

AGENDA

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

Monday, June 3, 2019 - 5:30 p.m.

El Camino Hospital | Conference Room A&B
2500 Grant Road, Mountain View, CA 94040

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

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1. CALL TO ORDER/ROLL CALL	Julie Kliger, Quality Committee Chair		5:30 – 5:32pm
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Julie Kliger, Quality Committee Chair		5:32 – 5:33
3. CONSENT CALENDAR ITEMS: <i>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</i> Approval a. Minutes of the Open Session of the Quality Committee Meeting (May 6, 2019) Information b. Patient Story c. FY20 Pacing Plan d. Progress Against FY19 Quality Committee Goals e. Hospital Update f. List of Medical Directorships	Julie Kliger, Quality Committee Chair	<i>public comment</i>	Motion Required 5:33 – 5:35
4. REPORT ON BOARD ACTIONS ATTACHMENT 4	Julie Kliger, Quality Committee Chair		Information 5:35 – 5:40
5. FY19 QUALITY DASHBOARD ATTACHMENT 5	Mark Adams, MD, CMO		Discussion 5:40 – 5:50
6. FY20 QC DASHBOARD CONTENT ATTACHMENT 6	Mark Adams, MD, CMO		Discussion 5:50 – 6:20
7. INFECTION PREVENTION PLAN AND HAND HYGIENE COMPLIANCE REPORT ATTACHMENT 7	Mark Adams, MD, CMO	<i>public comment</i>	Motion Required 6:20 – 6:30
8. PFAC REPORT ATTACHMENT 8	Cheryl Reinking, RN, CNO		Discussion 6:30 – 6:45
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE ATTACHMENT 9	Cheryl Reinking, RN, CNO		Discussion 6:45 – 7:00
10. COMPARISON DATA ATTACHMENT 10	Mark Adams, MD, CMO		Discussion 7:00 – 7:05

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) 988-7504 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. PSI-90 PT. SAFETY INDICATORS ATTACHMENT 11	Mark Adams, MD, CMO		Discussion 7:05 – 7:15
12. AD HOC COMMITTEE: PROGRESS REPORT	Julie Kliger, Quality Committee Chair		Information 7:15 – 7:20
13. PUBLIC COMMUNICATION	Julie Kliger, Quality Committee Chair		Information 7:20 – 7:21
14. ADJOURN TO CLOSED SESSION	Julie Kliger, Quality Committee Chair		Motion Required 7:21 – 7:22
15. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Julie Kliger, Quality Committee Chair		7:22 – 7:23
16. CONSENT CALENDAR <i>Any Committee Member may pull an item for discussion before a motion is made.</i>	Julie Kliger, Quality Committee Chair		Motion Required 7:23 – 7:25
Approval <i>Gov't Code Section 54957.2.</i> a. Minutes of the Close Session of the Quality Committee Meeting (May 6, 2019)			
17. 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 7:20 – 7:25
18. ADJOURN TO OPEN SESSION	Julie Kliger, Quality Committee Chair		Motion Required 7:30 – 7:31
19. RECONVENE OPEN SESSION/ REPORT OUT	Julie Kliger, Quality Committee Chair		7:31 – 7:32
To report any required disclosures regarding permissible actions taken during Closed Session.			
20. ADJOURNMENT	Julie Kliger, Quality Committee Chair	<i>public comment</i>	Motion Required 7:32 – 7:33 pm

Upcoming FY 20 Meetings: August 5, 2019



**Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, May 6, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040**

Members Present

Peter C. Fung, MD
Julie Kliger, Chair
Jeffrey Davis, MD
George O. Ting, MD
Melora Simon
Ina Bauman
Wendy Ron

Members Absent

Katie Anderson

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 5:30pm by Chair Kliger. <i>A silent roll call was taken.</i> Melora Simon and Katie Anderson were absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	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	<p>Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. The Committee pulled Item 3(b) Proposed FY20 Committee Goals for discussion.</p> <p>Motion: To approve the consent calendar: a. Minutes of the Open Session of the Quality Committee (April 1, 2019), b. Proposed FY20 Committee Goals; and for information: c. Patient Story, d. FY19 Pacing Plan, e. Progress Against FY19 Quality Committee Goals, f. Hospital Update.</p> <p>Movant: Fung Second: Bauman Ayes: Kliger, Fung, Davis, Ting, Bauman, Ron Noes: None Abstentions: None Absent: Anderson, Simon Recused: None</p>	<i>Consent Calendar Approved</i>
4. REPORT ON BOARD ACTIONS	Jeffrey Davis, MD provided brief highlights of board actions as further detailed in the report.	
5. FY19 QUALITY DASHBOARD	<p>Mark Adams, MD, CMO, provided an overview of the Quality Dashboard.</p> <ol style="list-style-type: none"> Mortality Index: <ul style="list-style-type: none"> Mortality Index dropped in February; and Fewer deaths with documentation of active treatment and co-morbidities. Readmission Index (All Patient, All Cause Readmit): <ul style="list-style-type: none"> Readmission Index dropped to below target level for FYTD with fewer COPD, Total Joint, and CHF readmissions, none for Pneumonia; Patients sent home with Telehealth per grant funding have a lower readmission rate; and Providing patients with rehabilitation has shown great results in decreasing readmissions. Patient Throughput-Median minutes from emergency room (ED) 	<i>Chair Julie Kliger would like to add a report of who makes up the patient census coming into the ED to the Pacing Plan</i>

	<p>Door to Patient Admitted:</p> <ul style="list-style-type: none"> ▪ Patient Throughput was better at the Los Gatos campus; ▪ With increased volume Mountain View was above goal in March; <ul style="list-style-type: none"> – Discovered issues around how patients are triaged. ▪ Steps to address delays: <ul style="list-style-type: none"> – Ten beds in 3CW now can be used for med/surg/telemetry to reduce holding in the emergency room; – In MV, a Capacity Management Center in the emergency room as a pilot for centralized bed management started April 2019 to support managing flow across the hospital; – In LG, nurses will step in and transport patients as needed; <p>4. Hospital-acquired Infections:</p> <ul style="list-style-type: none"> ▪ Zero CLABSI for March 2019: ▪ Two CAUTIs in March: Both cases related to extended urinary catheter days (7, 10 days) and both patients experienced increased bowel incontinence due to their treatments. <p>5. ALOS/GMLOS increased in February to above target level.</p> <p>In response to questions from the Committee, Dr. Adams discussed acute care needs, how to flex when needed, that the cancer infusion center has high demand and not enough capacity causing patients to wait for availability. He also commented on other approaches to taking care of patients in the home and beyond.</p> <p>Cheryl Reinking, RN, CNO, provided an overview of the HCAHPS portion of the Quality Dashboard.</p> <ol style="list-style-type: none"> 1. HCAHPS Nursing Communication improved in March 2019 – Successful interventions include leader rounding and nursing scripts 2. Responsiveness of Staff also improved in March <p>Chair Julie Kliger would like to add a report of who makes up the patient census of the ED to the Pacing Plan.</p> <p><i>Melora Simon joined the meet at 6:00pm.</i></p>	
<p>6. CDI DASHBOARD</p>	<p>Dr. Adams provided an overview of the Clinical Documentation Improvement Program. He discussed the following:</p> <ol style="list-style-type: none"> 1. The physician response rate to queries is at 100%; 2. The query agree rate has increased over last year; At the highest level ever registered; 3. Physicians are very engaged in documentation clarification opportunities; 4. Focus continues on physician education to document patient co-morbidities and to understand the effect of this documentation; 5. The importance of having the right information for the patient from the physicians, and the way in which it impacts our quality scores and our ability to be paid; 6. Team lead by a physician was successful in obtaining this information; 7. MCCs on medical and surgical side do not always want to fill out all of that information; and 8. The performance is good but could get better. 	
<p>7. CORE MEASURES</p>	<p>Dr. Adams provided an overview of the Core Measures. He discussed the following:</p> <ol style="list-style-type: none"> 1. The need to eliminate elective deliveries prior to 39 weeks 	

<p>8. MEDICAL DIRECTOR GOAL PROCESS AND ACCOUNTABILITY</p>	<p>gestation unless medically necessary;</p> <ol style="list-style-type: none"> 2. Increase of elective deliveries is mostly for patient convenience; and 3. Literature shows babies delivered before 39 weeks do have difficulties. <p>Dr. Teagle commented on the core measures and reasons for not inducing labor before 39 weeks.</p> <ol style="list-style-type: none"> 4. Admit Decision Time to ED Departure Time for Admitted Patients; The data is getting better, the times are shrinking; <p>Dr. Adams reported on the Hospital Based Inpatient Psychiatric Services (HBIPS). He discussed:</p> <ol style="list-style-type: none"> 1. Influenza Immunization; 2. Transition Record; 3. The use of seclusion and restraint; and 4. Valuing and respecting an individual's autonomy, independence. <p>Dr. Adams provided an overview of the Medical Directorships. He discussed:</p> <ol style="list-style-type: none"> 1. There are 50 Medical Directors across the organizations; 2. Physicians are reimbursed at an hourly rate; 3. Staff verifies the hours of work performed for compensation purposes; 4. Medical Directors are required to have two individual goals that are aligned with organizational goals. One is an outcome goal and the other is a process goal. 20% of compensation is withheld until goals are achieved. The assigned Director verifies metrics and final approval rests with the CMO; <p><i>The Committee asked to see the list of all 50 Medical Directorships.</i></p> <p><i>Ms. Ron left the meeting at 6:55pm.</i></p>	<p><i>The Committee asked to see the list of all 50 medical directorships.</i></p>
<p>9. PROPOSED FY20 ORGANIZATIONAL GOALS</p>	<p>Dr. Adams provided an overview of management's organizational incentive goals for Quality.</p> <p>Dr. Adams discussed the background and strategy that goes into establishing the goals, and how they align to the organization. He explained that the incentive goals were selected based on the following principles: significantly impacts quality, safety, and experience; easy to understand, broad reach across the organization; impacts financial performance; impacts consumer choice; and aligns with strategic goals.</p> <p>Dr. Adams commented about the Value Based Purchasing program and how there are mortality outcomes that impact the reimbursement that ECH receives from the Centers for Medicare and Medicaid Services (CMS). He also explained that the CMS Readmission Reduction (penalty) program has a significant impact on the amount of reimbursement that ECH receives and the rate of readmissions is seen as a proxy for the quality of care. Dr. Adams noted that ECH wants to be in the top tier of the country and a multiyear plan has been laid out with a target date of FY 2022. He said the work of improving the mortality index and readmission index is underway with 10 interdisciplinary teams at work.</p>	<p><i>The Committee requested to have an opportunity to discuss the proposed organizational goals at two meetings placed on the FY 20 Pacing Plan.</i></p>

	<p>Ms. Reinking discussed the proposed HCAHPS service measures - discharge information and staff responsiveness - that were selected by management to be included in the organizational incentive goals for FY20 as these goals also align with the principles above.</p> <p>Some Committee members commented that the new goals are uninspiring, and fewer than the year before. They wanted to see Patient Throughput and physician/nurse engagement and satisfaction included as goals.</p> <p>Dan Woods, CEO, explained that the organizational incentive goals are a small subset of the many activities and metrics followed by the Quality Committee related to quality, safety, and experience. He also explained that the Quality Committee would be tracking other metrics that include the aforementioned topics, and that these goals are the incentive goals with compensation tied to them.</p> <p>Motion: To approve recommending the proposed organizational incentive goals that reflects patient quality, safety, and service to the ECH Board for approval. Movant: Fung Second: Ting Ayes:, Davis, Fung Bauman, Ting Noes: None Abstentions: Simon, Kliger Absent: Anderson, Ron Recused: None</p>	
10. PROPOSED FY20 PACING PLAN	<p>Motion: To approve the Proposed FY 20 Pacing Plan Movant: Simon Second: Davis Ayes:, Bauman, Davis, Fung, Kliger, Simon, Ting Noes: None Abstentions: None Absent: Anderson, Ron, Recused: None</p>	<i>FY 20 Pacing Plan Approved</i>
11. AD HOC COMMITTEE: PROGRESS	Chair Julie Kliger reported on the Committees efforts to recruit new members to fill three vacancies.	
12. PUBLIC COMMUNICATION	There was no comment from the public.	
13. ADJOURN TO CLOSED SESSION	<p>Motion: To adjourn to closed session at 7:40pm. Movant: Simon Second: Davis Ayes:, Bauman, Davis, Fung, Kliger, Simon, Ting Noes: None Abstentions: None Absent: Anderson, Ron, Recused: None</p>	<i>Adjourned to closed session at 7:40pm</i>
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:57 pm. Agenda Items 15-17 were covered in closed session. During the Closed Session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (December 3, 2018, February 4, 2019, March 4, 2019 and April 1, 2019).	

15. AGENDA ITEM 20: ADJOURNMENT	Motion: To adjourn at 8:00 pm. Movant: Ting Second: Simon Ayes: , Bauman, Davis, Fung, Kliger, Simon, Ting Noes: None Abstentions: None Absent: Anderson, Ron Recused: None	<i>Meeting adjourned at 8:00pm</i>
--	--	---

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

Julie Kliger
Chair, Quality Committee

From: .
To: [Miguel Gonzalez](#)
Cc: [Iftikhar Hussain](#); [Ashlee Fontenot](#)
Subject: FW: Thank you and Above and Beyond
Date: Monday, April 15, 2019 10:19:10 AM

Hi Miguel

This is such a wonderful e-mail and thank you note from one of our Patients, and such a great compliment to you and the great work you are doing for our patients, you have an amazing way of communicating to our patients that puts them at ease and takes the stress out of their situation. You are doing such a wonderful job and I appreciate all that you do. This is not the first letter I have received from a patient about your work

El Camino is lucky to have you help our patients with their financial situations in a way that is a personal touch and showing true empathy and compassion.

Thanks for all that you do!!!!!!

Sent: Tuesday, March 26, 2019 2:19 PM
To: Terri Manifesto
Cc: Charity Care
Subject: Thank you and Above and Beyond

WARNING: This email originated outside of the El Camino Hospital email system!
DO NOT CLICK links if the sender is unknown, and never provide your User ID or Password.

Dear Terri,

Yesterday I got word from Miguel that you made a one time exception and approved me for charity care. I want to thank you from the bottom of my heart for taking the time to review my case independently, and so graciously taking this action on my behalf. I am in deep gratitude. This year has had more challenges than I have ever had, ever. And this news was like a ray of sunshine that there are good people in the world and good things to come.

This also brings me to Miguel. Usually a hospital has some sort of "Above and Beyond" system in which a patient can thank an individual that has cared for them in an exceptional way. I wanted to express my thanks and my "Above and Beyond" feedback for Miguel Gonzalez.

When I first spoke to Miguel I was your typical patient in serious distress about all that had happened with this case previously and my own stressors added into this. I had received two formal, impersonal rejection letters already to applications for help in my situation. I had talked with some people at the hospital who treated me pretty much like a number, and I was very discouraged.

I called charity care very upset because I had been treated so impersonally and I was simply very disappointed. I didn't think anyone would do anything at this point, I just wanted to be heard. And, then I spoke to Miguel. I want to say that this is an exceptional human being. It is quite obvious. He took my state of stress, and disarmed me, so that after talking with him, I had a sense of relief just because of how he handled me. He didn't make any promises, but he fully listened to my story with true empathy and compassion and told me that he would personally bring this to the attention of his director (I'm assuming you) and at least it would be heard. This was the first person (actually aside from Rosalie and Lisa in patient care who really cared and referred me to Miguel!) that I felt was in service to patients. He also assured me that he would follow up with a phone call (and not an impersonal letter or no response, which had also happened to me in the past). Regardless of the outcome (which I have to tell you I am of course extremely happy and grateful for), Miguel is a person in your organization who has incredible value. He knows how to talk to people, cares for them individually, with high emotional intelligence, and I am going to make an educated guess that this translates to many other areas in the workplace and his life. He is a really good person.

I was blessed and lucky to have his personal attention and hope this serves to demonstrate how one caring individual can not only make a difference but also represent an entire organization to look like it is a compassionate, holistic place.

I want to thank you again and Miguel. If I were there in person, I would give you both the warmest hugs and a big bouquet of flowers.

You helped to relieve a tremendous amount of stress from a situation that was reaching boiling point.

I am happy to ever be a testament to how well I was treated at El Camino Hospital and by Miguel. Thank you again, for your caring and attention. I wish you both the very best.

Sincerely,

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY20 Pacing Plan

FY2020 Q1		
JULY 2019	AUGUST 5, 2019	SEPTEMBER 9, 2019
<p>No Board or Committee Meetings</p> <p>Routine Consent Calendar Items:</p> <ul style="list-style-type: none"> ▪ Approval of Minutes ▪ Patient Story ▪ Progress Against FY 2020 Committee Goals ▪ FY20 Pacing Plan ▪ Med Staff Quality Council Minutes 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items</p> <ol style="list-style-type: none"> 1. FY19 Quality Dashboard Results (Includes FY19 Org. Incentive Goals) 2. LEAN Progress Report 3. Q4 FY19 Quarterly Quality and Safety Review 4. Physician Engagement 5. Committee Recruitment (If needed) 6. Who makes up census 7. draft Board-level QC reporting 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda items:</p> <ol style="list-style-type: none"> 7. Update on Patient and Family Centered Care 8. Recommend FY20 Organizational Goal Metrics 9. Annual Patient Safety Report 10. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals) 11. Pt. Experience (HCAHPS) 12. ED Pt. Satisfaction (Press Ganey)
FY2020 Q2		
OCTOBER 7, 2019	NOVEMBER 4, 2019	DECEMBER 2, 2019
<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Report on Medical Staff Peer Review Process 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. CDI Dashboard 2. Core Measures 3. Safety Report for the Environment of Care 4. Q1 FY20 Quarterly Quality and Safety Review 5. Performance Improvement with Physician Management 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda items:</p> <ol style="list-style-type: none"> 1. Update on Patient and Family Centered Care 2. Readmission Dashboard 3. PSI-90 Pt. Safety Indicators

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY20 Pacing Plan

FY2020 Q3		
JANUARY 2020	FEBRUARY 3, 2020	MARCH 2, 2020
No Meeting	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 7. Q2 FY20 Quality and Safety Review 8. Update on Patient Care Experience 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. Proposed FY21 Committee Goals 2. Proposed FY21 Organizational Goals
FY2020 Q4		
APRIL 6, 2020	MAY 4, 2020	JUNE 1, 2020
<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. Value Based Purchasing Report 2. Pt. Experience (HCAHPS) 3. Approve FY21 Committee Goals 4. Proposed FY21 Committee Meeting Dates 5. Proposed FY21 Organizational Goals 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. CDI Dashboard 2. Core Measures 3. Approve FY21 Committee Goals (if needed) 4. Proposed FY21 Organizational Goals 5. Proposed FY21 Pacing Plan 6. Q3 FY20 Quality and Safety Review 	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. FY20 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed <p>Special Agenda Items:</p> <ol style="list-style-type: none"> 1. Update on Patient and Family Centered Care 2. Readmission Dashboard 3. PSI-90 Pt. Safety Indicators 4. Approve FY21 Pacing Plan 5. Leapfrog Survey

FY19 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**, 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	<ul style="list-style-type: none"> - FY18 Achievement and Metrics for FY19 (Q1 FY19) - FY20 Goals (Q3 – Q4) 	Review management proposals; provide feedback and make recommendations to the Board – reviewed FY18 results on 9/5/18; FY20 goals review paced for 5/6/19
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	<ul style="list-style-type: none"> - Receive update on implementation of peer review process changes (FY20) N/A - Review Medical Staff credentialing process (FY19) – COMPLETE - reviewed at 10/1/2018 meeting
3. Review Quality, Patient Care and Patient Experience reports and dashboards	<ul style="list-style-type: none"> - FY19 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 timeline – on track
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – paced quarterly
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals – on the FY19 dashboard

SUBMITTED BY:

Chair: David Reeder

Executive Sponsor: Mark Adams, MD, CMO

Approved by the El Camino Hospital Board on June 13, 2018

Hospital Update

June 3, 2019

Mark Adams, MD, CMO

Operations

To address recent high patient volumes, on April 15, 2019, a multi-disciplinary activation project team prepared the 10-bed unit on 3CW to become a flexible unit that can accommodate medical/surgical patients. Between April 15th and April 26th, the unit was open 9 days with an average daily census of 8 patients. The lack of available beds in the hospital has negatively impacted our Emergency Department throughput measures.

Information Services

We transitioned M*Modal voice recognition (talk to text) from the pilot phase and continues to be well received. Philips microphones are deployed throughout both hospitals and in all outpatient areas/clinics. We opened up training to all physicians, and are communicating via the Medical Staff Office and at MEC. Physicians now receive lab results on their mobile phone through a push notification on the mobile app from Epic called Haiku.

A new autonomous service robot was implemented in Los Gatos to assist with the delivery of medications, lab samples, and other critical items to support patient care. This endeavor required a very fast turnaround, taking less than three weeks from the initial discovery call to being installed, configured, and fully operational.

Push Text Notifications is now live in the ECH OR departments! For participating family & friends, text messages will be sent as the patient moves throughout different phases of care in the surgical suite. Epic OpTime will now automatically send messages as the patient advances through each peri-operative event such as when the patient's procedure has begun and the patient is out of the OR and is in the Recovery area. The nurses also have the ability to select a variety of preset messages to update family and friends.

MyChart enrollment continues to focus on the 50% patient enrollment goal with the following initiatives in process to increase patient enrollment and use. MyChart Scheduling for the Breast Health Center is now live! This allows patients to schedule their own appointments through the ECH MyCare web portal or through ECH MyCare mobile application with the aim to improve patient satisfaction. MyChart Bedside is live on 4 units (MCH, NICU, 3W, L/D) and the L/D unit was implemented last week. The 5th Unit (4A) is planned for go live in June 2019. A new report is available which highlights ECH patients who have active MyChart accounts from ECH or referring Epic organizations who have received care at ECH and demonstrates an increased enrollment number over 46%.

Workforce



This week is Nurses Week (May 6-12). Many nursing celebrations will occur during the week culminating with an event this Friday evening when we will present awards and hear a presentation from a nationally known speaker, Rich Bluni, RN.

Finance

Our cost initiative for FY19 is \$2,200,000. As of April 15, 2019 we have implemented \$3,034,570.24 in savings and cost avoidance of \$124,642.98. El Camino Hospital prevailed in a property tax appeal related to the Los Gatos Campus resulting in a one-time payment of \$102,000 and annual savings of \$23,000.

Government and Community Relations

Brenda Taussig and I met with newly elected Santa County Supervisor Susan Ellenberg, who serves as the Vice Chair of the Health and Hospitals Committee, regarding El Camino services and our community benefit programs. The hospital hosted both the Sunnyvale and the Los Altos/Los Altos Hill's civic leadership programs where we presented information about district and hospital governance and services, mental health needs and programs, and community benefit. For the third year, ECH hosted a health career event for 60 high school sophomores in the Mountain View/Los Altos school district "AVID" program, which provides support for students who will be among the first in their families to attend college. ECH sponsored Caminar/Family & Children's Service's annual luncheon which featured an award-winning local author discussing youth addiction and mental health. It was attended by ECH staff and community leaders who were invited as guests.

Corporate and Community Health Services

We presented FY20 Community Benefit ("CB") grant proposals to the Community Benefit Advisory Council (CBAC) in April. The District received 59 grant applications (\$8.7M requested) and the Hospital received 61 applications (\$5.1M requested). The CBAC achieved consensus on recommendations which we will present to each Board at upcoming meetings.

320 community members attended the Chinese Health Initiative's seventh annual Health Fair where we screened 232 individuals for diabetes and 151 for hypertension. The South Asian Heart Center raised \$236,000 at its Scarlett Express Gala.

Philanthropy

As of March 31, 2019, El Camino Hospital Foundation has secured \$18,230,426 and many fundraising activities and events are scheduled for the remainder of the fiscal year.

FY19 ECH Medical Directorships

No.	ECH Directorships (including ECMA-Employed Physicians)	Campus
1	Behavioral Health Services	Enterprise
2	Behavioral Health Services Chemical Dependency & Addiction Services	MV
3	Behavioral Health Services Maternal Outreach Mood Services (MOMS)	MV
4	Behavioral Health Services Continuing Care Program	Enterprise
5	Behavioral Health Services Aspire Program	LG
6	Behavioral Health Services Brain Stimulation	MV
7	Inpatient Dialysis Svcs	MV
8	Critical Care Unit	MV
9	Critical Care Services	LG
10	Palliative Care	Enterprise
11	Gyn/Robotics Program	MV
12	Electrophysiology	MV
13	Heart & Vascular Institute	Enterprise
14	Cardiothoracic Surgery	MV
15	Heart Failure Program	MV
16	Wound Care Program	MV
17	Cardiac Rehabilitation	MV
18	Echocardiography Services	MV

FY19 ECH Medical Directorships

No.	ECH Directorships (including ECMA-Employed Physicians)	Campus
19	Vascular Surgery	Enterprise
20	Catheterization Laboratory	MV
21	South Asian Heart Center	MV
22	Emergency Medicine	MV
23	Emergency Medicine	LG
24	Cancer Program	Enterprise
25	(including Medical Oncology Outpatient Department & Infusion	MV
26	Radiation Oncology	MV
27	Obsetrical Services	Enterprise
28	OB Hospitalist Program	Enterprise
29	Radiology Services & Breast Center, including Radiation Safety Officer	Enterprise
30	Sleep Medicine	Enterprise
31	Stroke Program	Enterprise
32	Infection Control	Enterprise
33	NICU	MV
34	Level II NICU	LG
35	Men's Health Services	LG
36	Urology Services	Enterprise

FY19 ECH Medical Directorships

No.	ECH Directorships (including ECMA-Employed Physicians)	Campus
37	Interventional Pulmonology Program	MV
38	Pulmonary Rehabilitation	MV
39	Respiratory Care Services	MV
40	Respiratory Therapy & Pulmonary Function Laboratory	LG
41	Surgical Quality Improvement (NSQIP)	Enterprise
42	Bariatric Program	Enterprise
43	Rehabilitation Services	MV
44	Anatomic Pathology & Laboratory Medicine	Enterprise
45	Utilization & Resource Management	MV
46	Endoscopy Program	Enterprise
47	Quality and Physician Services	Enterprise
48	Associate Chief Medical Officer- LG	LG
49	Anesthesiology Department	Enterprise

**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: June 3, 2019
Subject: Report on Board Actions

Purpose:

To keep the Committee informed with regards to actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. **Situation:** It is important to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive, but 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 Quality Committee Meeting the Hospital Board has met once and the District Board has met twice. In addition, the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee. Going forward, those approvals will also be noted in this report.

A. ECH Board Actions

May 8, 2019

- Approved Resolution 2019-06 acknowledging the Stroke Team for receiving Thrombectomy Capable Stroke Center Designation from The Joint Commission
- Elected Board Officers for Two-Year Term effective July 1, 2019
 - o Lanhee Chen, Board Chair
 - o John Zoglin, Vice Chair
 - o Julia Miller Secretary/Treasurer
- Approved Revised Executive Incentive Plan Policy

B. ECHD Board Actions

May 20, 2019

- Added Jeffrey Davis to list of Board Candidates to be interviewed

May 21, 2019

- Reviewed Community Benefit Advisory Council's FY2020 Grant Funding Recommendations

Report on Board Actions
June 3, 2019

- Elected Jack Po, MD, to a 3-year term on the El Camino Hospital Board expiring on June 30, 2022.
- Elected Don Watters to fill a vacancy on the El Camino Hospital Board created by Neysa Fligor's departure. That term expires on December 4, 2020.

C. Finance Committee and Compliance and Audit Committee: None since last report

D. Executive Compensation Committee Actions: None since last report

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None

**EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO**

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: June 3, 2019
Subject: FY 19 Quality Dashboard

Recommendation(s):

Summary:

- Provide the Committee with a snapshot of the FY19 metrics monthly with trends over time and compared to the actual results from FY2018 and the FY 2019 goals.
- Annotation is provided to explain actions taken affecting each metric.
- Committee request to add a rolling 12-month average for each metric included.

1. 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.
2. Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2019 Quality, Efficiency and Service Goals.
3. Assessment:
4. Other Reviews:
5. Outcomes:

Suggested Committee Discussion Questions:

1. The Mortality and Readmission Index are both above target, reflecting March and February data.
2. Hospital-acquired Infections: Zero CAUTI and C. Diff infections for April 2019.
3. Sepsis Mortality metrics continue to be low.

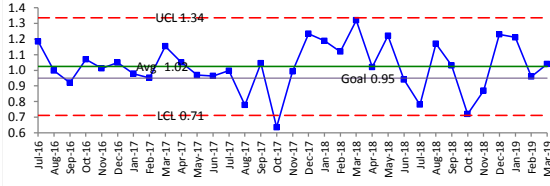
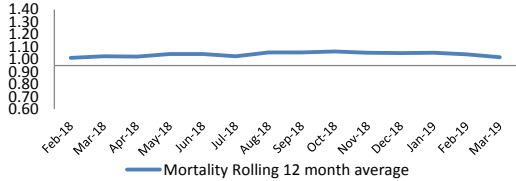
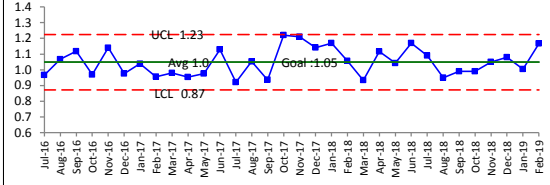
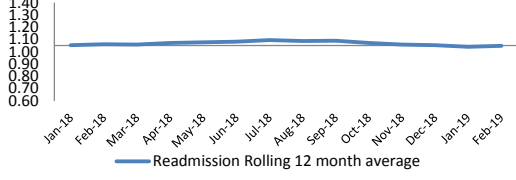
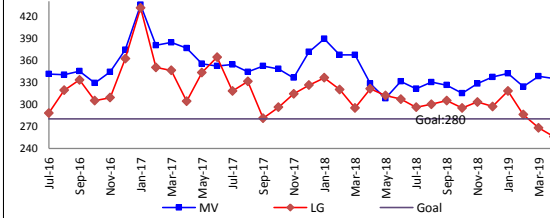
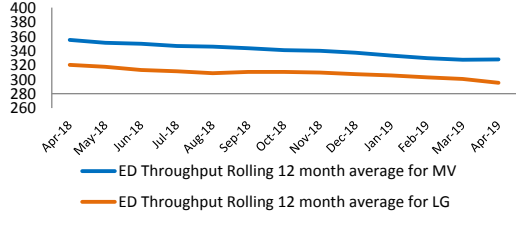
List of Attachments:

FY19 Quality Dashboard April data unless otherwise specified - final results

FY19 Organizational Goal and Quality Dashboard Update

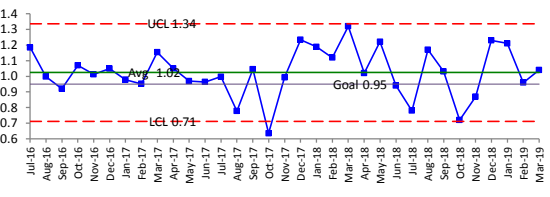
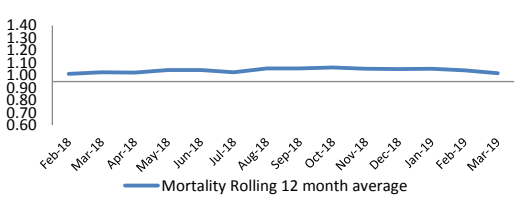
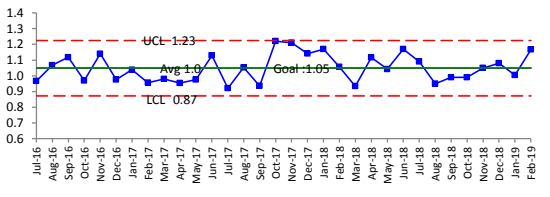
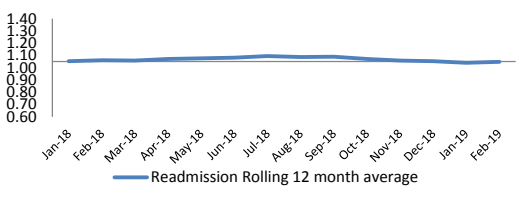
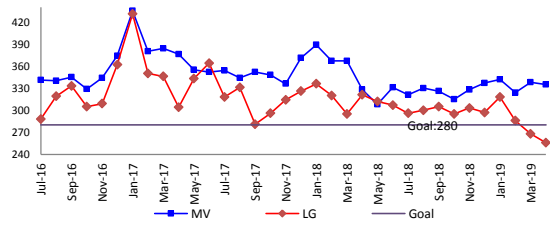
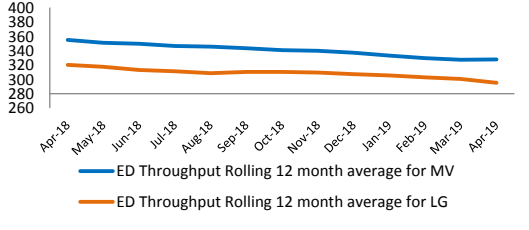
March 2019 (Unless otherwise specified)

Month to Board Quality Committee:
May, 2019

Quality		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
		Month	FYTD				
1	* Organizational Goal Mortality Index Observed/Expected Premier Standard Risk Calculation Mode Date Period: March 2019	1.04 (1.82%/1.75%)	1.01 (1.56%/1.55%)	1.05	0.95	 <p>UCL: 1.34 Avg: 1.02 Goal: 0.95 LCL: 0.71</p>	 <p>Mortality Rolling 12 month average</p>
2	* Organizational Goal Readmission Index (All Patient, All Cause Readmit) Observed/Expected Premier Standard Risk Calculation Mode Index month: February 2018	1.17 (9.39%/8.05%)	1.04 (7.48%/7.19%)	1.08	1.05	 <p>UCL: 1.23 Avg: 1.0 Goal: 1.05 LCL: 0.87</p>	 <p>Readmission Rolling 12 month average</p>
3	* Organizational Goal Patient Throughput-Median minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients) Date Period: April 2019	MV: 335 mins LG: 256 mins	MV: 328 mins LG: 292 mins	MV: 350 mins LG: 314 mins	280 mins	 <p>Goal: 280</p>	 <p>ED Throughput Rolling 12 month average for MV ED Throughput Rolling 12 month average for LG</p>

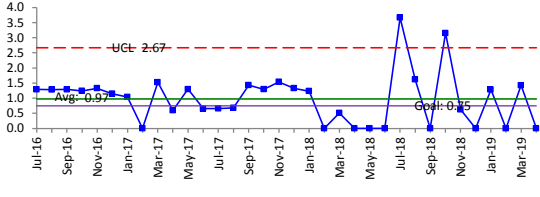
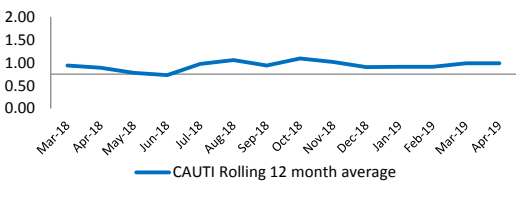
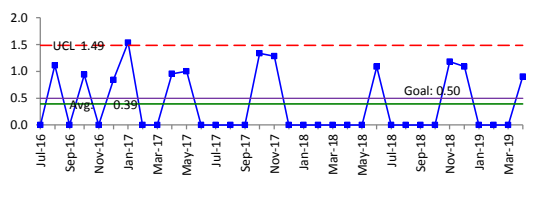
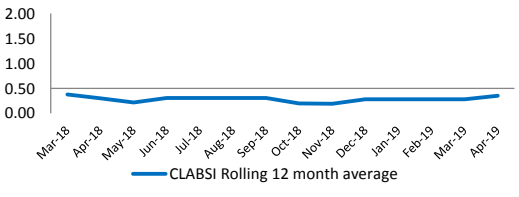
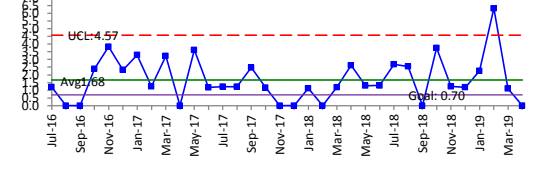
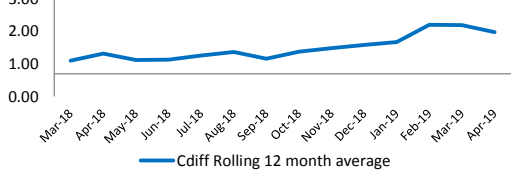
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Fewer in-hospital deaths than in January: 16 of 20 patients who died had DNR and Comfort Care orders at admission or with a week of admission. Expected ROM value higher than observed with better physician documentation of patient's co-morbidities and treatment.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor
Readmission Index (All Patient, All Cause Readmit) Observed/Expected	In Jan. fewer COPD readmits @ 8.33%, down from 16% in November. No readmits fro Pneumonia and low readmits for CHF (O/E 0.89%) and low for Total Joints @ 0.46 O/E. Weekly Readmit team reviewed 62 readmissions in January looking for preventable readmissions, issues with complications, or post-op infections, medication compliance, or social issues, with referrals as appropriate to medical staff peer review.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor
Patient Throughput-Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	In LG, the team has started to review daily delays for the various intervals to understand what barriers are slowing down flow. The nurses will step in and transport patients as needed. They are piloting a robot to help transport of lab specimens and are seeing an improvement in the frequency of times that the target for lab turn-arounds are met. They are also managing to the standard of nurse hand off to reduce phone tag. In MV, March volumes were higher, and there were many days were we didn't have enough of the right types of beds (i.e. PCU or tele). That led to a decision to create a flex unit on 3CW, which we could use for med/surg/tele or mother/baby as demand requires. The team was able to open up the unit the week of April 15 based on demand. A Capacity Management Center, pilot centralized bed mgmt, which started April 8th, to support managing flow across the hospital.	Cheryl Reinking, Michelle Gabriel; Heather Freeman				iCare Report: ECH ED Arrival to Floor

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
Quality		Month	FYTD				
1	* Organizational Goal Mortality Index Observed/Expected Premier Standard Risk Calculation Mode <i>Date Period: March 2019</i>	1.04 (1.82%/1.75%)	1.01 (1.56%/1.55%)	1.05	0.95		
	* Organizational Goal Readmission Index (All Patient, All Cause Readmit) Observed/Expected Premier Standard Risk Calculation Mode <i>Index month: February 2018</i>	1.17 (9.39%/8.05%)	1.04 (7.48%/7.19%)	1.08	1.05		
	* Organizational Goal Patient Throughput-Median minutes from ED Door to Patient Admitted <i>(excludes Behavioral Health Inpatients)</i> <i>Date Period: April 2019</i>	MV: 335 mins LG: 256 mins	MV: 328 mins LG: 292 mins	MV: 350 mins LG: 314 mins	280 mins		

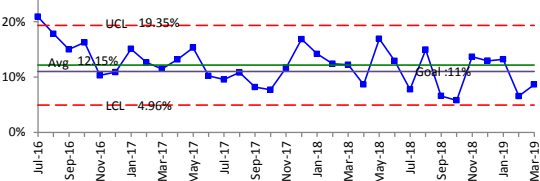
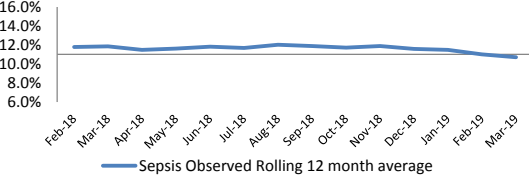
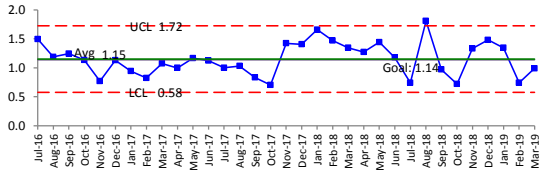
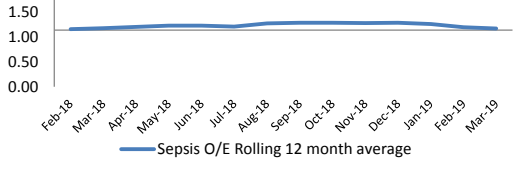
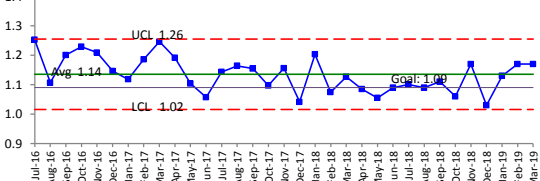
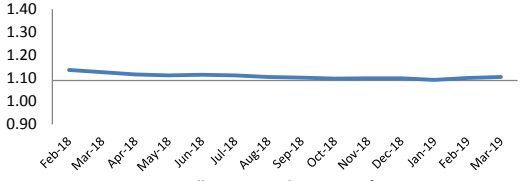
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Mortality Index is just above the expected value and increased slightly over February.	Catherine Carson			For the Trends graph: UCL and LCL are $2\pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor
Readmission Index (All Patient, All Cause Readmit) Observed/Expected	Readmission Index also increased in February. Weekly Readmission Review team found 67 Readmissions in February, with several due to UTI, medication side effects, and post-procedure infections. 10.5 % of these readmissions were sent for medical staff peer review due to complications.	Catherine Carson			For the Trends graph: UCL and LCL are $2\pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor
Patient Throughput-Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	<p>In Mountain View, the Capacity Management Center continues to help support throughput and identify barriers. 3CW (MCH overflow) has been opened as a med/surg unit during certain times as well when there has been a need for telemetry or med/surg overflow. The ED providers continue to have focus on the initial work up time. There has been improvement in discharge by noon which helps to create capacity for admits from the ED.</p> <p>In Los Gatos, the team continues to review barriers and partner with providers to understand when delays occur. The Relay Robot has been put into use to support transport of specimens to the lab to reduce variation in turn-around times. The ED RNs hand-off transfer of care in one call to the floor RNs. Floor RNs also proactively attempt to call the ED to get report.</p>	Cheryl Reinking, Michelle Gabriel; Heather Freeman				iCare Report: ECH ED Arrival to Floor

Quality		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	
Month		FYTD					
7	Hospital Acquired Infection (Infection rate) Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 urinary catheter days Date Period: April 2019	0.00 (0/1320)	1.13 (15/13256)	0.77	SIR Goal: ≤ 0.75		
8	Central Line Associated Blood Stream Infection (CLABSI) per 1,000 central line days Date Period: April 2019	0.90 (1/1110)	0.31 (3/9549)	0.28	SIR Goal: ≤ 0.50		
9	Clostridium Difficile Infection (CDI) per 10,000 patient days Date Period: April 2019	0.00 (0/8757)	2.07 (17/81953)	1.13	SIR Goal: ≤ 0.70		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Zero CAUTI's in April. Monthly A3 HAI Teams developing a checklist for nursing to assure a 2 RN insertion process.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIs were observed than predicted, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicted.	For the Trends graph: UCL and LCL are $2 \pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	1 CLABSI for April. Cancer patient with severe anemia admitted with Mediport in place. Infection developed after 6th hospital day and 6 of 10 hospital days with gaps in hygiene. Pt. refused baths.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIs were observed than predicted, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicted.	For the Trends graph: UCL and LCL are $2 \pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Zero C. Diff infections identified.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIs were observed than predicted, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicted.	For the Trends graph: UCL and LCL are $2 \pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_

	FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
	Month	FYTD				
10 Sepsis Mortality Observed Rate Enterprise, based on ICD-10 codes <i>Date Period: March 2019</i>	8.65%	10.05%	11.72%	11.00%		
11 Sepsis Mortality Index, based on ICD 10 codes (Observed over Expected) <i>Date Period: March 2019</i>	0.99 (8.65%/8.74%)	1.13	1.22	1.14		
Efficiency						
12 Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS) <i>(Medicare definition, MS-CC, Inpatient)</i> <i>Date Period: March 2019</i>	1.17	1.12	1.12	1.09		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Observed Rate Enterprise, based on ICD 10 codes	Sepsis mortality rate continues to be low, and the 12 month rolling average demonstrates a continued trend. The ED physician's goal and focus on ordering and giving antibiotics within the first hour of presentation may be contributing to improved survival. The addition of Bio Fire blood culture testing in late 2018 to provide a rapid identification of the organism leads to the selection of effective antibiotics at treatment onset which also may contribute to improve survival.	Catherine Carson			For the Trends graph: UCL and LCL are $2\pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Sepsis mortality index is below the expected value of 1.00 and well below the target goal.	Catherine Carson			For the Trends graph: UCL and LCL are $2\pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor
Arithmetic Observed LOS Average over Geometric LOS Expected (Medicare definition, MS-CC, Inpatient)	A LOS Committee meets weekly to review patients with long lengths of stay and to address identified barriers to discharge. The Committee reports over Jan-March, there were many patients with long lengths of stay with surgical and oncology diagnoses and were medically complex cases. Many of these patients remained at full codes status per patient and family requests when their prognosis was very poor.	Cheryl Reinking Catherine Carson (Cornel Delogramatic)		The Observed LOS over the Expected LOS Ratio is determined by calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient's MD-DRG.	For the Trends graph: UCL and LCL are $2\pm$ the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Premier Quality Advisor

FY19 Organizational Goal and Quality Dashboard Update

March 2019 (Unless otherwise specified)

Month to Board Quality Committee:
May, 2019

	FY19 Performance	HCAHPS Baseline Q4 2017 - Q3 2018	FY19 Target	Trend	Rolling 12 Months Average
Service	Month FYTD				
4 * Organizational Goal HCAHPS Nursing Communication Domain Top Box Rating of Always Date Period: April 2019	81.4 (201/247)	80.5 (2089/2596)	80.0		
5 * Organizational Goal HCAHPS Responsiveness of Staff Domain Top Box Rating of Always Date Period: April 2019	66.7 (161/241)	65.3 (1612/2468)	65.1		
6 * Organizational Goal HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always Date Period: April 2019	76.3 (187/245)	77 (1977/2568)	76.0		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	<ul style="list-style-type: none"> Continuing Care Team Coaching of staff Unit tours to encourage "Join the PPEPP Squad" with flyers distributed to the different units and door signs placed Assignment of HealthStream Module "Enhanced Interaction/PPEPP" to all nursing staff 	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are ± 1 the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Press Ganey Tool
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	<ul style="list-style-type: none"> Training all AS staff members on the standard work for call lights Implementing a sustainability plan for standard call light answering 	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are ± 1 the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Press Ganey Tool
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	<ul style="list-style-type: none"> Presenting all current and incoming EVS Staff with the new "EVS AIDET Scripting" training video Working with EVS to re-inforce EVS introductions and business cards 	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are ± 1 the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Press Ganey Tool



FY19 Organizational Goal and Quality Dashboard Update

April 2019 (Unless otherwise specified)

Month to Board Quality Committee:
June, 2019

	FY19 Performance		HCAHPS Baseline Q4 2017 - Q3 2018	FY19 Target	Trend	Rolling 12 Months Average
Service	Month	FYTD				
<p>4</p> <p><i>* Organizational Goal</i></p> <p>HCAHPS Nursing Communication Domain</p> <p>Top Box Rating of Always</p> <p>Date Period: April 2019</p>	81.4 (201/247)	80.5 (2089/2596)	80.0	81.0		<p>Communication Rolling 12 month average</p>
<p>5</p> <p><i>* Organizational Goal</i></p> <p>HCAHPS Responsiveness of Staff Domain</p> <p>Top Box Rating of Always</p> <p>Date Period: April 2019</p>	66.7 (161/241)	65.3 (1612/2468)	65.1	67.0		<p>Responsiveness Rolling 12 month average</p>
<p>6</p> <p><i>* Organizational Goal</i></p> <p>HCAHPS Cleanliness of Hospital Environment Question</p> <p>Top Box Rating of Always</p> <p>Date Period: April 2019</p>	76.3 (187/245)	77 (1977/2568)	74.5	76.0		<p>Cleanliness Rolling 12 month average</p>

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	<ul style="list-style-type: none"> Continuing Care Team Coaching of staff Unit tours to encourage "Join the PPEPP Squad" with flyers distributed to the different units and door signs placed Assignment of HealthStream Module "Enhanced Interaction/PPEPP" to all nursing staff 	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are ± 1 the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Press Ganey Tool
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	<ul style="list-style-type: none"> Training all AS staff members on the standard work for call lights Implementing a sustainability plan for standard call light answering 	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are ± 1 the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Press Ganey Tool
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	<ul style="list-style-type: none"> Presenting all current and incoming EVS Staff with the new "EVS AIDET Scripting" training video Working with EVS to re-inforce EVS introductions and business cards 	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are ± 1 the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Press Ganey Tool

Att. 06
- [PLACEHOLDER] –
FY20 QC DASHBOARD CONTENT

**This document is in process and will
be made available when ready.**

**You will receive notification when this
is added to the packet.**

**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality, Patient Care and
From: Catherine Nalesnik, R.N., Infection Prevention Director
Carol Kemper, M.D., Infection Prevention Medical Director
Date: June 3, 2019
Subject: Infection Prevention Plan and Annual Hand Hygiene Compliance Report

Purpose:

1. To obtain the Committee's recommendation that the Board approve El Camino Hospital's Annual Infection Prevention Plan
2. To inform the Committee of El Camino Hospital's FYTD 2019 Hand Hygiene Compliance.

Summary:

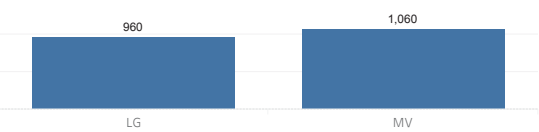
1. **Situation:** The Annual Infection Prevention Plan guides the work and actions of the Infection Prevention Committee of the Medical Staff and the Infection Prevention Department. Board.
2. **Authority:** An update to Infection Prevention Plan is required annually by the California Department of Public Health, the Santa Clara Valley Department of Public Health, and The Joint Commission. The plan includes an updated risk assessment regarding communicable diseases in the population served. As part of the Hand Hygiene Practices section of the Leapfrog Hospital Survey, hospitals are encouraged to report compliance and trends recognized regarding hand hygiene to hospital leaders and the Board.
3. **Background:** The primary function of the plan and department is to prevent transmission of infections agents among patients, staff, medical staff, and visitors. Strategies are developed each year to address issues with hospital-acquired infections, antimicrobial resistance, and the presence of infectious disease in the community that impacts the hospital, i.e. Clostridium difficile, Tuberculosis, Influenza, etc. Routine and expanded audits of hand hygiene compliance were initiated in FY 2018 as part of ECH's Quality Goal on reducing hospital-acquired infections. The work of sustaining the changes in FY 2018 continues in the HAI A3 Team that meets monthly to review these data and address trends and issues with hand hygiene.
4. **Assessment:** The Infection Prevention Plan reflects the community risks of infection.
5. **Other Reviews:** The Infection Prevention Plan was approved by ECH's Infection Prevention Committee, and is required reporting to the Board by Leapfrog. Hand Hygiene compliance data is routinely reported to the Patient and Employee Safety Committee. Each Nursing Unit receives monthly hand hygiene compliance data on their dashboard
6. **Outcomes:** N/A

List of Attachments:

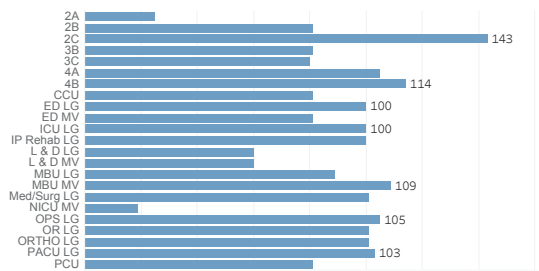
1. Infection Prevention Plan
2. Hand Hygiene Compliance Report

Suggested Committee Discussion Questions: None.

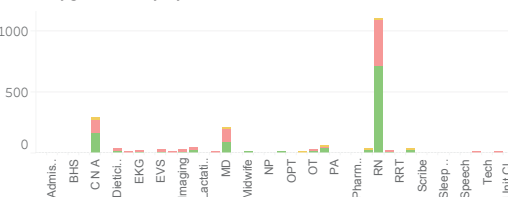
Total Audit



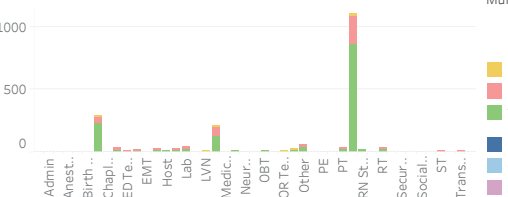
Total Audit by Unit



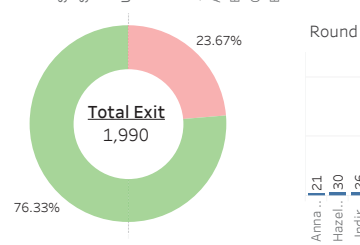
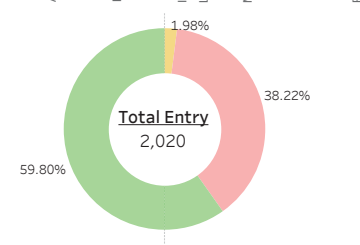
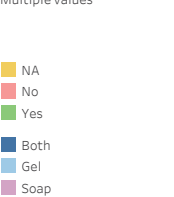
Hand Hygiene Entry by Role of Staff



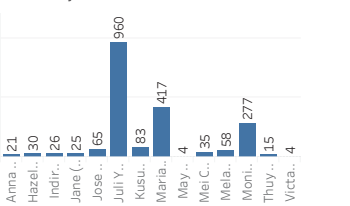
Hand Hygiene Exit by Role of Staff



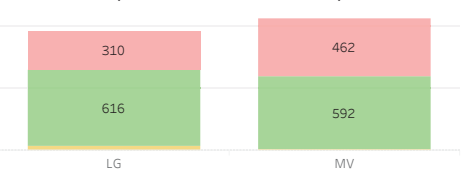
Month, Year of Rounded Date



Round By

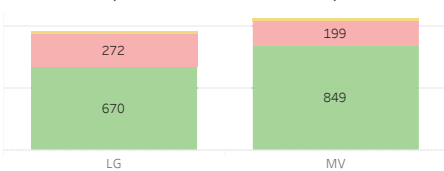


Wash Hand Upon Entry
(Include C.Diff and Isolation)



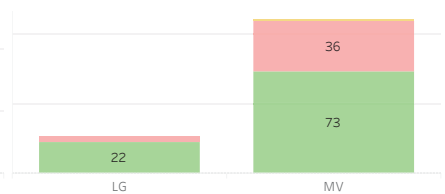
Location	Yes	No	NA
MV	592 (55.85%)	462 (43.58%)	6 (0.57%)
LG	616 (64.17%)	310 (32.29%)	34 (3.54%)
Grand Tot.	1,208 (59.80%)	772 (38.22%)	40 (1.98%)

Wash Hand Upon Exit
(Include C.Diff and Isolation)



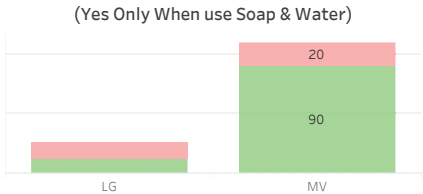
Location	Yes	No	NA
MV	849 (80.09%)	199 (18.77%)	12 (1.13%)
LG	670 (69.79%)	272 (28.33%)	18 (1.88%)
Grand T..	1,519 (75.20%)	471 (23.32%)	30 (1.49%)

C.Diff Entry

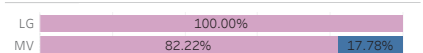
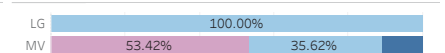
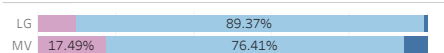
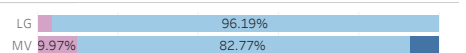


Location	Yes	No	NA
MV	73 (66.36%)	36 (32.73%)	1 (0.91%)
LG	22 (84.62%)	4 (15.38%)	
Grand T..	95 (69.85%)	40 (29.41%)	1 (0.74%)

C.Diff Exit
(Yes Only When use Soap & Water)



Location	Yes	No
MV	90 (81.82%)	20 (18.18%)
LG	13 (50.00%)	13 (50.00%)
Grand T..	103 (75.74%)	33 (24.26%)



TITLE: Infection Control – Infection Control Plan

CATEGORY: Infection Control

LAST APPROVAL: 3/2019

TYPE:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Policy | <input type="checkbox"/> Protocol | <input type="checkbox"/> Scope of Service/ADT |
| <input type="checkbox"/> Procedure | <input type="checkbox"/> Standardized Process/Procedure | <input checked="" type="checkbox"/> Plan |

SUB-CATEGORY: Infection Control Program

OFFICE OF ORIGIN: Infection Control

ORIGINAL DATE: 1/1996

I. COVERAGE:

All El Camino Hospital staff

II. PURPOSE:

- To plan, coordinate and monitor policies, procedures and practices related to the identification, control and prevention of hospital associated infections.
- To identify areas of improvement and appropriate changes in the plan that would increase the effectiveness of the infection prevention and control program.

III. STATEMENT:

The El Camino Hospital Infection Control and Prevention Plan is a comprehensive, dynamic document which is based on a risk assessment for acquiring and transmitting infections within the hospital environment.

The El Camino Hospital Infection Prevention & Control Program primary function is to prevent transmission of infectious agents among patients, staff and visitors. It is the goal of the Infection Prevention and Control Department to reduce infection and infectious risk through strategic plans for surveillance and control of healthcare-associated infection; to identify trends and patterns in antimicrobial resistance; to address epidemiologically important issues; and to advise hospital employees, departments and services in developing policies, procedures, and practices which reflect current infection control guidelines and standards of care.

Goals to reduce the possibility of transmitting infections will be set based upon the identified risks. The plan includes risk reduction strategies supported by evidence based guidelines and expert consensus. At least annually, and whenever risks significantly change, an evaluation of the effectiveness of the infection prevention and control plan will be completed. This evaluation will include a review of the prioritized risks, the goals, objectives, and the infection prevention strategies. The results of the evaluation will be used to make revisions to the plan. The revised plan will be communicated to the organization.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

Evaluation of the Infection Control Plan shall be done at least annually or upon changes in the scope of the Infection Control Program or changes in the risk analysis. Assessment of the prevention strategies will be based on their effectiveness at preventing and controlling infection. The Infection Prevention Department reports all communicable diseases to the Public Health Departments to help prevent spread of certain infections within the public at large.

The Infection Prevention and Control Plan evaluates the risk of communicable disease transmission based on the following:

- Santa Clara County geographic location and demographics
- Mountain View and Los Gatos demographics
- Santa Clara County Community health status assessment
- TB Risk Assessment: California and Community profiles
- Threats facing Santa Clara County

Santa Clara County Geographic Location and Demographics:

<https://www.census.gov/quickfacts/fact/table/santaclaracountycalifornia/PST045216>

With 1.9million residents, Santa Clara County is the sixth most populated of California's 58 counties and the most populated in the Bay Area. More than one-third (37%) of county residents are foreign-born. The largest percentage of foreign-born residents were born in Mexico (21%), followed by Vietnam (15%), India (13%), the Philippines (9%), and China, excluding Hong Kong and Taiwan (8%). Santa Clara County encompasses 1,312 square miles and runs the entire length of the County from north to south, ringed by the rolling hills of the Diablo Range on the east, and the Santa Cruz Mountains on the west. Salt marshes and wetlands lie in the northwestern part of the county, adjacent to the waters of San Francisco Bay. Nearly 92% of the population lives in cities. The local industry of the County of Santa Clara is dominated by the technology sector. The County has three main interstate highways; 280, 680, and 880, one U.S. Route (101), and the following CA State Routes; 9, 17, 82, 85, 87, 130, and 237. Airports include: Norman Y. Mineta International Airport, Moffett Federal Airfield, and three County airports: Reid Hillview, Palo Alto, and South County.

Mountain View Demographics:

<https://www.census.gov/quickfacts/fact/table/mountainviewcitycalifornia,santaclaracountycalifornia/>

The resident population of Mountain View is approximately 76,260. More than half the population is between 20 and 54, while nearly 25% is in the 25 to 34 year age bracket. The median age is 34.6 years old.

Los Gatos Demographics:

<https://www.homefacts.com/demographics/California/Santa-Clara-County/Los-Gatos.html>

TITLE: Infection Control – Infection Control Plan
CATEGORY: Infection Control
LAST APPROVAL: 3/2019

The resident population of Los Gatos is approximately 30,705. The median age resident is 45.4 years young. The largest racial/ethnic groups are White (73.8%) followed by Asian (14.5%) and Hispanic (6.3%)

Santa Clara County Community Health Status Assessment:

(Data: 2014 Santa Clara County Community Assessment Project Survey)

Access to Care	87% of adults have health insurance
Chronic Disease	8% of adults have diabetes. Heart disease: 22% of the death among county residents.
Overweight and Obesity	Over 50% of adults and over 33% of adolescents in the county are overweight or obese
HIV/ AIDS	Over 3342 adults in Santa Clara County are living with HIV (61% Sexual transmission; 33% unknown, 6% IV Drug use
Tobacco use	1 in 10 adults and 1 in 12 adolescents in the county smoke cigarettes

TB Risk Assessment: *(retrieved from Santa Clara County TB Control Report; based on CY 2016)*

California Overview

- CA reported 2056 new TB cases in 2017 compared to 2059 cases in 2016 California's annual TB incidence remained at 5.2 cases per 100,000 persons.
- More than 2 million Californians (6% of the population) are estimated to have LTBI which can progress to active TB without diagnosis and treatment.

COMMUNITY TB PROFILE

www.SCCPHD.ORG

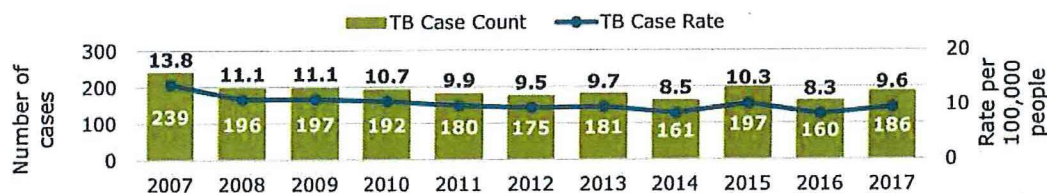
- Santa Clara County (SCC) has the third highest number of cases among all jurisdictions in California, after Los Angeles and San Diego counties.
- Santa Clara County (SCC) had 186 cases of active tuberculosis in 2017, which increased compared with 2016 (160 TB cases) and was similar compared with 2015 (197 TB cases).
- TB cases in SCC during 2017 occurred predominantly among Asian (84%) and Hispanic (11%) populations, with a small percentage in African-American/African-Ancestry (4%), White (1%), and Native Hawaiian or other Pacific Islander (1%) populations.
- This represents a case rate of 9.6 per 10,000 residents.
- The case rate is 1.8 times as high as the overall California rate (5.2/100,000 persons) and 2.9 times as high as the national rate (2.9 per 100,000 persons).

TITLE: Infection Control – Infection Control Plan

CATEGORY: Infection Control

LAST APPROVAL: 3/2019

Figure 1: Trends in TB Case Counts and Rates in Santa Clara County, 2007-2017



Cases meet the laboratory (positive culture, nucleic acid amplification test, or demonstration of acid-fast bacilli or granulomas when a culture was not obtained or is falsely negative), or clinical case definition, or are verified by provider diagnosis.

Source: Santa Clara County Public Health Department, Tuberculosis Information Management System, 2007-2009; California Reportable Disease Information Exchange, 2010-2017. Data as of February 12, 2018, and are provisional; Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2010, Sacramento, California, September 2012; State of California, Department of Finance, E-2. California County Population Estimates and Components of Change by Year — July 1, 2010-2017. Sacramento, California, December 2017.

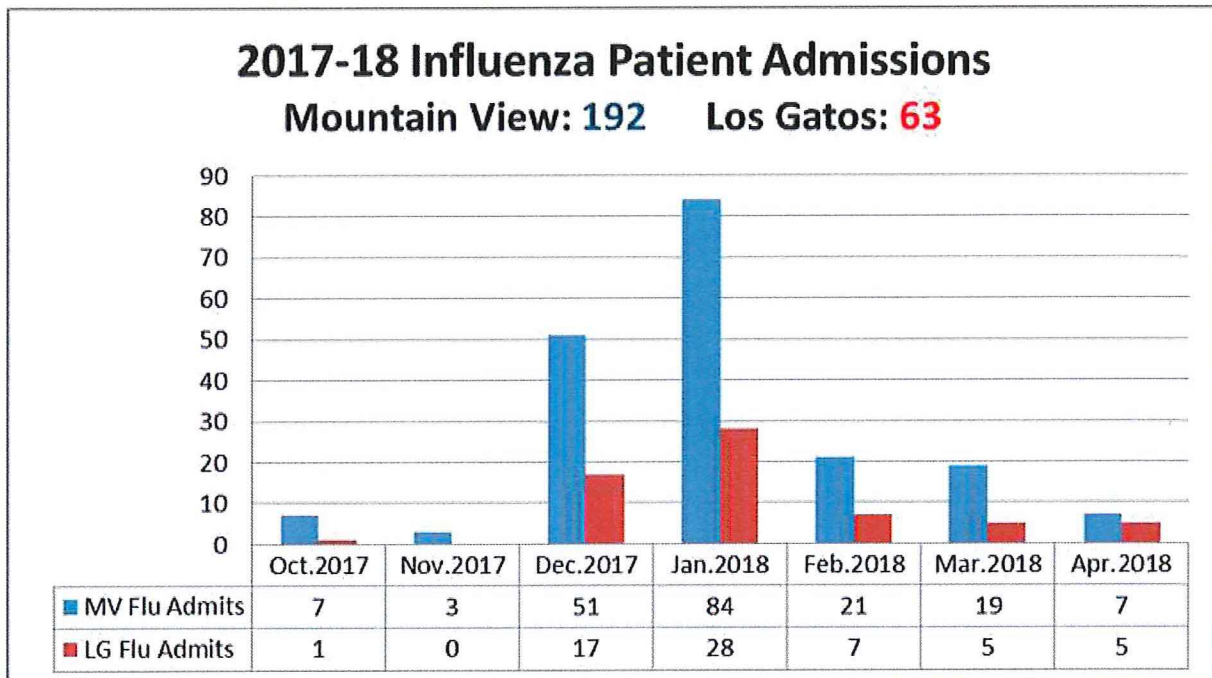
El Camino TB Profile : Medium Risk Facility

In 2017, ECH MV had 23 total cases with 10 INPATIENT and 13 OUTPATIENTS which is an increase from 13 cases in 2016. El Camino Mountain View is considered a medium risk facility for TB based on a community rate of infection.

Year	Total Patients	In Patient	Out Patient	Pulmonary	Extra-pulmonary
2017	23	10	13	18	5
2016	13	7	6	11	2
2015	25	13	12	22	3
2014	16	9	7	9	7
2013	10	6	4	8	2
2012	18	4	14	16	2
2011	12	8	4	7	5
2010	6	3	3	3	3

TITLE: Infection Control – Infection Control Plan
CATEGORY: Infection Control
LAST APPROVAL: 3/2019

Seasonal Influenza Activity: 2017 – 2018 Influenza Season



Threats facing Santa Clara County:

1. Major Earthquake

The Operational Area is in the vicinity of several known active and potentially active earthquake faults including the San Andreas, Hayward, and Calaveras faults.

Two major local earthquakes that have impacted the County include:

- The San Francisco Earthquake (1906), magnitude 7.8, approximately 3000 fatalities
- The Loma Prieta Earthquake (1989), magnitude of 6.9, 63 fatalities.

Other significant local earthquakes near or within the County include:

- The Concord Earthquake (1955), magnitude 5.4, 1 fatality
- The Daly City Earthquake (1957), magnitude 5.3, 1 fatality
- The Morgan Hill Earthquake (1984), magnitude 6.2, no fatalities
- The Alum Rock Earthquake (2007), magnitude 5.6, no fatalities.

2. Wild land Urban/Interface Fire

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.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

The months of August, September and October have the greatest potential for wild land fires as vegetation dries out, humidity levels fall, and off shore winds blow.

3. Hazardous Material Incident

There are four major highways in the county that carry large quantities of hazardous materials: U.S. 101, I-880, and I-680, and I-280. Truck, rail, and pipeline transfer facilities are concentrated in this region, and are involved in considerable handling of hazardous materials.

4. Flood

There are approximately 700 miles of creeks and rivers in the County, all of which are susceptible to flooding. An Emergency Action Plan exists for the Anderson Dam and a general Dam Plan exists which includes other dams within Santa Clara County. These plans are maintained by the Santa Clara Valley Water District.

5. Landslide

For Santa Clara, the hillside areas in the Los Gatos areas have the greatest potential for economic loss due to landslides. The winters of 1982, 1983, 1986, and 1996/1997 provided a reminder of the degree of hazard from landslides in Santa Clara County

IV. PROCEDURE:

A. Objectives

1. Maintain Enterprise Central Line Associated Bloodstream Infection (CLABSI) rate below Standardized Infection Ratio (SIR) $SIR < 0.50$ with a goal of "0" CLABSI's.
2. Maintain Neonatal Intensive Care Unit (NICU) CLABSI rate below $SIR < 0.50$ with a goal of "0" CLABSI's
3. Achieve 95% bundle compliance rate with Central Line Insertion Practice (CLIP) organization-wide.
4. Maintain Enterprise hospital onset *Clostridium difficile* Rate below Standardized Infection Ratio (SIR) ≤ 0.70
5. Maintain Enterprise hospital onset Methicillin Resistant *Staphylococcus aureus* (MRSA) infection rate to ≤ 0.70 /10,000 patient days.
6. Maintain Enterprise MRSA screening compliance rate to 91% or more.

TITLE: Infection Control – Infection Control Plan

CATEGORY: Infection Control

LAST APPROVAL: 3/2019

-
7. Maintain Enterprise hospital onset Multi- Drug Resistant Gram Negative Rods (MDRGNR) infection rate to $\leq 0.5 / 10,000$ patient days.
 8. Maintain Coronary Artery Bypass Graft (CABG) SSI rate at or below NHSN Rates/Risk of SIR <1.00 (MV campus).
 9. Maintain Total Knee Surgical Site Infection rate at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).
 10. Maintain Total Hip Surgical Site Infection rate to at or below NHSN Rates/Risk of SIR <1.0 . (MV and LG campus).
 11. Maintain laminectomy surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).
 12. Maintain spinal fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).
 13. Maintain spinal re-fusion surgical site infection rate to at or below NHSN Rates/Risk of SIR <1.00 (MV and LG campus).
 14. Maintain hand hygiene compliance at $\geq 95\%$.
 15. Maintain Personal Protective Equipment (PPE) compliance at $\geq 95\%$.
 16. Maintain Enterprise Catheter Associated Urinary Tract Infection Rate below Standardized Infection Ratio (SIR) ≤ 0.75
 17. Flu Vaccination rate: Maintain Enterprise Vaccination Rate of __LG: 96%/MV: 90%

B. Goals

1. Recommend methods for early identification of infections using epidemiological and scientific methodologies.
2. Analyze practices that have the potential to affect hospital onset infection rates and recommend changes.
3. Provide advice and consultation as appropriate to other departments including but not limited to: Nursing, Employee Wellness and Health Services, Clinical Laboratory,

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

Environmental Services, Sterile Processing Department and Safety/Emergency Management.

4. Monitor compliance with hospital regulatory reporting requirements to various public health agencies, National Healthcare Safety Network (NHSN), California Department of Public Health (CDPH), Santa Clara County Public Health Department (SCCPHD), Santa Clara County TB Control, Centers for Medicare and Medicaid Services (CMS) Hospital Inpatient Quality (IQR).
5. Coordinate monitoring and surveillance activities for targeted infections and microorganisms selected by Infection Control Committee based on annual Risk Assessment monitor infection control practices of healthcare workers. Provide feedback and education with recommendations for improvement.
6. Provide guidelines on infection prevention and control and how to reduce the spread of infections at the general hospital orientation in for all employees.
7. Review and revise infection control policies every three years, or as needed.
8. Recognize and maintain an awareness and working knowledge of guidelines and recommendations that are published by Centers for Disease Control, Occupational Safety and Health Administration, The Joint Commission, Association of perioperative Registered Nurses (AORN), Society for Healthcare Epidemiology of America (SHEA) and the Association of Professionals in Infection Control and Epidemiology (APIC) that impact infection control. Maintain and enhance own knowledge of infection control and epidemiology.
9. Provide liaison activities with community health care providers that impact our ability to control communicable diseases. Continue to expand infection control role over the continuum of care with the assistance of Public Health Department.
10. Provide input and education on infection control issues related to construction and renovation within the hospital. Perform infection control risk assessment prior to start of construction projects and monitor construction sites for compliance with infection control practices.

C. Infection Prevention and Control Program and the Infection Control Committee (ICC)

1. The responsibility for monitoring the Infection Prevention and Control Program is invested in the Infection Control Committee (ICC). The Infection Control (IC) Medical Director has the

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

authority to institute any appropriate control measures or studies when a situation is reasonably felt to be a danger to any patient, Healthcare Worker (HCW) or visitor, or in the event of an infection control crisis situation (The committee functions as the central decision and policymaking body for infection control). The Infection Control Committee shall meet not less than quarterly.

2. The ICC shall be a multi-disciplinary committee consisting of representatives from at least the Clinical Laboratory, Quality Department administration, Sterile Processing Department, Perioperative services, Nutrition Services, Environmental Services, Employee Wellness and Health and the Infection Prevention Nurses. The Chairman is the Infection Control Medical Director, a physician with knowledge of and special interest in infectious disease. Representatives from key hospital departments such as but not limited to Facilities Services, Pharmacy, and shall be available on a consultative basis when necessary.
3. The Infection Prevention and Control Department will collaborate with the ICC in developing a hospital-wide program and maintain surveillance over the program.
4. The Infection Prevention and Control Department in collaboration with the ICC shall develop a system for reporting, identifying and analyzing the incidence and cause of all hospital onset infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
5. The Infection Prevention and Control Department in collaboration with the ICC shall develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating isolation precautions and cleaning and disinfection techniques. Such techniques shall be defined in written policies and procedures.
6. The Infection Prevention and Control Department shall develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.
7. The Infection Prevention and Control Department will collaborate with the ICC to identify new indicators and thresholds of diseases, recommend and assess corrective measures based upon the analysis of relevant data, and communicate its findings and interventions to the appropriate departments.
8. The Infection Control Medical Director of the Infection Control Committee is responsible for medical direction and decisions as required for the review, analysis and presentation of data to the Medical Staff.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

9. The committee minutes shall be reviewed by the Medical Executive Committee.

D. Infection Prevention Department

1. The Director of Infection Prevention is responsible for the development, implementation, and evaluation of the infection prevention performance improvement activities, ensuring that they are based upon accurate data collection, analysis, and interpretation.
2. Provides input and assistance in the revision, updating and formulation of policies and procedures related to infection prevention and control.
3. Identifies possible trends and risks of disease transmission through ongoing surveillance process.
4. Participates with members of Infection Control Committee to provide solutions to potential infection control problems.
5. Communicates potential infection control risks to appropriate departments either verbally or through written report.
6. Notifies the Santa Clara County Public Health Department, The Santa Clara County TB Control Department and the California Department of Public Health, either verbally or by written communication for mandatory disease reporting.
7. Provides education for all staff, patients and families regarding infection prevention and control principles that reduce the spread of disease.
8. Acts as consultant in the management of patient's infection problem while in the hospital or upon discharge.

E. Scope of Services

1. The infection control program is divided into functional groups of routine activities that address the integrated facets of surveillance and prevention of infections, monitoring and evaluation, epidemiological investigation, risk reduction, consultation and education.
2. Hospital Onset Infection Surveillance and Prevention

TITLE: Infection Control – Infection Control Plan
CATEGORY: Infection Control
LAST APPROVAL: 3/2019

- a. For the purpose of surveillance, hospital onset infections shall be clinically active infections occurring in hospitalized patients in whom the infection was not present or incubating at the time of admission.
- b. Infections with endogenous organisms of the patient and those organisms transmitted either by healthcare workers or indirectly by a contaminated environment shall be included. Some hospital onset infections are potentially preventable-while others may be considered inevitable.
- c. Strict criteria shall be used for assessment in regard to targeted hospital onset infections. Not all hospital onset infections in the hospital shall be counted and presented for statistical analysis. The type of data collection to be used and analyzed shall be determined by the Infection Control Committee (ICC) based upon the annual Risk Assessment.
- d. The criteria written by the Center for Disease Control and Prevention (CDC) shall be used when calculating infection rates for statistical analysis.

F. General Surveillance Activities

1. Active infection surveillance within the hospital shall be an ongoing observation of the occurrence and distribution of disease or disease potential and of the conditions that increase or decrease the risk of disease transmission.
 - a. The surveillance of patients, staff and environment shall ensure appropriate patient placement, initiation of appropriate isolation or special precautions, identification of patient care problems associated with hospital infection control, prevention of targeted hospital onset infections in high risk, high volume procedures, facilitation of data collection for selected quality indicators and the collection of required information for reporting to the Public Health Department.
 - b. Daily laboratory reports, utilization review reports and verbal communications with staff shall be reviewed routinely by the Infection Prevention Nurses. Surveillance shall be a blend of routine physical presence in all areas of the facility and the use of clinical and laboratory computer information systems.
 - c. The amount of time spent on infection surveillance, control and prevention activities is based upon the following:
 - Acute Care Hospital Services:
El Camino Hospital is a General Acute Care Community hospital with 2 campuses serving Santa Clara County, a large urban area in Northern California.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

- Licensed beds:
 - El Camino Hospital Mountain View:**
 - 275 General Acute Care
 - 44 Perinatal Services
 - 24 Intensive Care
 - 20 Intensive Care Newborn Nursery
 - 7 Pediatric Services
 - 180 Unspecified General Acute Care
 - 25 Acute Psychiatric
 - El Camino Hospital Los Gatos:**
 - 143 General Acute Care
 - 30 Rehabilitation Center
 - 14 Perinatal Services
 - 8 Coronary Care
 - 7 Intensive Care
 - 2 Intensive Care Newborn Nursery
 - 82 Unspecified General Acute Care
- Patient Population: Various ages, ethnic, socio-economic backgrounds
- Risk factors of the population: Infectious agents related to the population
 1. Tuberculosis
 2. Methicillin resistant Staph aureus (MRSA)
 3. Carbapenem-resistant enterobacteriaceae (CRE)
 4. Extended spectrum beta-lactamase (ESBL)
 5. Multi-Drug Resistant Gram Negative Rods (MDRGNRs)
 6. *Clostridium difficile*
- Complexity of the services provided:
 1. Basic Emergency Medical Services
 2. Behavioral Health
 3. Cardiac Catheterization Lab
 4. Cardiovascular Surgery
 5. Critical Care- adult and NICU
 6. Dialysis-inpatient
 7. General Surgery (including Bariatrics)
 8. Infusion Center (outpatient)
 9. Medical / Surgical

TITLE: Infection Control – Infection Control Plan
CATEGORY: Infection Control
LAST APPROVAL: 3/2019

10. Oncology – inpatient and outpatient
11. Nuclear medicine, radiology, diagnostic imaging
12. Radiation oncology (outpatient)
13. Rehabilitation Services
- 14.

G. The selection of clinical indicators is determined by the Infection Control Committee and is based upon the assessment of problem prone, high risk/high volume services provided. Results of these measures are reported in rates rather than raw numbers using valid epidemiological methods. Results are evaluated annually using data trend analysis generated by surveillance activities during the year and shall reflect changes in the hospital's assessed needs.

1. Surgical Site Infection Surveillance
2. Specific surgical site infection surveillance in accordance with California Department of Public Health Senate Bill 1058 requirements shall be monitored and reported to NHSN on a monthly basis. Surveillance activities include: daily census review of admission diagnosis, daily review of positive cultures, daily review of surgical list, notification from peri-operative staff of potential SSI cases requiring repeat surgical procedures and Review of Electronic Medical Record list of potential patients with SSIs based on post-operative ICD-10 diagnostic flag codes. .
3. Targeted "high-risk" surgical procedures are monitored for surgical site infections and results are reported quarterly to the Infection Control Committee.

H. Targeted Surveillance Indicators for upcoming Calendar Year based upon the annual evaluation of the IC plan:

1. Monitor targeted hospital and community onset infections and specific organisms as determined by the annual Risk Assessment.
2. Surveillance for FY 2019:
 - a. Surgical site infections of all surgical procedures including high-risk procedures: Total knee, total hip, laminectomy, fusion, refusion and CABG procedures.
 - b. Marker organisms: MRSA, *C. difficile*, CRE and MDR GNRs
 - c. Blood Stream Infections related to central lines hospital-wide
 - d. Foley catheter related Urinary Tract Infections hospital-wide
3. Active disease surveillance at both campuses

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

-
- a. Daily surveillance of MRSA, C difficile, Multi-Drug Resistant Organisms (MDRO), Tuberculosis, & other communicable diseases
 - b. Active surveillance of Surgical Site Infections (SSI), Central Line-Associated Blood Stream Infection (CLA-BSI), Catheter-Associated UTI (CA-UTI)
 - c. Carbapenem Resistant Enterobacteriaceae (CRE) surveillance (patients hospitalized outside the U.S. within 1 year, admissions from skilled nursing facilities with patients identified with CRE)
 - d. Perform review and Tracking: for mold-related organisms in construction areas
 - e. Daily surveillance of patients admitted with influenza during seasonal influenza period (October – April).
 - f. Specialized response to exposure & outbreaks
- I. Diff Prevention Strategy Plan:** Use Clostridium rates as quality indicators to evaluate the effectiveness of compliance with transmission-based precautions and cleaning and decontamination protocols. Goal is to reduce hospital onset infections of C. difficile.
1. Do: (1) Determine number of new C. difficile cases per 10,000 patient days. (2) Track daily C.diff patients by room location.
 2. Study: Review and analyze data on a quarterly basis to identify trends and potential high-risk areas.
 3. Act: (Clostridium difficile) – Staff to cleanse hands of patients with soap and water before each meal. Place patient on Contact Precautions. Provide education to patient and family on Clostridium difficile infection. Bathe patient daily. Change linens daily or when soiled. Clean/disinfect patient room with bleach product and UVC (ultraviolet disinfection) upon transfer/ discharge or clearance. Provide education to staff, physicians, patients, and families
- J. Data Collection Methods**
1. All identified cases related to targeted infections and communicable diseases will be maintained in a database. Specific methods used by infection control to obtain surveillance data include daily lab reports, patient census reports, daily serological reports, patient charts, referred cases from case managers and verbal communication with staff and physicians.
 2. Surveillance shall be a blend of routine physical presence in all area of the facility and use of clinical and laboratory computer information systems.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

K. Investigation of Disease Clusters (Outbreak Control)

1. The Infection Control Medical Director in coordination with the Director of Infection Control shall have ultimate authority and responsibility for investigating epidemic/outbreak situations and implementing appropriate interventions in order to prevent and to control further disease and to identify factors that contributed to the outbreak. (See Infection Control Procedure Outbreak Investigation).

L. Reporting to Outside Agencies

1. Specified communicable diseases (in accordance with Title 17, California Code of Regulation) identified at El Camino Hospital shall be reported to the Santa Clara Department of Public Health (SCDPH) in the required timelines to prevent the spread of certain communicable diseases to the public at large. (See Infection Control Procedure on Communicable Disease Reporting).
2. El Camino Hospital shall provide follow-up management for pre-hospital caregivers who may have been exposed to a communicable disease during the performance of their duties and reporting of these exposures to the proper authorities. (See Infection Control Procedure Pre-hospital Communicable Disease Exposure).
3. El Camino Hospital shall report to NHSN the following:
 - a. Hospital Onset and community onset MRSA BSI's
 - b. Hospital Onset and community onset VRE BSI's
 - c. Hospital Onset and community onset CRE-Klebsiella BSI's
 - d. All Hospital cases of *Clostridium difficile* infections
 - e. Hospital wide CLABSI's
 - f. Hospital Wide CAUTI's
 - g. Number of Operative procedures identified by CDPH as consistent with meeting the requirements of Health and Safety Code (HSC) Section 1288.55 for reporting SSI's.
 - h. All Healthcare associated Surgical Site infections of deep incisional or organ space surgical sites, healthcare associated infections of orthopedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated as outlined in HSC 128.55.

M. Education

1. Orientation for all hospital employees shall include general information on potential infection risks, transmission routes, and infection prevention measures, proper hand hygiene, isolation precautions, and environmental cleaning and disinfection.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

2. Annual review of infection control principles shall be done through a computer-based learning system (Health Stream) and tracked by the Education Department.
3. Department specific education shall be done as deemed necessary by the Infection Control Medical Director and/or the Infection Prevention Nurses, working in conjunction with department managers.
4. Training material in all areas of education shall be kept current and conform to current information pertaining to the prevention and control of infectious diseases. Infection Control Nurses shall attend annual hospital-funded continuing education programs to maintain current in principles of Infection Prevention and Control and epidemiology.
5. Quarterly In-service presentations are provided to the Infection Control Resource Groups (ICRG). The ICRG is comprised of staff members from all nursing departments and ancillary departments (Lab, RT, etc.).

**N. ECH Infection Prevention and Management
Infection Control Committee Involvement– FY 2018**

1. The Infection Prevention Nurses are active members of the following committees:
 - a. Hospital Acquired Infection (HAI) CAUTI Reduction Task Force
 - b. HAI CLABSI Reduction Taskforce
 - c. HAI C.diff Reduction Taskforce
 - d. SSI Reduction Task Force: Enterprise Los Gatos and Mountain View
 - e. Critical Care Committee
 - f. Antibiotic Stewardship
 - g. Emergency Management
 - h. Clinical Microbiology Lab, Pharmacy and IC Committee
 - i. Value Analysis

O. Research

1. Research and investigate unusual cases, infections, or issues pertaining to Infection Control through ongoing literature review and web-based search activities.
2. Identify and report unusual cases, infections, or trends at scientific meetings or in the medical literature.

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

-
3. Participate in any regional or national Infection Control projects as is feasible and appropriate.
 4. Participate in government- or pharmaceutically-sponsored clinical research projects pertaining to Infection Control as feasible and appropriate.
 5. Identify opportunities for independent directed clinical research and focused projects within the hospital and surrounding facilities as feasible and appropriate.
 6. Lend knowledge and practical support to other departments or units participating in clinical research studies including but not limited to the Microbiology Laboratory, Employee Health Services, Pharmacy Services, and Patient Care Services.

P. Liaison

1. Provide ongoing expert advice and consultation as appropriate to other departments including but not limited to Microbiology Laboratory, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
2. Coordinate Infection Control activities with other departments or units including but not limited to Dialysis Services, Patient Care Services, Microbiology Laboratory, Pathology, Employee Wellness and Health Services, Pharmacy Services, and Environmental Services.
3. Function as a liaison to the Santa Clara Public Health Department and other agencies.
4. Function as a liaison to Infection Control Programs at other hospitals and long-term care facilities.

Q. Policy Formation

1. Policies and procedures shall be reviewed on a regular basis with changes made as new guidelines and information become available.
2. Standard Precautions shall be practiced in all areas of the hospital and are the basic standard of care for all patients.
3. Additional transmission-based precautions shall be used in addition to standard precautions for specific diseases or organisms to prevent their transmission.
4. Infection control departmental policies are found on the toolbox.

R. Quality Improvement

TITLE:	Infection Control – Infection Control Plan
CATEGORY:	Infection Control
LAST APPROVAL:	3/2019

1. Provide ongoing evaluation and assessment of the goals and accomplishments of the Infection Control Program to ensure that it meets the needs of the hospital, employees, physicians, patient population, and visitors.
2. Evaluation of the Infection Control Plan shall be done at least annually or when a change in the scope of the Infection Control Program or in the Infection Control risk analysis occurs. Assessment of Infection Control strategies shall also be evaluated for their effectiveness at preventing infections.

S. Environmental Conditions

1. To ensure a safe environment during times of construction and or remodeling, protective measures shall be approved by the Infection Control Staff and implemented before the project commences. All construction projects will have an Infection Control Risk Assessment (ICRA) performed by the Infection Control staff prior to start of construction.
2. Routine microbiological surveillance of the inanimate hospital environment or of personnel, with the exception of research purposes, shall be done on an as needed basis (to be determined by the Infection Control Nurse).
3. Sterile Processing: Cleaning, disinfection and sterilization. Steam, Sterrad and high level disinfection (HLD) shall be monitored according to current best practice guidelines. Instrument cleaning, disinfection and sterilization procedures shall be performed according to the manufacturer's recommended instructions for use.
4. Endoscopes and bronchoscopes: Instrument cleaning, disinfection and high level disinfection (HLD) shall be monitored each cycle by Steris/ Medivators quality indicators according to current best practice guidelines and manufacturer's instructions for use. Additional quality control checks will be performed after the manual cleaning stage using the Adenosine triphosphate bioluminescence (ATP) device. A quarterly Quality Report will be presented to the Infection Control and Committee meeting.
5. All probes & TEE scopes: Instrument cleaning, disinfection and sterilization shall be monitored each use by quality indicators according to current best practice guidelines and manufacturer's instructions for use.

TITLE: Infection Control – Infection Control Plan
CATEGORY: Infection Control
LAST APPROVAL: 3/2019

-
6. Dialysis water testing: Water used to prepare dialysis fluid shall be tested according to current AAMI standards. Current testing includes at least once a month. It shall contain a total viable microbial count not greater than < 100 cfu/ml; Endotoxin level < 0.25 EU/MI).

T. Reporting Mechanisms

1. Patients admitted with a reportable or communicable disease or who develop such a disease while hospitalized shall be reported to Infection Control by admitting staff, care coordinators, case managers or direct care providers.
2. Physicians shall be encouraged to report infections that occur after discharge that could be related with a recent hospitalization.
3. Suspected exposure of pre-hospital care providers to infectious diseases shall be reported to infection control by emergency department staff or by the designated officer of the pre-hospital care giver. Each case shall be evaluated and exposure confirmation determined. The proper forms shall be sent to the designated officer and to the Public Health Department. (See Procedure Pre-hospital Communicable Disease Exposure.)
4. A report regarding all infection control activities shall be made each quarter to the Infection Control Committee. The report shall include appropriate results related to routine surveillance, sentinel organisms, emerging pathogens, public health issues, employee health issues and special studies or reports. Copies of the committee meeting minutes shall be forwarded to the Medical Executive Committee. *C. diff*, *CAUTIs*, *CLABSIs* and MRSA Hospital Onset cases will be reported to the departmental manager on a monthly basis. Hand hygiene compliance will be reported to the departmental managers monthly. ,

POLICY/PROCEDURE TITLE: Infection Control Plan

I. APPROVAL:

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Infection Control Committee:	1/2019
ePolicy Committee:	2/2019
Medical Executive Committee:	2/2019
Board of Directors:	2/2019
Historical Approvals:	5/01, 7/03, 3/05, 10/05, 1/06, 5/07, 11/07, 9/09, 4/10, 5/11, 10/12, 2/14, 2/15, 1/16, 4/17, 3/18

POLICY/PROCEDURE TITLE: Infection

REFERENCES:

1. Deborah Yokoe et al. Compendium of Strategies to Prevent Hospital Acquired Infections in Acute Care Hospitals ICHE 2008:29; S12-S21.
2. Jonas Maschall et al. Strategies to Prevent Central Line Associated Blood Stream Infections in Acute Care Hospitals ICHE 2008:29; S22-S30.
3. Susan Coffin et al. Strategies to Prevent Ventilator Acquired Pneumonia in Acute Care Hospitals ICHE 2008:29; S31-S60.
4. Deverick J. et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals ICHE 2008:29; S51-S61.
5. David Calfee et al. Strategies to Prevent Transmission of Methicillin Resistant *Staphylococcus aureus* in Acute Care Hospitals ICHE 2008:29; S62-S80.
6. Erik Dubberke et al. Strategies to Prevent *Clostridium difficile* Infection in Acute Care Hospitals ICHE 2008:29; S81-S92.

ATTACHMENTS: See top right hand corner Attachments tab
IC Plan Evaluation-Annual Report FY 2018

Infection Control Risk Assessment

Enterprise Risk Event FY 18 Outcome Measurement: FY 18 Rate/ NHSN SIR	FY18 Goal	Probability risk will occur 1=low/ 2=mod/ 3=high	Probability Severity if Risk occurs 1=low/ 2=mod/ 3=high	Stability of Process 1=High. 2=needs improvement	FY18 Outcome 1=met goal/ 2=Goal not met	Priority Rank	FY19 Goal	Comments
--	--------------	---	--	--	---	------------------	--------------	----------

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.

POLICY/PROCEDURE TITLE: Infection

Hip SSI: FY2018 MV: 3 SSI/ LG: 3 SSI MV SIR: 1.07 / LG SIR: 3.2	SIR < 1.0	3	3	2	2	10	SIR < 1.0	Enterprise rate increased from FY17 (0.51) to FY18 (1.11). Did not meet Goal (SIR <1.0). IP Team continues to review SSIs in depth; identify areas of deficiency and report the outcomes to Enterprise Multi-disciplinary SSI Task Force.
Laminectomy SSI: FY2018 MV: 1 SSI/ LG: 0 SSI MV SIR: 1.38 / LG SIR: 0.0	SIR < 1.0	3	3	2	2	10	SIR < 1.0	Enterprise rate increased from FY17 (0.20) to FY18 (0.25). Did not meet Goal (SIR <1.0). SSI Task Force in place; review all SSIs in depth; concurrent with monitoring best practice guidelines, Helped OR sample cases, identify areas of potential deficiency.
Pacemaker SSI: FY2018 MV: 3 SSI/ LG: 0 SSI MV SIR: 3.5 / LG SIR: 0.0	SIR < 1.0	3	3	2	2	10	SIR < 1.0	MV SSI cases increased from FY17 (1 SSIs) to FY18 (3 SSIs). Did not meet Goal MV SIR 3.5. Plan in place: Cardiac Cath Lab (CCL) leadership, Cardiologists and NSQIP Coordinator continue to work on SSI reduction measures and OR best practice guidelines.
Knee SSI: FY2018 MV: 0 SSI/ LG: 0 SSI MVSIR: 0.0 / LG SIR: 0.0	SIR < 1.0	3	3	2	1	9	SIR < 1.0	Enterprise rate decreased from FY17 (0.56) to FY18 (0%). Continue to review all SSIs in depth; continue to monitor best practice guidelines collaboration in with SSI Task Force.

POLICY/PROCEDURE TITLE: Infection

Enterprise Risk Event FY 18 Outcome Measurement: FY 18 Rate/ NHSN SIR	FY18 Goal	Probability risk will occur 1=low/ 2=mod/ 3=high	Probability Severity if Risk occurs 1=low/ 2=mod/ 3=high	Stability of Process 1=High. 2=needs improvement	FY18 Outcome 1=met goal/ 2=Goal not met	Priority Rank	FY19 Goal	Comments
Fusion SSI: FY2018 MV: 0 SSI/ LG: 0 SSI MVSIR: 0.0 / LG SIR: 0.0	SIR < 1.0	3	3	2	1	9	SIR < 1.0	Enterprise rate decreased from FY17 (0.17) to FY18 (0%). Continue to review all SSIs in depth and report potential deficiencies of best practice guidelines to SSI Task Force.
Enterprise Endoscopy Units Quality: All endoscopes/ bronchoscopes will pass ATP quality check after manual clean, prior to HLD.	Pass rate: 100%	2	3	2	2	9	Pass rate 100%	FY19 Improvement Plan in place. FY18 -Instituted a new quality process for ATP testing and monitoring. Continue to monitor cleaning and HLD procedures and ATP results monthly. Endo Manager to provide quarterly reports to ICC meeting.

POLICY/PROCEDURE TITLE: Infection

HO CAUTI <i>(Catheter Associated Urinary Tract Infection):</i> FY 18 Enterprise Rate: 0.90 (MV:14 CAUTI/ LG:1 CAUTI) SIR: MV: 1.276/ LG SIR: 0.582	SIR < 0.75	3	3	2	2	10	SIR < 0.75	Rate decreased from FY17 (1.06) to FY18 (0.90) Enterprise: FY17 (21 CAUTIs) vs FY18 (15 CAUTIs) 1)FY19 HAI Task Force in place. 2)Standardized procedure for Foley removal in place.3) HOUUDINI protocol approved. 4)Event reviews on all CAUTI cases with Clinical Manager, front line staff, HAI team.5)Daily Foley utilization tracking
Enterprise Risk Event FY 18 Outcome Measurement: FY 18 Rate/ NHSN SIR	FY18 Goal	Probability risk will occur 1=low/ 2=mod/ 3=high	Probability Severity if Risk occurs 1=low/ 2=mod/ 3=high	Stability of Process 1=High. 2=needs improvement	FY18 Outcome 1=met goal/ 2=Goal not met	Priority Rank	FY19 Goal	Comments
HO CLABSI <i>(Catheter Associated Bloodstream Infection):</i> FY 18 Enterprise Rate: 0.30 (MV:4 CLABSI/ LG:0 CLABSI) SIR: MV: 0.398/ LG SIR: 0.0	SIR < 0.50	3	3	2	1	9	SIR < 0.50	Rate decreased from FY17 (0.57) to FY18 (0.30) In FY17 (7 CLABSI) vs FY18 (4 CLABSI) Plan: 1)FY19 HAI Task Force in place. 2)Event reviews on all CLABSI cases with Clinical Manager, front line staff, HAI team. 3)Education update on blood draws for staff
HO C.diff <i>(Clostridium difficile):</i> FY 18 Enterprise Rate: 0.30 (MV:12 C.diff/ LG:0 C.diff) SIR: MV: 0.398/ LG SIR: 0.0	SIR < 0.70	3	3	2	1	9	SIR < 0.50	Decreased HO rate from FY17 (1.69) to FY18 (1.24) Plan: Continue surveillance procedures in place for high risk admissions; IC staff member a member of the Antibiotic stewardship committee and HAI committee

POLICY/PROCEDURE TITLE: Infection

HO MRSA: (Methicillin resistant <i>Staph aureus</i>) Enterprise rate: 0.62 (MV: 6 cases/ LG: 0 cases)	Rate: < 0.90	2	2	1	1	6	Rate< 0.70	Increased enterprise HO rate from FY17 (.50) to FY18 (0.62)
HO MDRO GNR: (Multi drug-resistant Gram negative rods) Enterprise rate: 0.21 (MV: 2 cases / LG: 0 cases)	Rate: < 0.50	2	2	1	1	6	Rate< 0.50	continue current surveillance and isolation practices to sustain current successfully low rates of hospital transmission;
Hand Hygiene (HH) Enterprise Observed Compliance: HH on entry: average 70% HH on exit: average 70%	Rate: >95%	1	2	1	2	6	Rate > 80%	FY18: Developed new strategies by HAI Hygiene Committee: 1)monthly hand hygiene observations to be performed by clinical units.2) HH results entered into Vocera tracking system. 3)HAI committee reviews monthly data outcomes
MRSA Nares Screening (CDPH requirement) FY18 Enterprise Rate: 97%	Rate: >90%	1	2	1	1	5	Rate >92%	Continue current surveillance practice to sustain outcomes.



PFAC Report

Cheryl Reinking, MS, RN, NEA-BC

Patient Family Advisory Council (PFAC) Updates For May

- Review of signage near the valet stands to state "free patient and visitor valet parking, please pull forward". Currently, it is unclear to visitors that the valet service is free and it often becomes backed up because visitors do not realize they need to pull all of the way forward.
- Education and training will be provided to the registration staff to share parking information with patients when scheduling their appointments.
- Safety concerns in the main lobby after hours will continue to be addressed and reviewed by security. A "Lobby Ambassador" recently started to greet visitors when the main desk is vacant.

Patient Family Advisory Council (PFAC) Updates For May

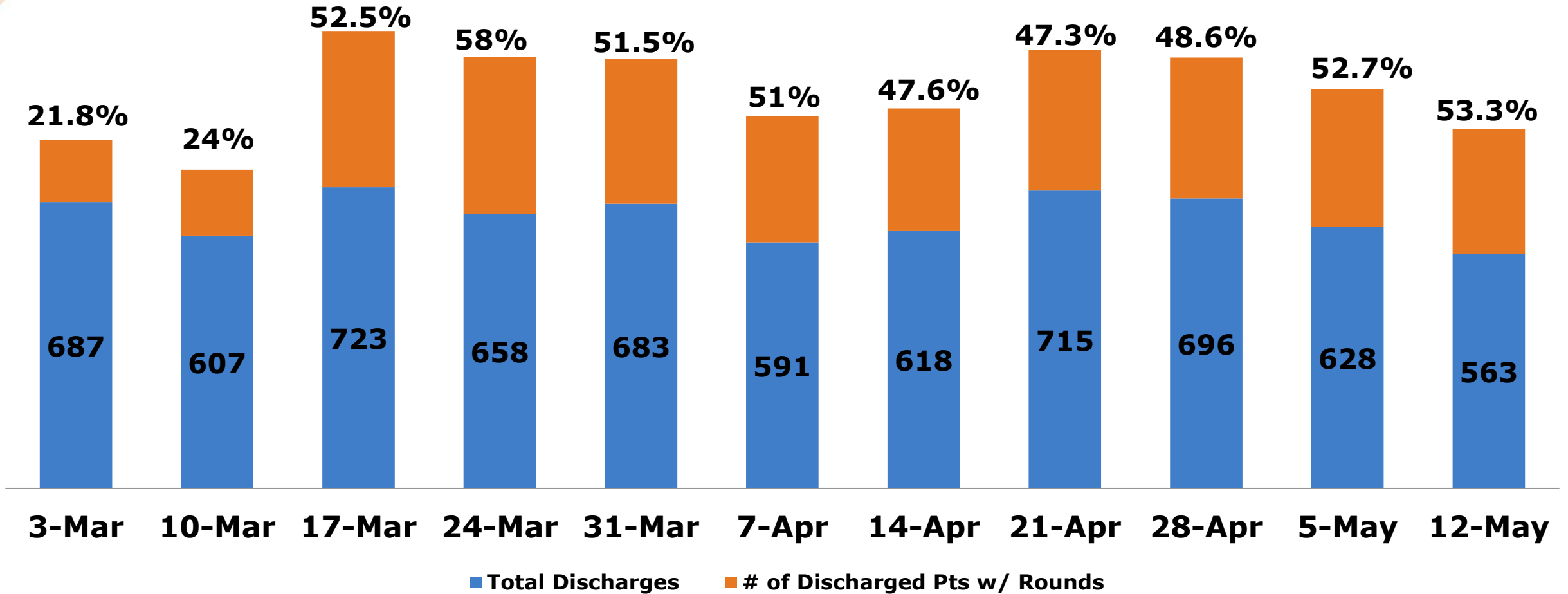
- Review of the use of the electric car charging stations has started in an effort to address the issue of limited spots. It has recently been noted that employees are leaving their cars in these spots for the duration of their shift. Therefore, there is consideration for charging by the hour, after one hour of use (the average charge time for an electric car).
- The Security Department will be making changes based on prior feedback about safety concerns in the ED. The security desk will be moving closer to the ED entrance and the officers stationed in the ED will not have other responsibilities outside of the ED.
- Patient Experience staff will be working with Nutrition Services to inquire about subsidizing food costs in the cafeteria for patients and visitors when healthy food selections are made.



Patient Experience Updates

Cheryl Reinking, MS, RN, NEA-BC

Leader Rounding Data



Leader Rounding Data

- When grouped, 40% of all comments related to seven categories.
- We are seeing an increase in our HCAHPS scores consistent when leader rounding started.
- We continue to work with leaders and departments that can best influence change for the areas of opportunity that have been identified.

Category	# of Times	%
Food	52	10%
Communication	38	8%
Responsiveness	27	5%
Behavior	26	5%
Parking	22	4%
Private Room	21	4%
Pain Management	17	3%
Other	302	60%



What are our patients saying?

**How have we been able to help our patients
and support our staff?**

- Patient was upset by the treatment of the hospitalist. The manager spoke to the physician who then went back to the patient's room to apologize.
- Leaders have been able to help address minor requests (toothbrush, bed extender, phone chargers, water and snacks with RN approval)
- Connecting patients with Patient Access to explain billing questions.
- During rounding, it was identified that a patient wanted special medication that we did not have available. He was able to receive it because pharmacy went to special effort to borrow from another hospital.
- “A patient's family member was really hungry and so I gave him a meal ticket as he had waited for a long time for his wife for surgery---longer than expected.”
- Leaders are often able to help support family members with warm blankets, food, water and other needs.

- “Staff asked for the names and photos of the newer members of the Executive Team to be added to their daily Vis Boards and I worked with Administration to provide them.”
- Acknowledgement of the improvement efforts and how they are working:
 - A patient said “The room gets cleaned every day ‘and’ they have business cards!! Very professional.”
 - A daughter of one patient stated “The hospital’s housekeepers are excellent employees! My father has been here for a few days, has seen excellent service with the cleaning staff. Today the housekeeper cleaned the room, was polite to the extreme, and asked before he cleaned anything, even though that is his job. One housekeeper engaged conversation with my dad as she kept working. He likes to talk, and she politely ended conversation with him when she was done cleaning. My dad enjoys talking to the housekeepers”



El Camino Hospital[®]

THE HOSPITAL OF SILICON VALLEY

Quality and Safety Comparisons to Other Regional Hospitals

ECH Board of Directors

Mark Adams, MD, CMO

June 3, 2019

Purpose:

At the April 10th Board Meeting we were asked to:

1. Provide information about how El Camino's quality and safety performance compares to other hospitals in the region.
2. Allow time for Board discussion of the data.

CMS Hospital Compare

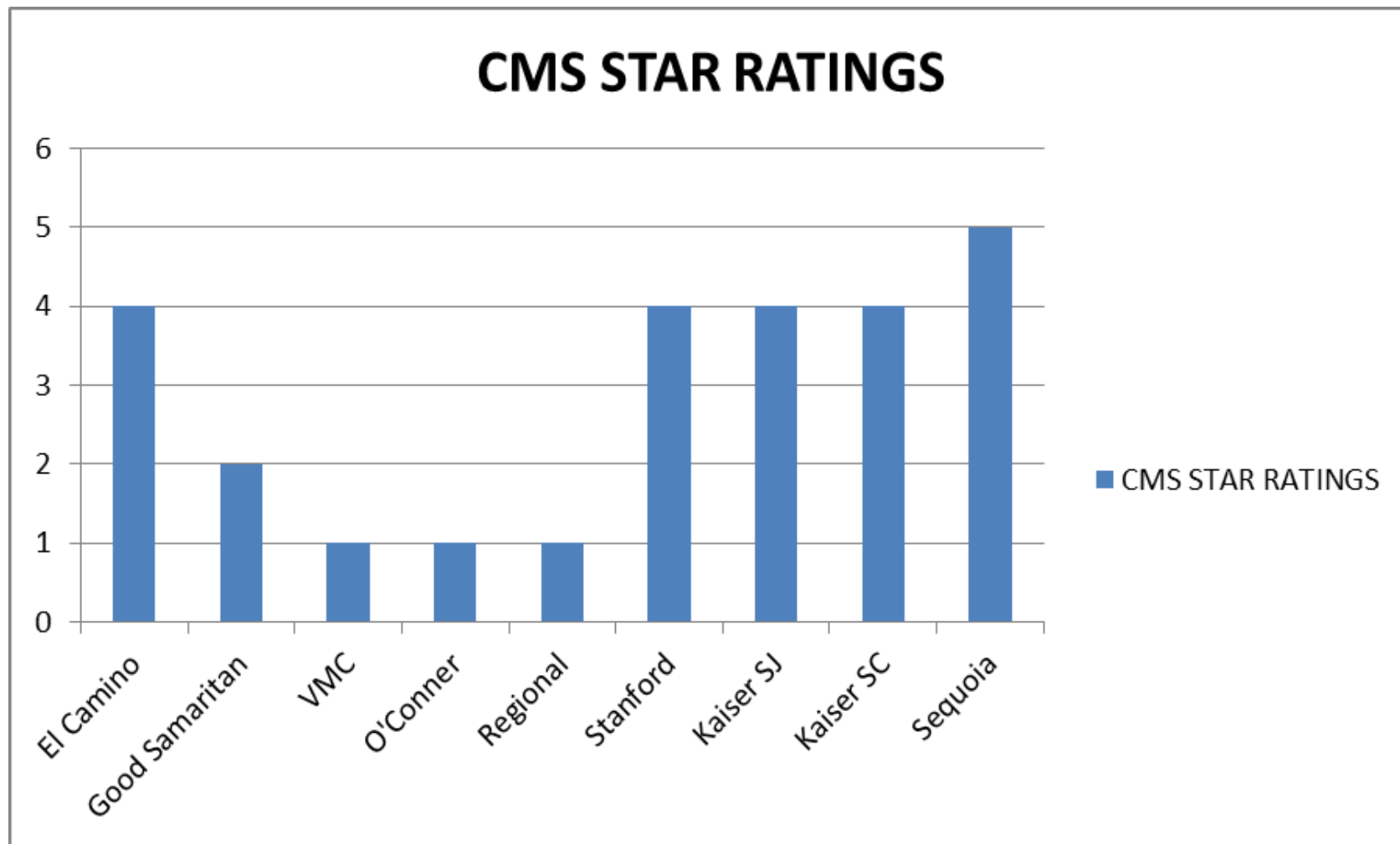
- CMS (Medicare) collects extensive quality of care data on over 4000 US hospitals. These data serve as the primary source of information for all other rating agencies
- Data are reported by collection periods that can be up to 18 months in arrears
- Measures represent wide agreement from CMS, the hospital industry and stakeholders (e.g., Joint Commission, National Quality Forum and Agency for Healthcare Research and Quality)
- The **CMS Stars Rating** represents a summary of 7 groups of measures

We Compared El Camino Hospital to 8 Other Regional Hospitals*

- Kaiser Redwood City
- Kaiser San Jose
- Kaiser Santa Clara
- Sequoia
- Stanford
- Good Samaritan
- O'Connor
- Santa Clara Valley Medical Center

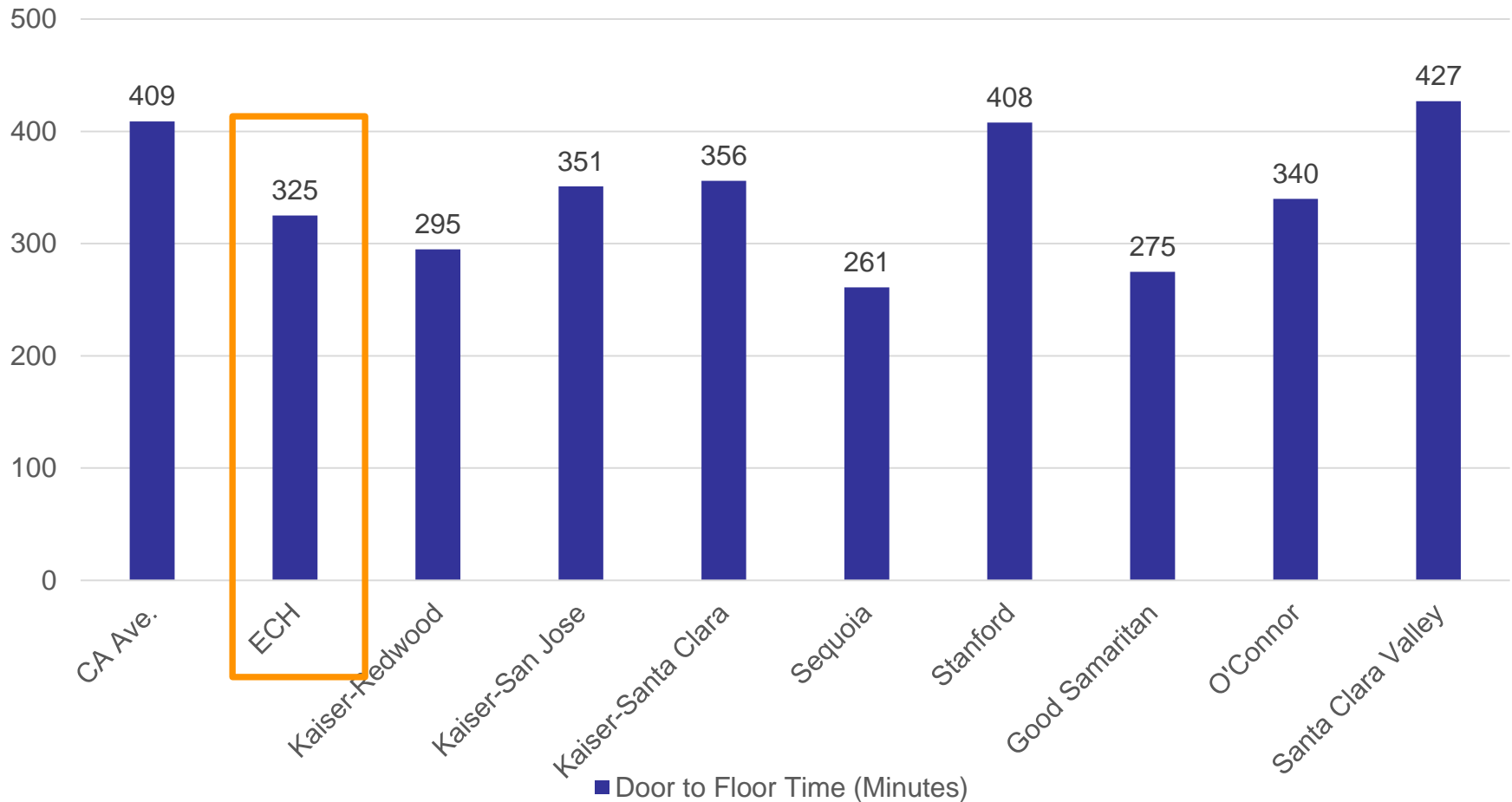
*Leapfrog data includes four additional Hospitals

Market Comparison



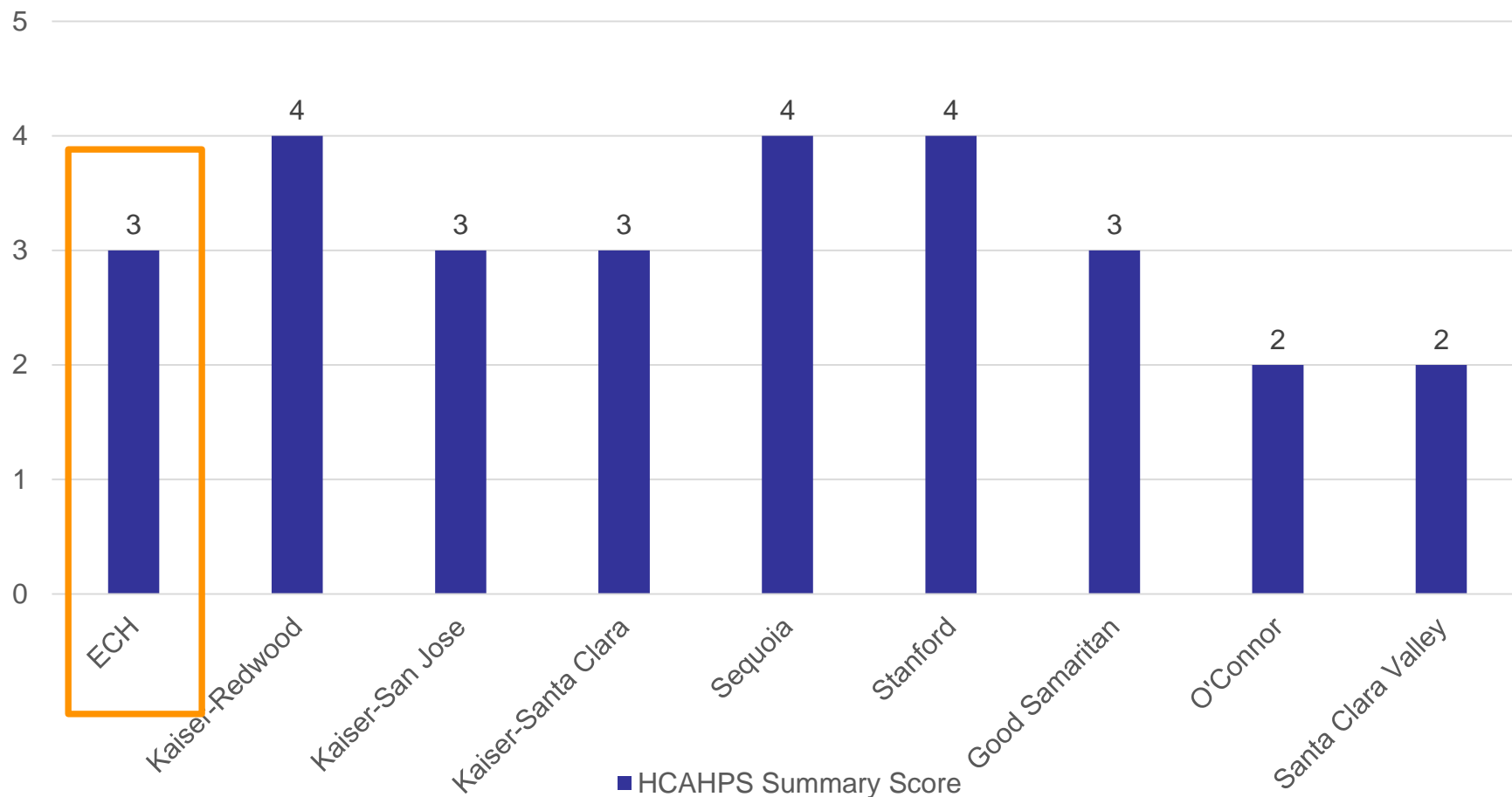
Emergency Department "Door to Floor" Time

ED Door to Inpatient Floor Time (Lower is Better)



Patient Experience

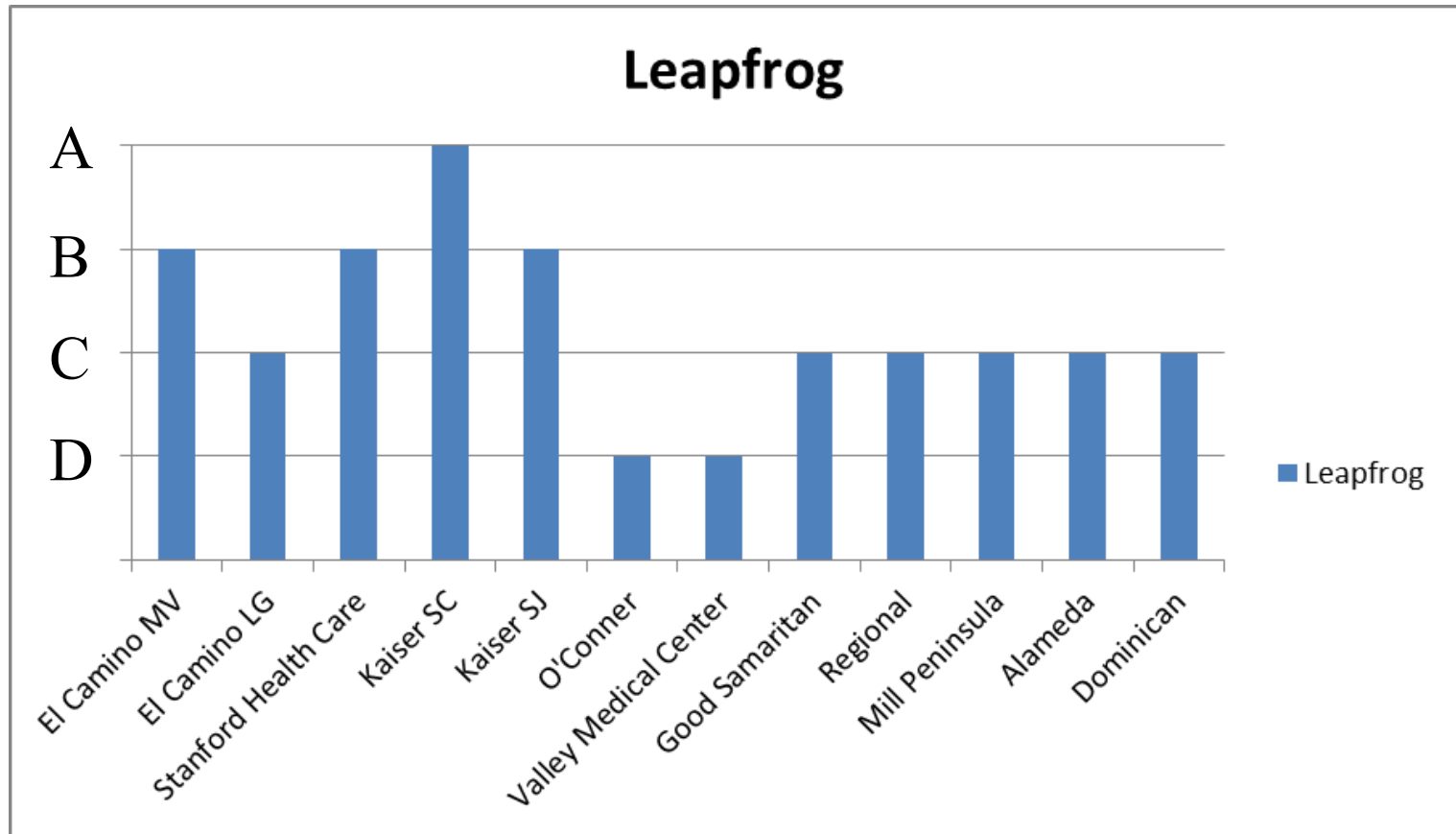
CMS Patient Experience Summary Score (1-5 Higher is Better)



The CMS “Pay for Performance” Program adjusts inpatient reimbursement based on quality and patient experience metrics

Hospital	FY19 Net Impact
Sequoia Hospital	\$484,654
Kaiser Foundation Hospital – Santa Clara	\$124,420
Kaiser Foundation Hospital – Redwood City	\$70,955
Kaiser Foundation Hospital – San Jose	(\$94,982)
El Camino Hospital (HRRP = 328K)	(\$428,082)
Santa Clara Valley Medical Center	(\$661,958)
O'Connor Hospital	(\$765,517)
Good Samaritan Hospital	(\$2,853,701)
Stanford Health Care	(\$4,202,320)

Market Comparison



Perinatal Care

Measures	El Camino	Nationwide		Statewide	
		Top 10%	Average	Top 10%	Average
C-section Rate	26.2%		32%		24.5%*
Elective Delivery prior to 39 weeks	3%	0%	2%	0%	1%
Exclusive Breast Feeding	68%	73%	51%	79%	63%
Antenatal Steroids	100%	100%	98%	100%	98%

Questions?

**EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO**

To: Quality Committee of the Board
From: Catherine Carson, Sr. Director/Chief Quality Officer

Date: June 3, 2019
Subject: PSI-90 Patient Safety Indicator Scores Q1 FY19

Purpose:

To provide an update on the AHRQ Patient Safety Indicators for Q1-Q3 FY19.

Summary:

1. **Situation:** The Patient Safety Indicators (PSIs) are a set of indicators providing information on potential in hospital complications and adverse events following surgeries, procedures, and childbirth. 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. The PSI's are from CMS's analysis of the data and the definition for CLASBI is different than the CDC's NHSN data definition.
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 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's 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.
5. **Other Reviews:**
6. **Outcomes:**

List of Attachments:

1. Patient Safety Indicators rates for Q1-Q3 Fiscal year 2019

Suggested Committee Discussion Questions:

1. None

Patient Safety Indicators

AHRQ QI Version 2018

Report Filter:

Facility: El Camino Hospital Los Gatos (661972) (CA) (Facility: 07-01-2013 to 05-14-2019) (Peer: 07-01-2013 to 03-31-2019), El Camino Hospital Mountain View (635796) (CA) (Facility: 07-01-2013 to 05-16-2019) (Peer: 07-01-2013 to 03-31-2019)

Month:

JULY 2018, AUGUST 2018, SEPTEMBER 2018, OCTOBER 2018, NOVEMBER 2018, DECEMBER 2018, JANUARY 2019, FEBRUARY 2019, MARCH 2019

Inpatient/Outpatient: Inpatient:

AHRQ QI Version: 2018

Population Size: 17,507

[Drill to Numerator Patients](#)

[Drill to Denominator Patients](#)

[Switch to Analytical View](#)

[PSI Stratified View](#)

Rate Measures

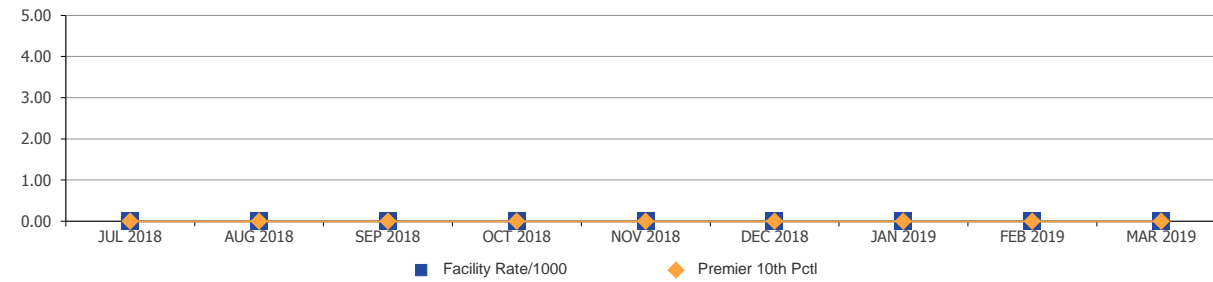
Patient Safety Indicator	Numerator	Denominator	Rate/1000	Premier Mean*	Premier Median*	Premier 25th Pctl*	Premier 10th Pctl*
PSI-02 Death in Low Mortality DRGs	0	2,095	0.00	0.46	0.00	0.00	0.00
PSI-03 Pressure Ulcer	4	6,313	0.63	0.52	0.16	0.00	0.00
PSI-04 Death in Surgical Pts w Treatable Complications	19	94	202.13	126.39	130.28	50.00	0.00
PSI-06 Iatrogenic Pneumothorax	2	10,046	0.20	0.15	0.00	0.00	0.00
PSI-07 Central Venous Catheter-Related Blood Stream Infection	2	6,715	0.30	0.06	0.00	0.00	0.00
PSI-08 In Hospital Fall with Hip Fracture	1	8,136	0.12	0.11	0.00	0.00	0.00
PSI-09 Perioperative Hemorrhage or Hematoma	2	3,301	0.61	1.64	1.23	0.00	0.00
PSI-10 Postoperative Acute Kidney Injury Requiring Dialysis	0	1,990	0.00	0.81	0.00	0.00	0.00
PSI-11 Postop Respiratory Failure	2	1,606	1.25	4.87	2.95	0.00	0.00
PSI-12 Perioperative PE or DVT	6	3,448	1.74	2.81	2.31	0.00	0.00
PSI-13 Postop Sepsis	5	1,944	2.57	4.76	1.99	0.00	0.00
PSI-14 Postop Wound Dehiscence	1	998	1.00	0.69	0.00	0.00	0.00
PSI-15 Unrecognized Abdominopelvic Accidental Puncture or Laceration	0	2,412	0.00	0.94	0.00	0.00	0.00
PSI-17 Birth Trauma Injury to Neonate	5	3,186	1.57	3.96	2.74	0.61	0.00
PSI-18 OB Trauma Vaginal Delivery with Instrument	38	168	226.19	107.10	90.91	44.12	0.00
PSI-19 OB Trauma Vaginal Delivery without Instrument	50	2,100	23.81	15.67	14.42	8.64	3.88

Count Measures

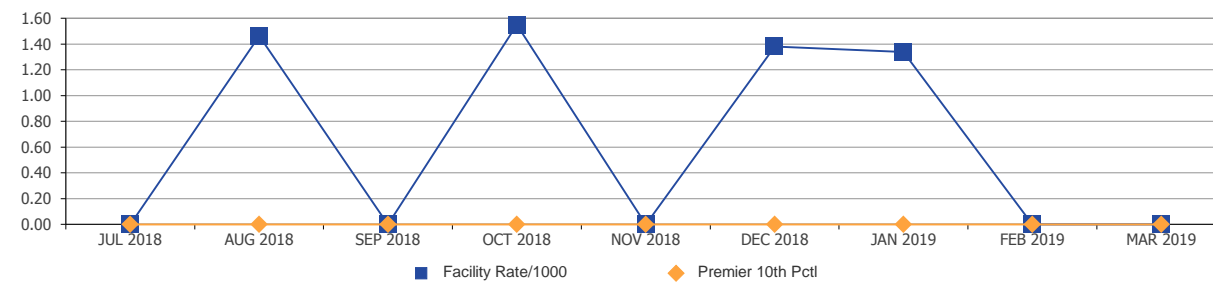
Patient Safety Indicator	Cases	Premier Mean Cases*
PSI-05 Retained Surgical Item or Unretrieved Device Fragment	1	0.14
PSI-16 Transfusion Reaction	0	0.02

* Premier Population Statistics (Rate/1000)
(10-01-2017 to 09-30-2018)

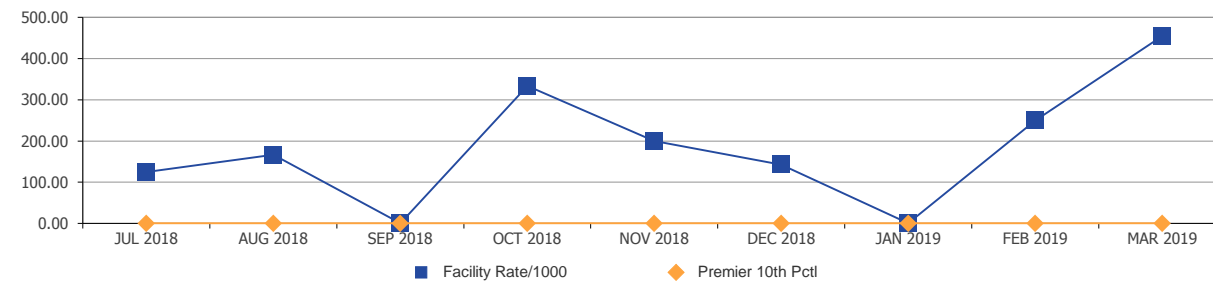
PSI-02:Death in Low Mortality DRGs



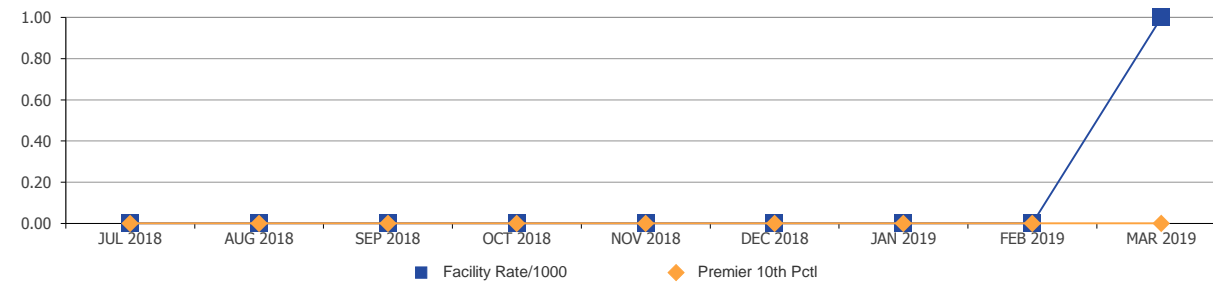
PSI-03:Pressure Ulcer



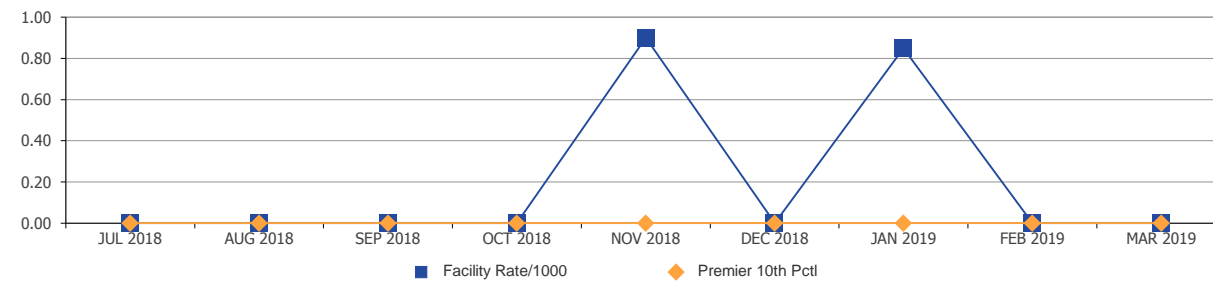
PSI-04:Death in Surgical Pts w Treatable Complications



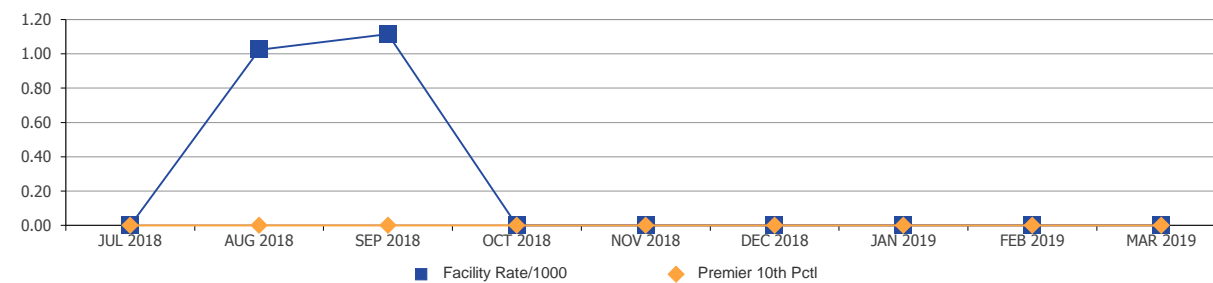
PSI-05:Retained Surgical Item or Unretrieved Device Fragment



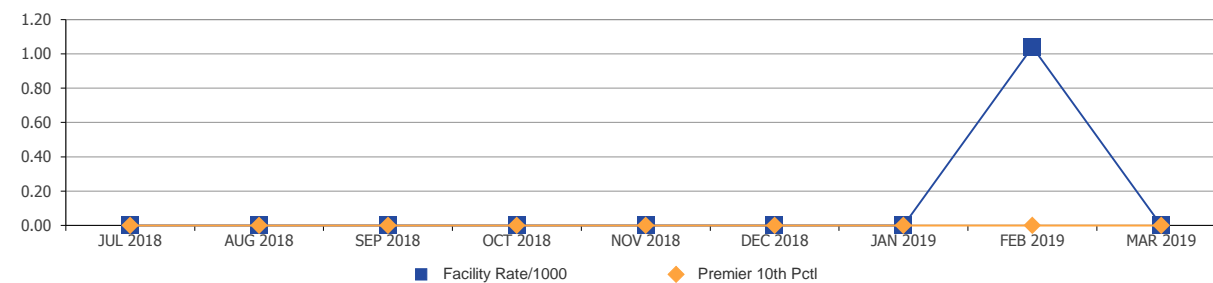
PSI-06: Iatrogenic Pneumothorax



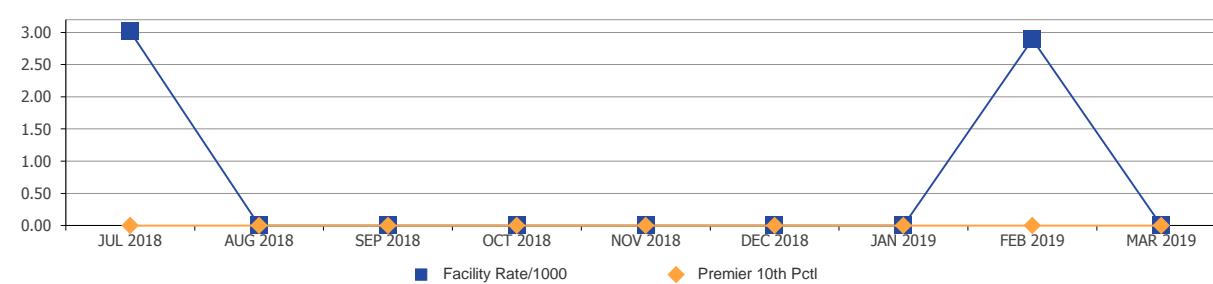
PSI-07: Central Venous Catheter-Related Blood Stream Infection



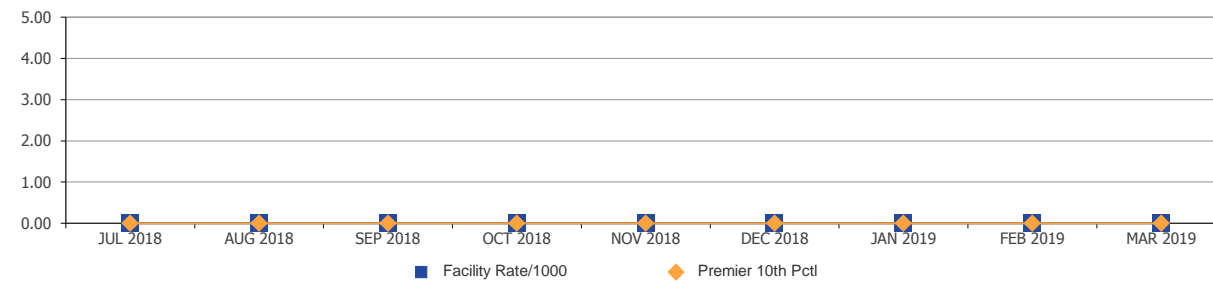
PSI-08: In Hospital Fall with Hip Fracture



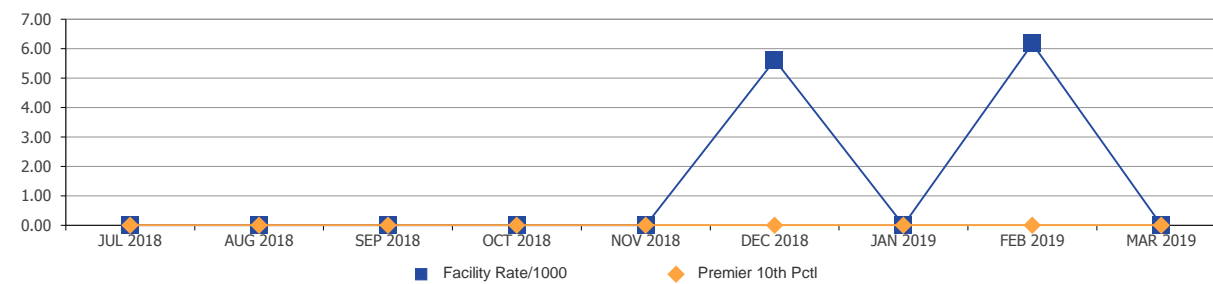
PSI-09: Perioperative Hemorrhage or Hematoma



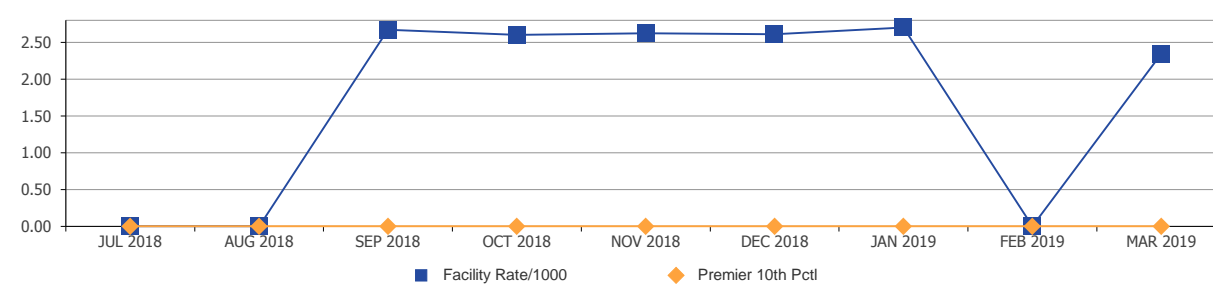
PSI-10:Postoperative Acute Kidney Injury Requiring Dialysis



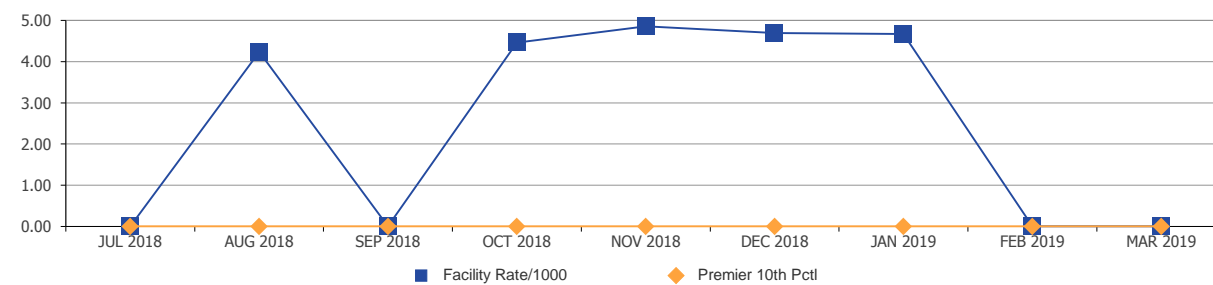
PSI-11:Postop Respiratory Failure



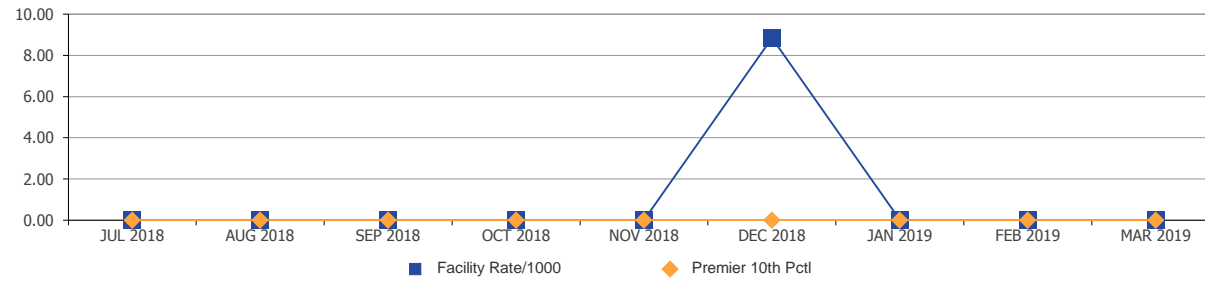
PSI-12:Perioperative PE or DVT



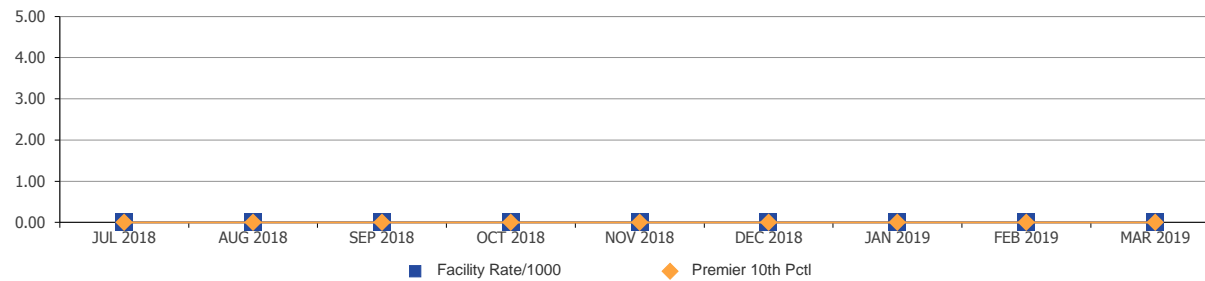
PSI-13:Postop Sepsis



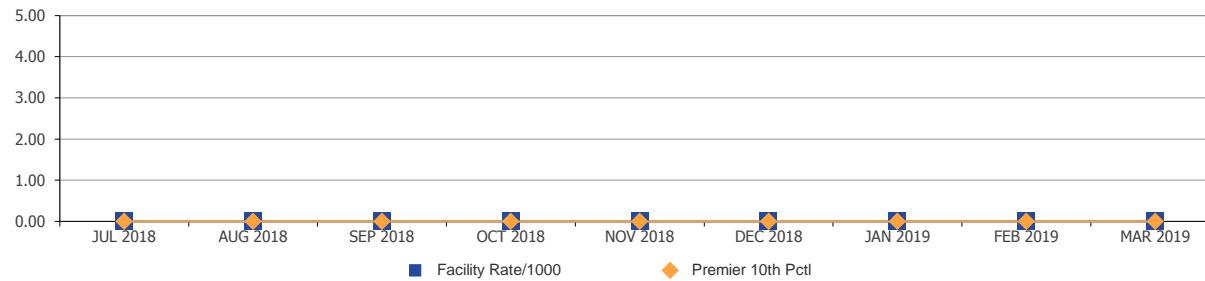
PSI-14:Postop Wound Dehiscence



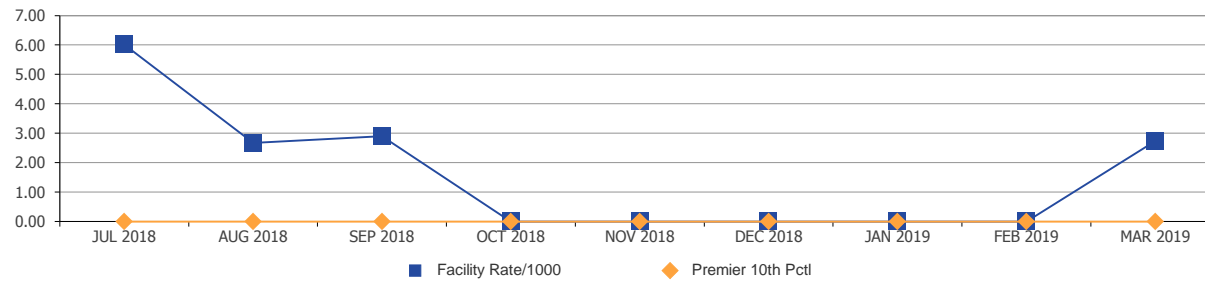
PSI-15:Unrecognized Abdominopelvic Accidental Puncture or Laceration



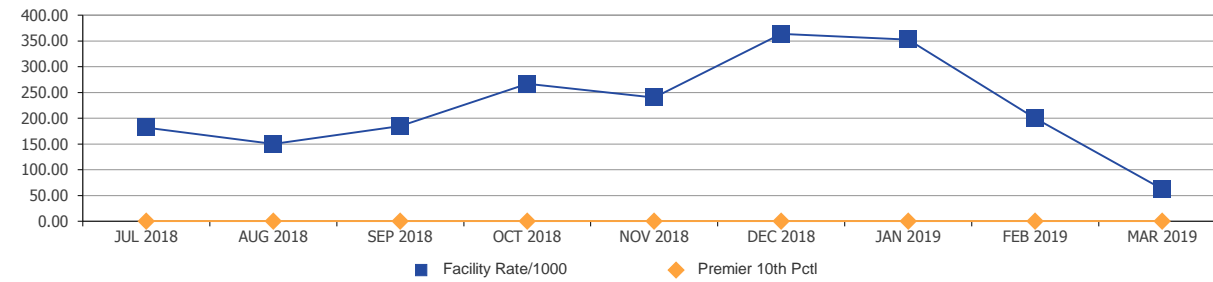
PSI-16:Transfusion Reaction



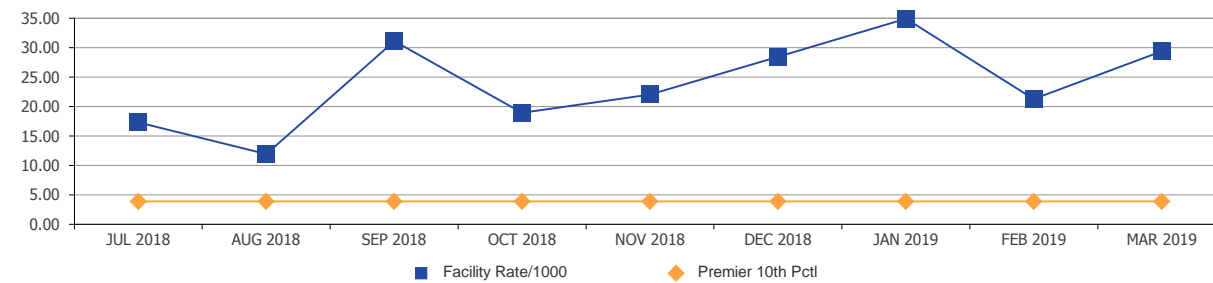
PSI-17:Birth Trauma Injury to Neonate



PSI-18:OB Trauma Vaginal Delivery with Instrument



PSI-19:OB Trauma Vaginal Delivery without Instrument



Confidential - Use Restricted by Agreement
Report Generated on 5/29/2019 4:17:55 PM