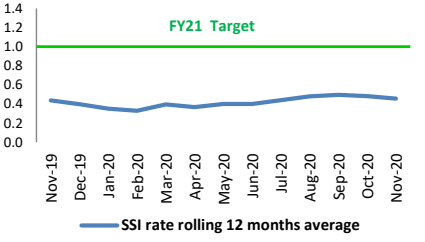
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
1. Readmission Index - All Patient All Cause Readmit (Observed/Expected)	Readmission Index dropped in September. New actions taken to alert discharging physician (hospitalist) of the patient's readmission and referring readmitted patients for review by the appropriate readmission team (such as Cancer team or Surgical Complications team) may be having an impact.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). Includes Inpatient and Psych patients. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
2. Serious Safety Event Rate (SSER)	4 SSEs occurred in October 2020 The trend in SSEs is increasing from July with 7 in September. Only 1 SSI in September. 2 Sepsis Management Concerns 2 Falls 1 SSI 1 Wrong Body Party Removed 1 Reportable HAPI	Sheetal Shah	Definition of serious safety event is an event where there was a deviation from generally accepted performance standard that resulted in moderate to severe harm or death to a patient. Inclusion is events determined to be serious safety events per Safety Event Classification team *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**HPI**
3. Mortality Index (Observed/Expected)	Expected mortality % increased from 1.49 to 1.85, most likely due to better physician documentation of each patient's severity of illness and co-morbidities, which reduces the index. # of moralities @ 28 versus 29 in September.	Catherine Carson	Updated 7/1/19 (JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
4. Inpatient - HCAHPS Likelihood to Recommend Top Box Rating of 'Always' % , Unadjusted	Although still above the California and National Average, our Inpatient LTR numbers remain flat or have slightly decreased due to COVID-19. The largest decrease was seen in our Los Gatos Inpatient Units. Our Mother Baby units in both locations saw a slight dip, but not as large as Inpatient. We have increased our leader and nurse leader rounding and have continued our roll out of our WeCare Standards. However the continued anxiety and fears over the pandemic still affects our patients, families and staff.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

November 2020 (unless otherwise specified)

Month to Board Quality Committee:
January, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
5	* Organizational Goal **ED Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: November 2020*	77.5	75.2	75.7	78.2		
6	* Organizational Goal **ECHMN** (El Camino Health Medical Network)**: Likelihood to Recommend** **Top Box Rating of 'Always' %, Unadjusted** *Latest data month: November 2020*	75.7	76.1	73.2	75.7		
7	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Latest data month: November 2020*	2.38 (2/8417)	1.38 (6/43362)	1.46	<= 1.46 (MV: 10/ LG: 3)		
8	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: November 2020*	0.00 (0/328)	0.44 (12/2718)	0.36	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
5. ED - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	The Enterprise ED numbers remain above the California and National Average and have seen some great increases over the past six months. The MV location surpassed their target during the month of October while the LG location saw a slight decrease. In preparation for the upcoming flu season and winter months, work is being done in the areas of wait space, texting, visitors, screening etc.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
6. ECHMN (El Camino Health Medical Network) - Likelihood to Recommend Top Box Rating of 'Always' %, Unadjusted	We are seeing a steady increase in our numbers for our outpatient setting and ECHMN is above target year to date. We recently launched WeCare to all Leaders and Leader Physicians throughout the network.	Christine Cunningham	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Data run criteria, 'Top Box, Received Date, and Unadjusted' *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**Press Ganey Tool**
7. Hospital Acquired Infection- C. Diff (Clostridium Difficile Infection)	No C.Difficile infections in the month of September and October. EPIC Documentation revised to include a flow sheet row for the CAN to document stool description.	Catherine Carson/Catherine Nalesnik	Infection Rate is predicted infections to meet Target/Goal: NHSN SIR. Inclusion criteria: in-patients only, based on NHSN definition Exclusion: ED and OP FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**CDC NHSN database - Inf. Control** **Patient Days from EPIC**
8. Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	Zero SSIs noted in October after 1 in September. BD Surgical Specialties provided personnel to observe in each OR, L&D and Cath Lab how surgical scrubs are preformed, OR attire, OR traffic, and other factors in surgical prep, the week of Nov. 16th. Report on findings to be shared the week of November 30th.	Catherine Carson/Catherine Nalesnik	**Inclusion:** 1) Based on NHSN defined criteria 2) All surgical cases that are categorized as "clean wound class" and "clean-contaminated wound class" are considered for investigation 3) SSIs that are classified: "deep –incisional" and "organ-space" are reportable **Exclusion:** 1) All surgical cases that have a wound class of "contaminated" and "dirty" are excluded. 2) All surgical case that are considered an infection PATOS (present at time of surgery). 3) All "superficial" SSIs are not reportable FY21 Target/ Goal received from Catherine N.'s email of 9/1/20. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average .Lower Control Limit is not visible if it is less than or equal to zero .*	**CDC NHSN database - Inf. Control**

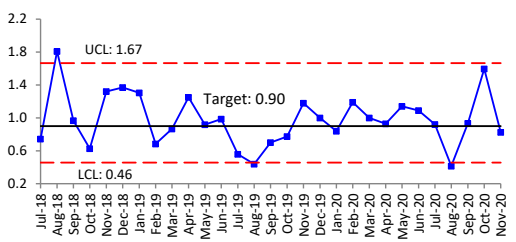
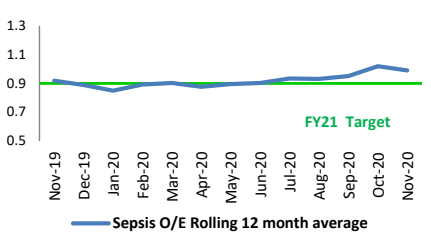
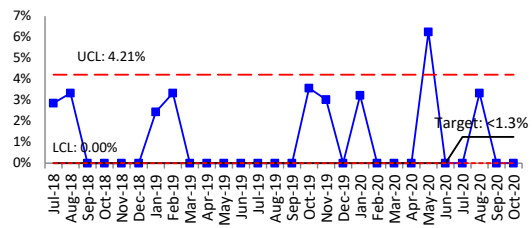
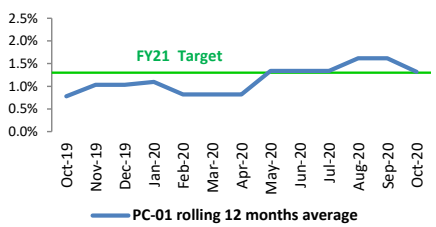
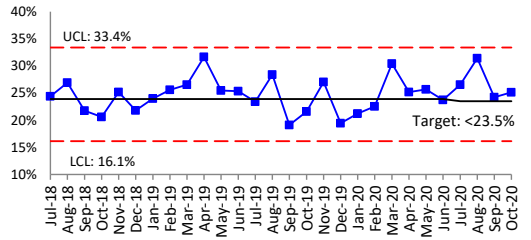
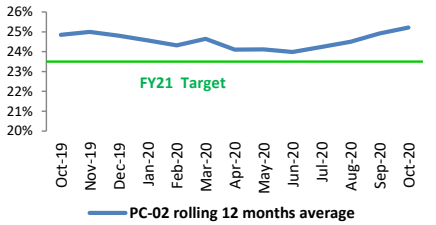
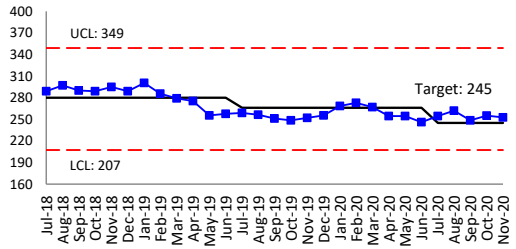
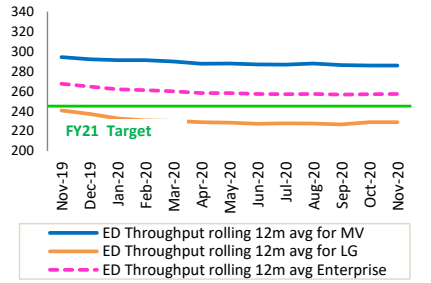
El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

November 2020 (unless otherwise specified)

Month to Board Quality Committee:

January, 2021

		FY21 Performance		Baseline FY20 Actual	FY 21 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: November 2020*	0.82 (10.91%/13.23%)	0.92 (10.24%/11.10%)	0.98	0.90		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: October 2020	MV: 0.0% (0/28) LG: 0.0% (0/6) **ENT: 0.0%** (0/34)	MV: 0.00% (0/77) LG: 3.57% (1/28) **ENT: 0.95%** (1/105)	MV: 1.47% (5/341) LG: 0.00% (0/48) **ENT: 1.29%** (5/389)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: October 2020	MV: 26.3% (36/137) LG: 21.1% (8/38) **ENT: 25.1%** (44/175)	MV: 28.4% (161/566) LG: 20.3% (25/123) **ENT: 27.0%** (186/689)	MV: 24.7% (412/1665) LG: 18.9% (48/253) **ENT: 23.9%** (460/1918)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Latest data month: November 2020*	MV: 283 min LG: 222 min **Ent: 253 min**	MV: 281 min LG: 226 min **Ent: 254 min**	MV: 304 min LG: 263 min **Ent: 284 min**	MV: 263 min LG: 227 min **Ent: 245 min**		

** data available up to October. SSER FYTD data displayed in rate per 10000 Acute Adjusted Patient Days for the reporting period December 2019 to October 2020

Report updated: 12/29/20

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
9. Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	The 28 mortalities for October are being reviewed by the Sepsis and CDI managers, with a focus on the low expected % this month as compared to FYTD, which is function of the clinical documentation about the patient's illness and co-morbid conditions. Questions about treatment are addressed by the mortality team and the SEE team.	Jessica Harkey, Catherine Carson	Effective 01/24/20: The original definition for Sepsis (used in this dashboard) 1) evaluated only the Principal diagnosis, & 2) excluded cases assigned the patient type of Rehabilitation or Other (Hospice). The definition has now been aligned with CMS' to 1) evaluate both principal AND secondary diagnoses, & 2) excludes: patients < 18 years, LOS => 120 days, or Transfers from Another Acute Hospital, as well as the Patient Type of Rehabilitation or Other (Hospice). This was reviewed with & approved by Jessica Harkey, Sepsis Manager and Catherine Carson Sr. Director Quality. *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**Premier Quality Advisor**
10. PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	All scheduled cases are reviewed proactively. Data is also reviewed retrospectively.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
11. PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Failed inductions lead to Cesarean Sections. MCH Inductions have been increasing since the publication of the ARRIVE trial and are the highest correlated factor related to the rising NTSV C/S rate. MCH will develop more evidence-based and standardized induction process to improve our outcomes to match the ARRIVE trial findings. In addition MCH will be changing how we manage low-risk inductions to improve maternal exhaustion issues and our patient flow.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.* *LCL is set to '0' if value is less than or equal to zero.*	**IBM CareDiscovery Quality Measures**
12. Patient Throughput- Median Time from Arrival to ED Departure (excludes psychiatric patients, patients expired in the ED and Newborns	ECH went live with the electronic handoff process (ED to Inpatient) on 10/20 and are currently closely monitoring the process and improving compliance. The goal of this project is to reduce the admission order to departure time of the process. Currently, there has not been a statistically significant change in order to departure since the go live, but we now have data allowing for additional targeting interventions. The project is moving into the next phase of working on centralized staffing and bed planning, with the goal of reducing any delays in patient throughput related to staffing.	Cheryl Reinking, Melinda Hrynewycz	This measure definition is changed in Feb. 2020 regarding the end point. New definition is "Arrival to ED Departure", and is the same as CMS ED Measure (ED 1b) ED Arrival to ED Departure for Admitted pts. Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit *For the Trended graph: UCL and LCL are 2+/- the Standard Deviation from the Average.*	**iCare Report: ED Admit Measurement Summary**

El Camino Health

Month to Quality Committee of the Board: February 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 21, Q2 (unless otherwise specified by *)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 20	FY 21	FYTD21, Q1	FYTD21, Q2	FYTD21, Q3	FYTD21, Q4	FYTD21 Total
Safe Care	Risk Adjusted Mortality Index	0.74	0.76	0.75	0.79			**0.77**
	Sepsis Mortality Index	0.96	0.90	0.76	1.14			**0.98**
	Serious Safety Events Rate (SSER) (baseline Dec'19 to Jun'20)	4.28	4.00	3.98	**3.87			**3.87**
	Surgical Site Infections (SSI)	0.36	1.0 (SIR)	0.62	0.12			**0.37**
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.47	<= 0.48	0.51	0.71			**0.51**
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.15	<= 0.2	0.0	0.71			**0.0**
	Clostridium Difficile Infection (CDI) - HAI	1.46	<= 1.46	1.6	1.44			**1.52**
	Modified PSI-90 CMS HAC Reduction Program	0.919	0.90	0.898	0.815			**0.857**
Timely	Patient Throughput - ED Door to Admit Order	190 min	181 min	188 min	197 min			**193 min**
	Patient Throughput - Median Time Arrival to ED Departure	284 min	245 min	255 min	274 min			**265 min**
	ED Arrival to Direct Discharge for ED Patients	151 min	145 min	152 min	154 min			**153 min**
Effective	Risk Adjusted Readmissions Index	0.96	0.93	0.88	*0.90			**0.89**
	CMS SEP-1 Compliance Rate	70.9%	86%	67.6%	81.8%			**75.6%**
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 1.3%	1.3%	1.4% (1/71)	*1.89% (1/53)			**1.6%**
	PC-02 NTSV C-Section	ENT: 24.0%	23.5%	27.6% (142/514)	*25.5% (85/333)			**26.8%**
	ECMN: CMS 165 Controlling High Blood Pressure	51.20%	63	58.0%	56.0%			**57.0%**
	ECMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	43.30%	<45	26.0%	29.0%			**28.0%**
	HEDIS: Composite	NA	3.0	3.25	3.3			**3.3**
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.32	1.00	1.32	1.32			**1.32**
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 18)	0.99	0.99	None updated annually, January			**0.99**
Equitable	Hospital Charity Care Support	$20.5 mil	NA	$6.6 mil	$5.7 mil			**$12.3 mil**
	Clinic Charity Care Support	$44.3k	NA	$8.5k	1.1k			**9.6k**
	Language Line Unmet Requests (data collection started Q2)	0.34%	<1%	0.39%	0.64%			**0.52%**
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.05	NA	3.98	4.56			**4.25**
		White: 3.79		3.81	3.97			**3.89**
		Asian: 3.64		3.54	3.38			**3.47**
Patient-centered	IP Enterprise - HCAHPS Likelihood to Recommend	83.1	83.6	80.7	78.6			**79.5**
	ED - HCAHPS Likelihood to Recommend	75.7	78.2	73.9	78.7			**76.5**
	ECHMN - HCAHPS Likelihood to Recommend	73.2	75.7	76.2	76.0			**76.1**
	MCH - HCAHPS Likelihood to Recommend	84.1	84.6	82.9	78.2			**80.5**
	OAS - HCAHPS Likelihood to Recommend	84.7	86.4	83.5	86.1			**84.9**
	NRC Net Promoter Score (NPS)	72.3	75	76.2	75.7			**76.0**

Report updated 1/25/21

* data available up to FYTD 21 November only

** data available FYTD 21 October only, displays rolling 12 month data (December 2019 to October 2020)

El Camino Hospital Data Registries - February 2021 Attachment F

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	CathPCI Registry®	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90' . Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all patients)	HVI	Quarterly
2	Chest Pain-MI Registry®–(old ACTION)	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI/ACS process performance: Overall AMI performance composite; STEMI performance composite; NSTEMI performance composite	HVI	Quarterly
3	ACC Patient Navigator Program Focus MI	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	This is a national program specifically designed to enhance the care and outcomes for myocardial infarction patients.	National benchmarks, with comparison data to reduce AMI patient readmission for quality improvement project	HVI	Quarterly
4	STS/ACC TVT RegistryTM	STS (Society of Thoracic Surgeons) ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)–Median Post Procedure (days) and outcome (TAVR & MitraClip): In Hospital, 30 day observed and 3-year risk adjusted mortality. Risk adjusted Stroke rate	HVI	Quarterly
5	LAAO RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per CMS indications; Proportion of LAAO procedures successful and medication stredegy and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
6	AFib Ablation RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures.	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
7	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for isoCABG, isoAVR and MV procedures. Composite quality rating (star rating) for isoCABG, isoAVR and MV procedures	HVI	Quarterly
8	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
9	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDIF; MRSA; CRE; VRE Device Associated Surveliace: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP Influenza Vaccination Data	Quality; Nursing EW&HS	monthly Yearly
10	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards.	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
11	PVI RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Provide national banchmarks and risk adjusted outcome of carotid artery stent, carotid endarterectomy and low extremity peripheral artery intervention procedures.	Last data submission in April 2021, then transitionto VQI Registry. Assesses the prevalence, demographics, management and outcomes of patients undergoing lower extremity peripheral arterial catheter-based interventions	HVI	Quarterly
12	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
13	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality indicators	Quality; Neuro	quarterly
14	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
15	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
16	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
17	California Maternity Quality Care Collaborative (CMQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
18	California Perinatal Quality Care Collaborative (CPQCC)	Hospital Collaborative	Perinatal Outcomes	Outcomes	Perinatal	Monthly
19	California Alliance for Nursing Outcomes	CALNOC	Actionable information and reearch on nursing sensitive quality indicators	Nursing indicators	Nursing	Quarterly
20	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit leel	Nursing indicators	Nursing	Quarterly
22	American Joint Replacement Registry	American Association of Orthopedic Surgeons	Hip and Knee Replacement Case Profile data, Risk Assessment data, and Outcomes data	Case data including implants, comorbidities, hospital complications. Patient reported outcomes Survey data fro HOOS JR, KOOS JR, and PROMIS-10	Ortho Director	Rolling submission with PRO data drawn quarterly
23	The Joint Commission - Disease-Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years
24	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	Outcome (part of STS) risk adjusted mortality and stroke rate. Comparison with all other CA hospitals	HVI	biannually
25	Santa Clara County-AMI and Cardiac Arrest	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome. Biannually County meeting	HVI	Quarterly

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
26	National Cancer Data Base	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Registry	Annually
27	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Registry	Monthly
28	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
29	Hospital Based Inpatient Psychiatrics Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
30	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
31	Parkinsons Registry	California Department of Public Health			IT Business Applications	Every month
32	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly
	ICAEl certification	Intersocietal Accreditation Commission	Adult Echocardiography facility standard and guidelines	Ongoing practice requirements: volume, experience, staff educations	HVI?	yearly
	VQI (Vascular Quality Initiative)	VQI (Vascular Quality Initiative) is a collaboration of the Society of Vascular Surgery	Demographic, clinical, procedural and outcomes data for Carotid Endaarterectomy, Endovascular AAA repair and Peripheral Vascular Intervention procedures	Quality and outcome benchmarks including risk adjusted mortality with follow-up	HVI	Biannually

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
	Transcatheter Valve Center Certification	American College of Cardiology	Provides external review that assists hospitals in meeting standards for multidisciplinary teams, formalized training, and shared decision-making with a focus on TVT Registry metrics and outcomes.	Process and Quality: In-Hospital, 30 day, and 1 year mortality and/or readmission, stroke rate, and bi-monthly M&M	HVI	Weekly, Quarterly, and Annual submissions

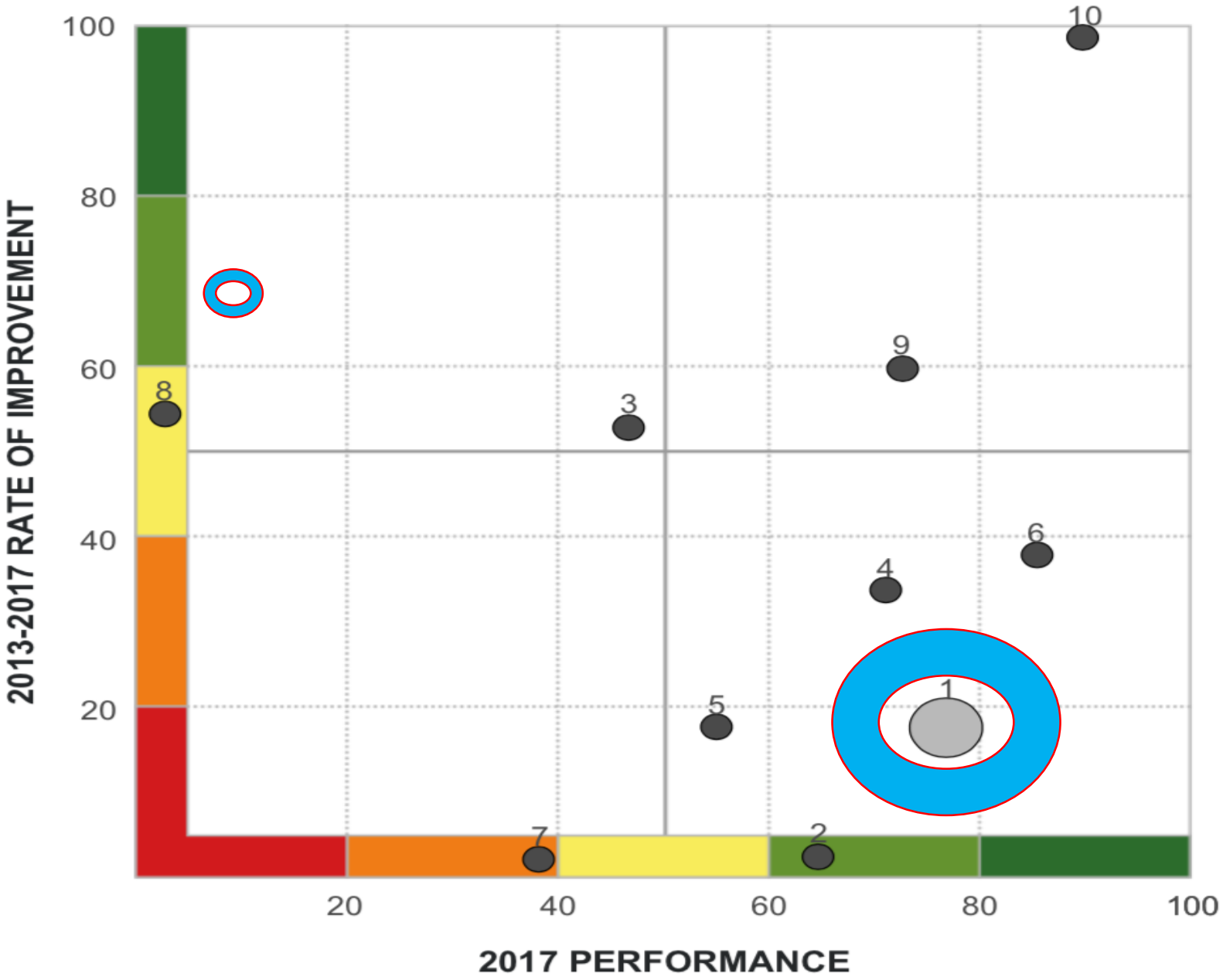
EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2021 REPORTING ATTACHMENT G

Indicator Name	Indicator Description	Regulatory/Accreditation source
Chart-Abstracted Clinical Core Measures Hospital Inpatient and Outpatient:		
OP-18:	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital Outpatient Quality Reporting (OQR) Program
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke	
PCB-05	Exclusive Breast Milk Feeding	TJC ORYX Performance Measurement Program
PCB-06.0	Unexpected Complications in Term Newborns - Overall Rate	
PCB-06.1	Unexpected Complications in Term Newborns - Severe Rate	
PCB-06.2	Unexpected Complications in Term Newborns - Moderate Rate	
PCM-02a	Cesarean Birth	
PCM-01	Elective Delivery	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
SEP-1	Early Management Bundle	Hospital Inpatient Quality Reporting (IQR) Program
SEP-3T	Sepsis Treatment 3-Hour Window	
SEP-6T	Sepsis Treatment 6-Hour Window	
SHK-3T	Septic Shock Treatment 3-Hour Window	
SHK-6T	Septic Shock Treatment 6-Hour Window	
HBIPS – Hospital-based Inpatient Psychiatric Services		
IMM-2	Influenza Immunization	TJC ORYX Performance Measurement Program
HBIPS-2	Physical Restraint	
HBIPS-3	Seclusion	
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate	
SUB-2	Alcohol Use Brief Intervention Provided or Offered	
SUB-2a	Alcohol Use Brief Intervention	
SUB-3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	
SUB-3a	Alcohol and Other Drug Use Disorder Treatment	
TOB-2	Tobacco Use Treatment Provided or Offered	
TOB-2a	Tobacco Use Treatment	
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	
TOB-3a	Tobacco Use Treatment at Discharge	

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2021 REPORTING ATTACHMENT G

Electronic Clinical Quality Measures (eCQM): **12 AVAILABLE eCQMs: Select 4 measures for two self-selected quarters (new measures are bolded) This is the first set of eCQM data that will be publicly reported, available as early as Fall 2022.** **Name and description;**	**Regulatory/Accreditation source**
eVTE-1 Venous Thromboembolism Prophylaxis	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis	
eSTK-2 Discharged on Antithrombotic Therapy	
eSTK-3 Anticoagulation Therapy	
eSTK-5 Antithrombotic Therapy / Day 2	
eSTK-6 Discharged on Statin Medication	
ePC-05 Exclusive Breast Milk Feeding	
eED-2 Admit Decision Time to ED Departure-Admit	
eOPI-1 Safe Use of Opioids	
ePC-01 Elective Delivery	
ePC-02 Cesarean Birth	
ePC-06 Unexpected Complications in Term Newborns	

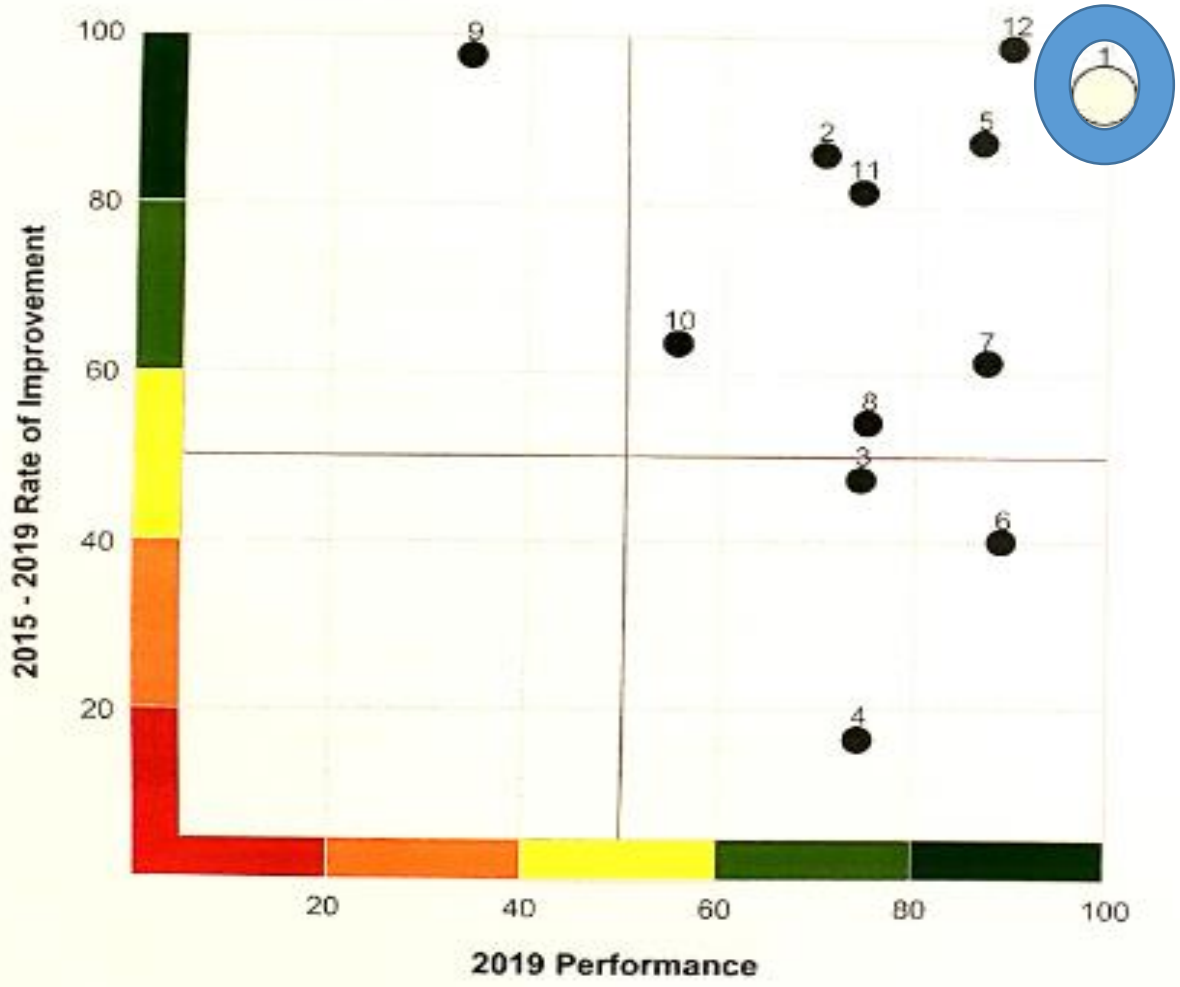
2017 Performance: Watson Top 100 Score



DATA POINT KEY

1	**OVERALL**
2	Inpatient Mortality
3	Complications
4	30-Day Mortality
5	30-Day Readmit
6	ALOS
7	ED Measures
8	IP Expense/Disch
9	Oper Profit Margin
10	HCAHPS

2019 Performance and Five-Year Rate of Improvement Matrix



DATA POINT KEY

1	OVERALL
2	Inpatient Mortality
3	Complications
4	HAI
5	30-Day Mortality
6	30-Day H-W Readmit
7	ALOS
8	ED Measures
9	IP Expense/Disch
10	MSPB
11	Oper Profit Margin
12	HCAHPS

- 80 to 100
- 60 to 80
- 40 to 60
- 20 to 40
- 0 to 20

PROFILED HOSPITAL compared to:

2019 large community hospitals: n = 254

2015-2019 large community hospitals: n = 248