El Camino Health

AGENDA

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

Monday, November 4, 2019 – 5:30pm
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		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (10/7/2019) b. Minutes of the Open Session of the Special Joint Meeting to Conduct a Study Session of the Hospital Board and the Quality Committee (10/23/2019) ***Information*** c. FY20 Quality Dashboard d. FY20 Pacing Plan e. Progress Against FY20 QC Goals f. Hospital Update	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:35**
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**information 5:35 – 5:45**
5.	**PATIENT STORY** **ATTACHMENT 5**	Cheryl Reinking, RN, CNO		**discussion 5:45 – 5:55**
6.	**DEBRIEF: JOINT MEETING OF THE QUALITY COMMITTEE AND THE HOSPITAL BOARD**	Julie Kliger, Quality Committee Chair		**discussion 5:55 – 6:10**
7.	**ANNUAL PERFORMANCE IMPROVEMENT REPORTS** **ATTACHMENT 7**	Mark Adams, MD, CMO		**discussion 6:10 – 6:25**
8.	**QUALITY AND SAFETY STRATEGIC PLAN** **ATTACHMENT 8**	Mark Adams, MD, CMO		**discussion 6:25 – 6:55**
9.	**ANNUAL SAFETY REPORT FOR THE ENVIRONMENT OF CARE** **ATTACHMENT 9**	Matthew Scannell, Director of Safety and Security; Steve Weirauch, Environmental, Health & Safety Manager	*public comment*	**possible motion 6:55 – 7:10**

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
10.	**CDI DASHBOARD** **ATTACHMENT 10**	Mark Adams, MD, CMO		**discussion** **7:10 – 7:20**
11.	**CORE MEASURES** **ATTACHMENT 11**	Mark Adams, MD, CMO		**discussion** **7:20 – 7:30**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**information** **7:30 – 7:33**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**motion required** **7:33 – 7:34**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information** **7:34 – 7:35**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (10/7/2019) ***Information*** b. Medical Staff Quality Council Minutes	Julie Kliger, Quality Committee Chair		**motion required** **7:35 – 7:37**
16.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Q1 Quality and Safety Review	Mark Adams, MD, CMO		**discussion** **7:37 – 7:47**
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** **7:47 – 7:57**
18.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required** **7:57 – 7:58**
19.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information** **7:58 – 7:59**
20.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion** **7:59 – 8:04pm**
21.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required** **8:04 – 8:05pm**

Upcoming Meetings:

Regular Meetings: December 2, 2019; February 3, 2020; March 2, 2020; April 6, 2020; May 4, 2020; June 1, 2020
Educational Sessions: April 22, 2020

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, October 7, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present
Terrigal Burn, MD
Caroline Currie
Alyson Falwell
Peter C. Fung, MD
Julie Kliger, Chair
George O. Ting, MD, Vice Chair
Jack Po, MD
Krutica Sharma
Melora Simon

Members Absent
None

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. A silent roll call was taken. Committee member Jack Po, MD joined the meeting at 5:42pm and Committee member Melora Simon joined the meeting at 5:55pm during Agenda Item 6: FY19 Organizational Score. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. Chair Kliger removed Agenda Item 3a: September 9, 2019 Open Session Minutes and Item 3d: Annual Performance Improvement Reports. Chair Kliger requested that Section 7 of the Minutes be corrected to reflect that HCAHPS Goal Achievement for FY20 (not FY10) was recommended for approval. In response to questions, Cindy Murphy, Director of Governance Services, explained that annual performance improvement reports are generated by various departments throughout the hospital annually on a rotating basis. The Quality Council reviews these reports and they are now forwarded to the Committee for review as a result of a finding from the June 2019 CMS Survey. The Committee discussed the Health Information Management Systems Report (HIMS), the Antimicrobial Stewardship Report and the Orthopedic Service Line Report, noting that a number of our internally set goals, particularly in the HIMS report, are not being met. The Committee asked that these reports be brought back in 6 months and that the charts be annotated showing what interventions were implemented and when so that the effectiveness of interventions can be assessed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee (9/9/2019); and for information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 QC Goals; Hospital	***Consent Calendar approved***

	Update; and Annual Performance Improvement Reports. **Movant:** Fung **Second:** Sharma **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma **Noes:** None **Abstentions:** None **Absent:** Simon **Recused:** None	
4. REPORT ON BOARD ACTIONS	The Committee reviewed the Report on Board Actions as provided in the meeting materials and engaged in a brief discussion regarding the upcoming education session with the Board scheduled for October 23rd.	
5. PATIENT STORY	The Committee reviewed two stories, one from a grateful ICU patient and one from a patient who had a positive ED experience, which highlighted success with efforts to quickly triage and treat patients in the ED. The Committee requested that next month's patient story be oriented toward one of the metrics it is following, specifically something that used to be problematic but has improved or something that is still a problem and what is being done to address it.	
6. FY19 ORGANIZATIONAL GOAL SCORE	The Committee reviewed the FY19 Organizational Goal Score for the quality and safety metrics [readmissions (.99 = maximum) and mortality (.97 = minimum). The Committee reviewed and voted to recommend approval of the HCAHPS goal scores at its last meeting. **Motion:** To recommend the Board approve the FY19 Organizational Scores for Mortality and Readmissions. **Movant:** Po **Second:** Fung **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** Simon **Recused:** None	***FY19 Org Score for Mortality and Readmissions recommended for approval***
7. FY20 ORGANIZATIONAL GOAL METRICS	Chery Reinking, RN, CNO, reminded the Committee that it and the Board approved the metrics and the methodology for setting minimum, target and maximum several months ago. The actual metrics for the quality and safety goals (readmissions and mortality) were delayed awaiting final FY19 data since the FY20 goals are based on improvement over FY19. The Committee reviewed and recommended approval of the HCAHPS goals at its last meeting. **Motion:** To recommend the Board approve the FY20 Mortality and Readmissions goal metrics. **Movant:** Po **Second:** Simon **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***FY20 Mortality and Readmissions goal metrics recommended for approval***
8. PATIENT EXPERIENCE STRATEGIC PLAN	Ms. Reinking presented the organization's Patient Experience Strategic Plan, explaining that the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a standardized national survey tool that asks discharged patients 27 questions about their stay. Ms. Reinking reported that	

	ECH (1) performs above the 50th percentile in nine of ten composites locally, eight of ten composites in California and seven out of ten nationally and (2) ECH's multi-year goal is to perform above the 50th percentile in all composites and in the top decile in two composites by the end of FY2022. The Committee also received information about the ED satisfaction, outpatient ambulatory services and outpatient oncology services surveys. Ms. Reinking also shared the team's plans for improvement to attain the multi-year goals.	
9. REVISED QUALITY COMMITTEE CHARTER	Ms. Murphy presented a proposal to revise the Quality Committee Charter to include review of the Medical Staff's monthly Credentialing and Privileges Report as part of the Committee's oversight responsibility. The Board would then review and approve the report on the closed consent calendar each month. The report currently goes directly to the Board from the Medical Executive Committee without any committee oversight. The proposal is being driven by the Board's direction to delegate work to the Committees where appropriate and where expertise lies as well as the CMO's view that this is a best practice in other leading organizations. The Committee had a robust discussion and deferred the topic for further review at its next meeting when the CMO is able to attend.	
10. PUBLIC COMMUNICATION	There was no written or oral public communication.	
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:22pm. **Movant:** Ting **Second:** Po **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 7:22pm***
12. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:30pm. Agenda items 12-15 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (9/9/2019); and for information: Medical Staff Quality Council Minutes.	
13. AGENDA ITEM 17: ADJOURNMENT	**Motion:** To adjourn at 7:31pm. **Movant:** Simon **Second:** Po **Ayes:** Burn, Currie, Falwell, Fung, Kliger, Ting, Po, Sharma, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:31pm***

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

_____

Julie Kliger, MPA, BSN
Chair, Quality Committee

Minutes of the Open Session of the
Special Joint Meeting to Conduct a Study Session of the
El Camino Hospital Board of Directors
and the Quality, Patient Care and Patient Experience Committee
Wednesday, October 23, 2019
2500 Grant Road, Mountain View, CA 94040
Conference Rooms E&F (ground floor)

Board Members Present
Lanhee Chen, Chair
Peter C. Fung, MD
Gary Kalbach
Julie Kliger
Julia E. Miller, Secretary/Treasurer
Jack Po, MD, PhD
Bob Rebitzer
George O. Ting, MD
John Zoglin, Vice Chair

Board Members Absent
Don Watters

Members Excused
None

Committee Members Absent
Caroline Currie

Committee Members Present
Terrigal Burn, MD
Alyson Falwell
Krutica Sharma
Melora Simon

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL/ WELCOME	The Open Session of the Special Joint Meeting to Conduct a Study Session of the El Camino Hospital of Board of Directors and the Quality, Patient Care and Patient Experience Committee (the "Board and Committee") was called to order at 6:00pm by Chair Chen. A silent roll call was taken. Director Watters and Committee Member Caroline Currie were absent. All other Board and Committee members were present at roll call. Leadership Team Members Bruce Harrison, CMO; Jim Griffith, COO; Mark Adams, MD, CMO; Cindy Murphy, Director of Governance Services; Dan Woods, CEO; Mary Rotunno, General Counsel; and Cheryl Reinking, RN, CNO also participated in the Study Session.	
2. POTENTIAL CONFLICTS OF INTEREST DISCLOSURES	Chair Chen asked if any Board or Committee members may have a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. GOALS OF THE SESSION	Chair Chen welcomed all of the participants to the session. Mr. Woods described the goals for the session and reiterated Chair Chen's comment that this session is a beginning of a discussion about how the Board and the Committee should govern and oversee quality. Mr. Woods also described the quality-related challenges that health care systems across the country are facing and suggested that the Board needs to better understand the process for credentialing the Medical Staff. Dr. Adams commented that that most Quality Committees are charged with the real scrutiny of credentialing.	
4. LEVEL SETTING	Mark Adams, MD, CMO described El Camino's "current state" related to Quality of Care, reviewed the quality pillar that cascades from the organizations' strategic plan, and explained the organization's long-term quality goal of zero preventable harm.	

5. ROUNDTABLE – REACTIONS TO PRE-READING MATERIAL	Guy Masters from Premier, Inc. facilitated a discussion regarding the participants' reactions to the pre-reading materials.	
6. ROLE OF GOVERNANCE IN QUALITY AND SAFETY	Mr. Masters facilitated a discussion about the roles of the Board and the Committee in Governance of Quality Care. The following were presented as Next Steps: 1. Bring Management's Quality and Safety Strategic Plan in a format digestible for the Board to the November 6th Board meeting. 2. Revalidate the metrics management is reporting to the Quality Committee and the Quality Committee is reporting to the Board. - Are the metrics the right ones? - Get consensus on the format - Report the "so what" and the "now what" - How do we compare? 3. Revisit long-term (multi-year) quality goal(s) annually. 4. Establish the scope and responsibility of the Chief Quality Officer. 5. Get to consensus on vision. - Is top performer good enough or top decile? - Cost analysis – resources needed to get to vision 6. Quality Committee to understand its role and function - Purpose - Span of authority - Clarify credentialing process/oversight	
7. AGENDA ITEM 18: ADJOURNMENT	**Motion**: To adjourn at 8:34pm. **Movant:** Kalbach **Second:** Po **Ayes:** Burn, Chen, Falwell, Fung, Kalbach, Kliger, Miller, Po, Rebitzer, Sharma, Simon, Ting, Zoglin **Noes:** None **Abstentions:** None **Absent:** Currie, Watters **Recused:** None	***Meeting adjourned at 8:34pm***

Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Hospital:

_____
Lanhee Chen
Chair, ECH Board of Directors

_____
Julia E. Miller
Secretary, ECH Board of Directors

_____
Julie Kliger, MPA, BSN
Chair, Quality, Patient Care and Patient Experience Committee

Prepared by: Cindy Murphy, Director of Governance Services

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: November 4, 2019
Subject: FY20 Quality Dashboard for November meeting

Purpose:

To provide the Committee with a snapshot of the FY20 metrics monthly with trends over time and compared to the actual results from FY19 and the FY20 goals.

1. Situation: Annotation is provided to explain actions taken affecting each metric.

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

3. Background: These thirteen (13) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY20 Quality, Efficiency, and Service Goals.

4. Assessment:

- Impact on inpatient hospice (GIP) continues and is evident on both the Mortality Index and Readmission Index.
- ED Throughput goal reduced to 266 minutes, and Enterprise results are below new goal.
- Each of the HCAHPS metrics are below target through September of this fiscal year.
- CAUTI and CLABSI continue to be sporadic at zero or 1/month. C. Diff infections are related to Antibiotic use in patients with severe infections and not to in-hospital transmission.
- New metrics of Surgical Site Infections, Elective Delivery <39 weeks gestation, and Primary Cesarean Birth have been added for FY20. The Perinatal Care Core Measures, PC-0 1 and PC-02, are reported by hospital campus and for the Enterprise.

5. Other Reviews: N/A

6. Outcomes: N/A

Suggested Committee Discussion Questions: None.

List of Attachments:

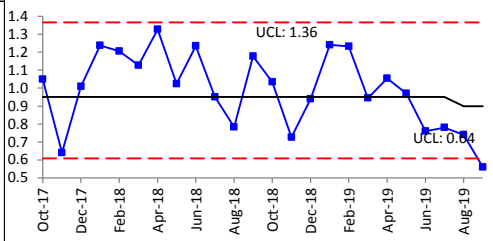
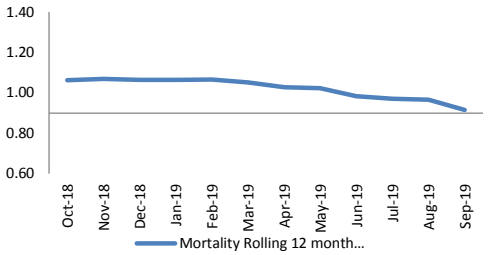
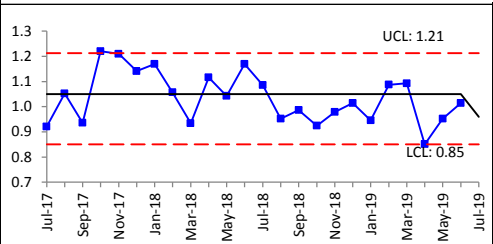
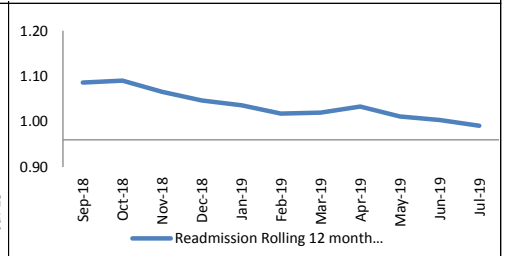
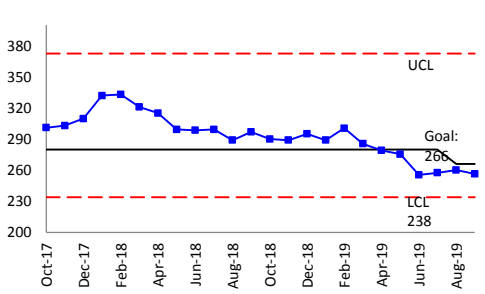
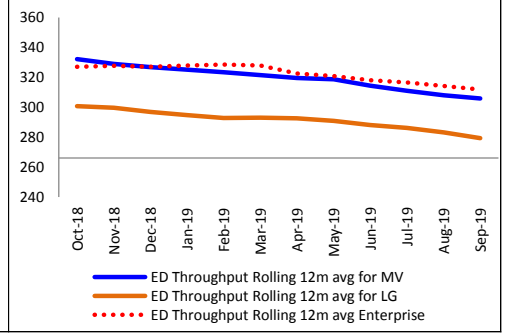
1. FY20 Quality Dashboard, September data unless otherwise specified - final results

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

September 2019 (Unless otherwise specified)

Month to Board Quality Committee: November, 2019

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Months Average
Quality		Current month	FYTD				
1	*** Organizational Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: September 2019*	0.58 (1.13%/1.94%)	0.62 (1.11%/1.80%)	0.97	0.90		
2	***Organizational Goal** **Readmission Index (All Patient All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: July 2019*	1.03 (8.13%/7.90%)	1.03 (8.13%/7.90%)	0.99	0.96		
3	**Patient Throughput-Median Time from Arrival to Head In Bed** *(excludes psychiatric patients, patients expired in the ED and Newborns)* *Date Period: September 2019*	MV: 290 min LG: 213 min Enterprise: 252 min	MV: 283 min LG: 231 min Enterprise: 257 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

Definitions and Additional Information

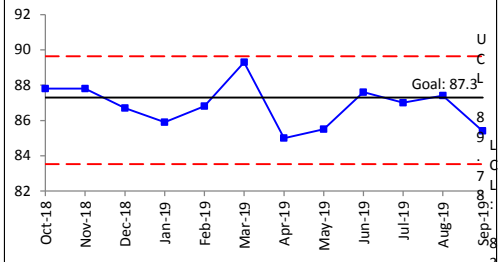
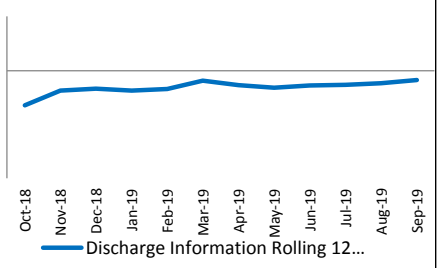
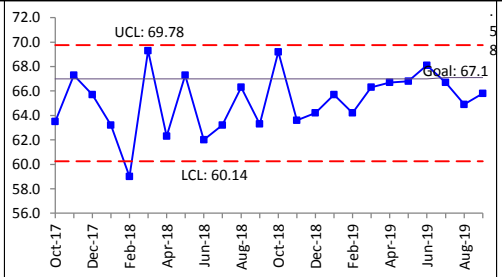
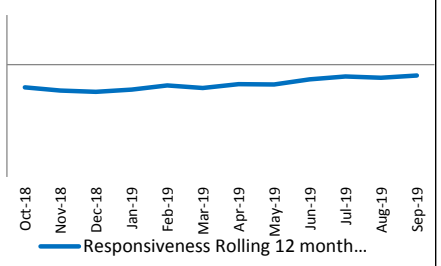
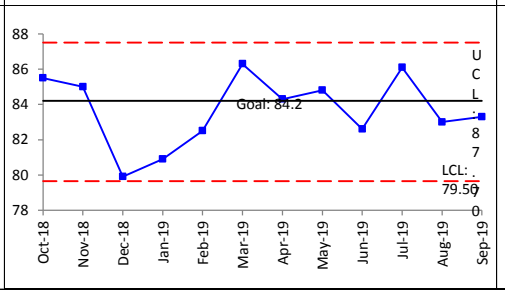
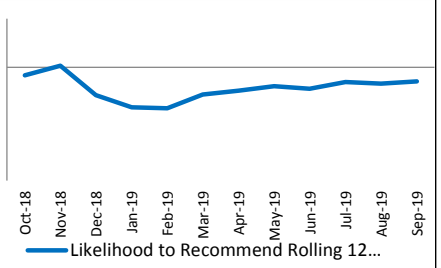
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Mortality Index (Observed/Expected)	The effect of transferring patients who qualify and accept GIP (inpt hospice) is clear since May 2019. Another factor is the better documentation of the complexity of each patient by the physician and encouraged by CDI.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the 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	The number of readmissions has increased as well as the index since a low in April.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). 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 and Newborns)	Both campuses continue to work on problem solving and implementing improvements that were identified from the ED value stream refresh earlier this July. Los Gatos recently completed 2 Rapid Process Improvement Workshops to help improve the initiation of care and ancillary testing. They are in the process of implementing the identified changes. MV completed a working session with ED MD and Hospitalist leaders to continue to work on opportunities to improve "Consult to Admit" order timeframes. Work is also in process on both campuses to help implement elements of Daily Management System related to ED throughput in the Emergency departments.	Cheryl Reinking, Dolly Mangla	Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit	**iCare Report: ECH ED Arrival to Floor**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

September 2019 (Unless otherwise specified)

Month to Board Quality Committee: November, 2019

	Service	FY20 Performance Month	FY20 Performance FYTD	Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Discharge Information** **Top Box Rating of Always** *Date Period: September 2019*	85.4	86.7	86.7	87.3		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: September 2019*	65.8	65.8	65.7	67.1		
6	**HCAHPS Likelihood to Recommend** **Top Box Rating of Always** *Date Period: September 2019*	83.3	84.1	83.5	84.2		

Definitions and Additional Information

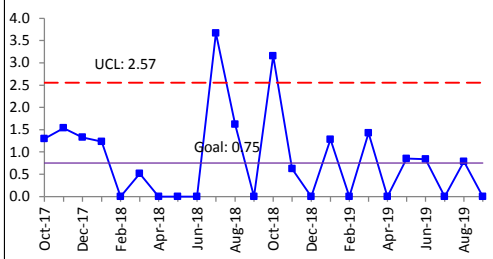
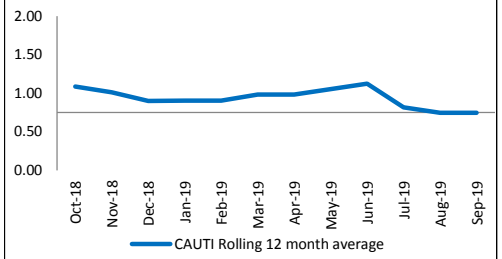
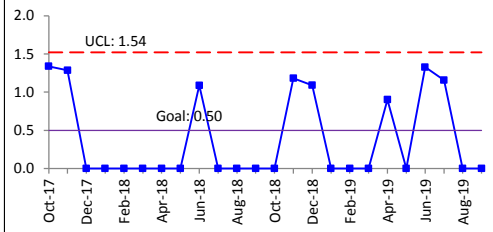
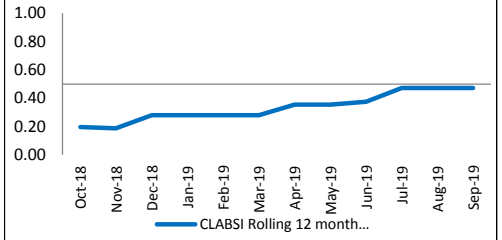
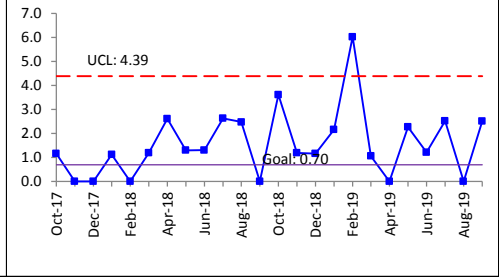
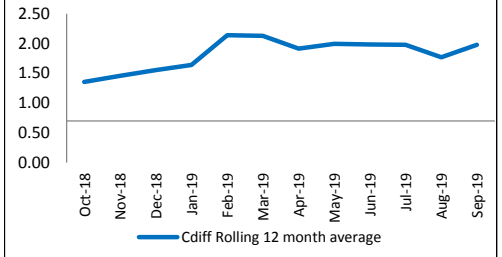
Measure Name	Comments	Definition Owner	- Arrival: Patient Arrived in ED	Source
HCAHPS Discharge Information Domain Top Box Rating of Always	• Attended PFAC meeting for patient feedback to inform upcoming initiatives • Modifying AVS to better serve patient needs • Publishing discharge checklist in Patient Guide Books to help include patients in the process • Modifying inpatient handbook to make it more patient-friendly • Evaluating feasibility of different programs to follow-up on patients post-discharge • Rewards and recognition for affirming best practices	Yvette Million Cheryl Reinking	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.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	• Added Patient and Family Advisory Council (PFAC) member in workgroup • Confirmed via call light audit the reasons patients ask for help (bathroom, pain) • Leader rounding questions on call lights and staff responsiveness • Reinforcing Enhanced Interactions Healthstream education • Implemented No Pass Zone on all inpatient units; more education to follow • Rewards and recognition for affirming best practices	Yvette Million Cheryl Reinking	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.	**Press Ganey Tool**
HCAHPS Likelihood to Recommend Top Box	• Team to meet to determine factors that influence Likelihood to Recommend. • Reinitiate and restructure Leader-Patient Rounding program for long-term sustainability • Provide daily/weekly/monthly/quarterly Leader-Patient Rounding data • Review leader rounding patient comments for opportunity for improvement • Discuss and address Emergency Department experience with patient/family during leader rounds.	Yvette Million Cheryl Reinking	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.	**Press Ganey Tool**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

September 2019 (Unless otherwise specified)

Month to Board Quality Committee: November, 2019

		FY20 Performance		Baseline FY18 Actual	FY19 Target	Trend	
Quality		Month	FYTD				
7	**Hospital Acquired Infections** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: September 2019*	0.00 (0/1186)	0.27 (1/3703)	1.09	SIR Goal: <= 0.75		
8	***Hospital Acquired Infections*** *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: September 2019*	0.00 (0/901)	0.39 (1/2554)	0.36	SIR Goal: <= 0.50		
9	***Hospital Acquired Infections*** *Clostridium Difficile Infection (CDI)* *per 10000 patient days* *Date Period: September 2019*	2.51 (2/7964)	0.17 (4/23764)	1.96	SIR Goal: <= 0.70		

Definitions and Additional Information

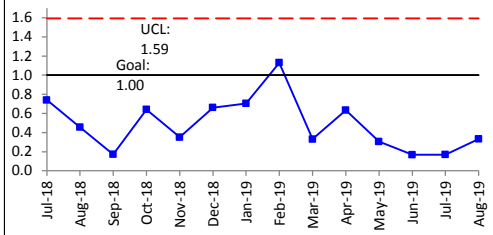
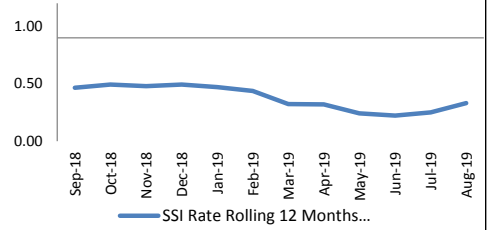
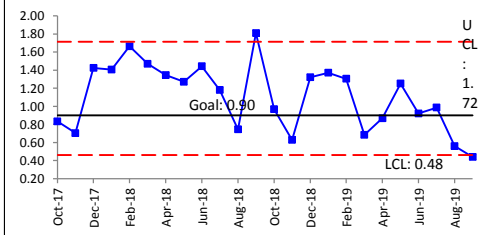
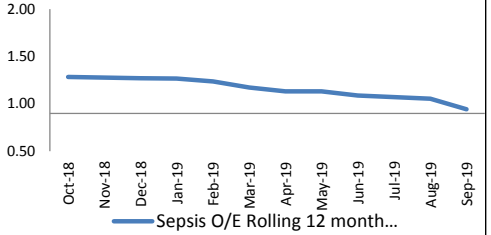
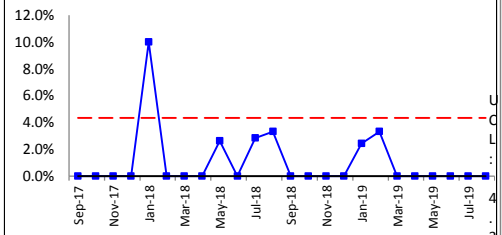
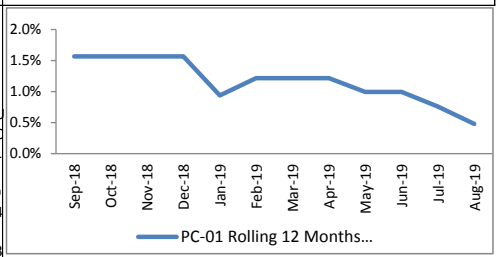
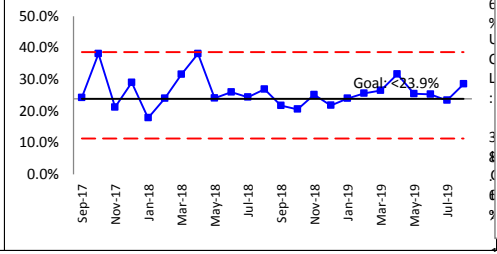
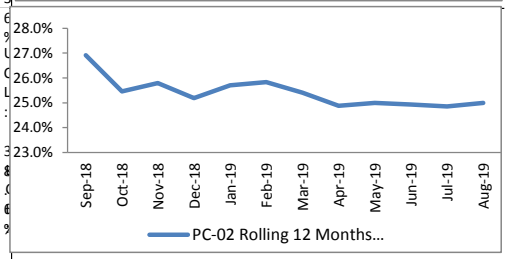
Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Zero CAUTI in September 2019	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**CDC NHSN data base - Inf. Control**
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Zero CLABSI in September 2019	Catherine Carson/Catherine Nalesnik	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.	**CDC NHSN data base - Inf. Control**
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	2 C.Diff infections in September: 1- MV - 73 y/o with Radical prostatectomy surgery, developed C.Diff diarrhea on day 6 after 4 Antibiotics. 1- LG Acute Rehab - 53 y/o with spinal surgery L1-3, transferred for acute rehab and developed C.Diff diarrhea after 3 Antibiotics, referred to Antibiotic Stewardship to review ABX use with surgeon.	Catherine Carson/Catherine Nalesnik	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.	**CDC NHSN data base - Inf. Control**

El Camino Health

FY 20 Organizational Goal and Quality Dashboard Update

September 2019 (Unless otherwise specified)

Month to Board Quality Committee: November, 2019

		FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
		Month	FYTD				
10	Organizational Goal **Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Date period: August 2019*	0.33 (2/601)	0.25 (3/1194)	0.52 (37/7167)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: September 2019*	0.70 (5.94%/8.50%)	0.55 (5.36%/9.79%)	1.06	0.90		
12	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower = better) Enterprise Date period: August 2019	MV: 0.00% (0/32) LG: 0.00% (0/7) ENT: 0.00% (0/39)	MV: 0.00% (0/63) LG: 0.00% (0/10) ENT: 0.00% (0/73)	MV: 1.11% (4/360) LG: 0.00% (0/44) ENT: 0.99% (4/404)	0.0%		
13	**PC-02: Cesarean Birth** (lower = better) Enterprise Date period: August 2019	MV: 29.68% (46/155) LG: 14.29% (2/14) ENT: 28.40% (48/169)	MV: 26.90% (78/290) LG: 18.92% (7/37) ENT: 25.99% (85/327)	MV: 26.28% (425/1617) LG: 14.29% (30/210) ENT: 24.90% (455/1827)	<23.9%		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100	2 new SSIs in August in Mountain View: 1- Robotic laparoscopice sleeve gastrectomy; readmitted with abdominal abscess, CT guided abscess drainage - blood culture and abscess srep anginousus. 1- Total Lap hysterectomy, salpingo-oophorectomy, readmitted w/bowel performation for exploratory lap,loop ileostomy.		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 predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated. *Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.* *Lower Control Limit is not visible if it is less than or equal to zero.*	**CDC NHSN data base - Inf. Control**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Sepsis mortality index remains low due to l better physician documentation risk of mortality amd improvements in Sep-1 Core Measure/Bundle compliance to 93% in August. Update, August 2019 O/E has changed from 0.45 to 0.44 with updated mortality data.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice For the 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**
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	MEC request to present Perinatal core measures by campus as well ad for Enterpirse. Elective Delivery challenges include those with prior cesarean section who desires repeat cesarean section and scheduled repeat cesarean section prior to 39 weeks. Both campus have sustained zero since March.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	**IBM CareDiscovery Quality Measures**
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Our internal goal is aligned with the Let's Get Healthy California (LGHC) target goal of 23.9% or lower. We've had 2 insurance providers who indicated not sending patients to us if our rate is higher than the target goal. CMQCC (California Material Quality Care Collaborative) data for PC-02 is different because they calculate this rate with different codes than CMS and TJC.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	**IBM CareDiscovery Quality Measures**

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

FY2020 Q1		
JULY 2019	**AUGUST 5, 2019**	**SEPTEMBER 9, 2019**
No Board or Committee Meetings **Routine Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 20 Quality Dashboard** ▪ **Progress Against FY 2020 Committee Goals** ▪ **FY20 Pacing Plan** ▪ **Med Staff Quality Council Minutes**	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY20 Quality Dashboard (Discuss - should this be on consent? Only discuss if something outside normal variation? Deeper Dive Quarterly?) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 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 in the ED? 7. draft Board-level QC reporting 8. PSI-90 metrics	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Introduction of New Members 8. Annual Performance Improvement Reports (rotating departments) Special Agenda items: 9. Update on Patient and Family Centered Care 10. Recommend FY20 Organizational Goal Metrics 11. Annual Patient Safety Report 12. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals) 13. Pt. Experience (HCAHPS) 14. ED Pt. Satisfaction (Press Ganey) 15. Quality and Safety Strategic Plan
FY2020 Q2		
OCTOBER 7, 2019	**NOVEMBER 4, 2019**	**DECEMBER 2, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Standing Agenda Items: 8. Report on Medical Staff Peer Review Process 9. FY20 Org. Goal and Quality Dashboard Metrics 10. FY19 Organizational Goal Achievement (M, RA)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Safety Report for the Environment of Care 11. Q1 FY20 Quarterly Quality and Safety Review 12. Debrief 10/23 Session~~Performance Improvement with Physician Management~~ 13. Q&S Plan	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda items: 8. Update on Patient and Family Centered Care 9. Readmission Dashboard 10. PSI-90 Pt. Safety Indicators 11. Peer Review Process ~~10.~~12. Draft Revised QC Charter

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

FY2020 Q3		
JANUARY 2020	**FEBRUARY 3, 2020**	**MARCH 2, 2020**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Q2 FY20 Quality and Safety Review 9. Update on Patient Care Experience	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Proposed FY21 Committee Goals 9. Proposed FY21 Organizational Goals
FY2020 Q4		
APRIL 6, 2020	**MAY 4, 2020**	**JUNE 1, 2020**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments – PLUS Bring Back HIMS, Ortho. Antimicrobial from October) Special Agenda Items: 8. Value Based Purchasing Report 9. Pt. Experience (HCAHPS) 10. Approve FY21 Committee Goals 11. Proposed FY21 Committee Meeting Dates 12. Proposed FY21 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Approve FY21 Committee Goals (if needed) 11. Proposed FY21 Organizational Goals 12. Proposed FY21Pacing Plan 13. Q3 FY20 Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments) Special Agenda Items: 8. Update on Patient and Family Centered Care 9. Readmission Dashboard 10. PSI-90 Pt. Safety Indicators 11. Approve FY21 Pacing Plan 12. Leapfrog Survey

El Camino Health

FY20 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY19 Achievement and Metrics for FY20 (Q1 FY20) (Complete) - FY21 Goals (Q3 – Q4) (Paced)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) (Paced For December) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline – (Paced)
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)
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Review quarterly at the end of the meeting (Use Closing Wrap-Up Time)	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting
6. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals

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

Approved by the ECH Board of Directors 6/12/2019

El Camino Health

Hospital Update
October 10, 2019
Mark Adams, MD, CMO

Quality and Safety

In early September, the *first in human* robotic assisted minimally invasive bronchoscopy was performed at El Camino Hospital in Mountain View. This new procedure uses the new Intuitive DaVinci ION robotic endoluminal platform which offers doctors unprecedented stability enabling the precision needed for biopsy far into the peripheral lung and to more easily diagnose lung cancer earlier than ever before.

Another "first," El Camino Health's Mountain View hospital is the first on the West Coast (and one of only 10 hospitals) to begin offering GammaTile™ Therapy, a new approach to treating recurrent brain tumors. GammaTile Therapy is a FDA-cleared, surgically targeted radiation therapy (STaRT) that is designed to delay tumor regrowth for patients with brain tumors. The first patient on the West Coast was treated by neurosurgeon James Doty, MD, and radiation oncologist Robert Sinha, MD, at El Camino Health.

The SOS Program (Support our Staff Program) was created to provide support to ECH employees and medical staff impacted by emotionally challenging events. Team Members attended training in providing emotional first aid and an expedited referral process to Concern EAP was established. Twenty-seven staff members & two physicians were deployed in September.

The EVS Department made substantial progress in the last three years to contribute to the El Camino Health culture of safety with 98% decrease in days away from work, a 50% reduction in job transfer, and a 32% reduction in total injuries.

The 9th cohort in the highly competitive *New Graduate Residency* program started on September 23rd, with a class of eleven.

2019 Influenza Campaign (September 23 – October 31) offering 24 days and 139 flu clinic hours among both campuses. The clinics are open to all (staff, physicians, volunteers, contractors, students).

Service

To improve ED patient throughput, the ED tracking board was modified to facilitate communication between the ED and Imaging department. Additionally, to help our patients during the MV ED construction project, the team has incorporated a new ED Patient text message into the workflow, informing them of what is going on.

Preparations continue for moving into our two new Pavilions at MV (Sobrato & Taube) and the Cancer Center at LG. Additional nursing staff has been hired with training and dress rehearsals planned for October.

El Camino Health launched online appointment scheduling for El Camino Medical Associates (ECMA) locations, allowing increased convenience to our patients.

People

The El Camino Health Foundation's new President, Andrew Cope, began on September 23, 2019. He is coming to us from Lucile Packard Foundation for Children's Health.

The new Executive Director of Patient Experience has been selected and will begin on Oct. 7th. Her name is Christine Cunningham and she comes to us from Stanford Children's Hospital.

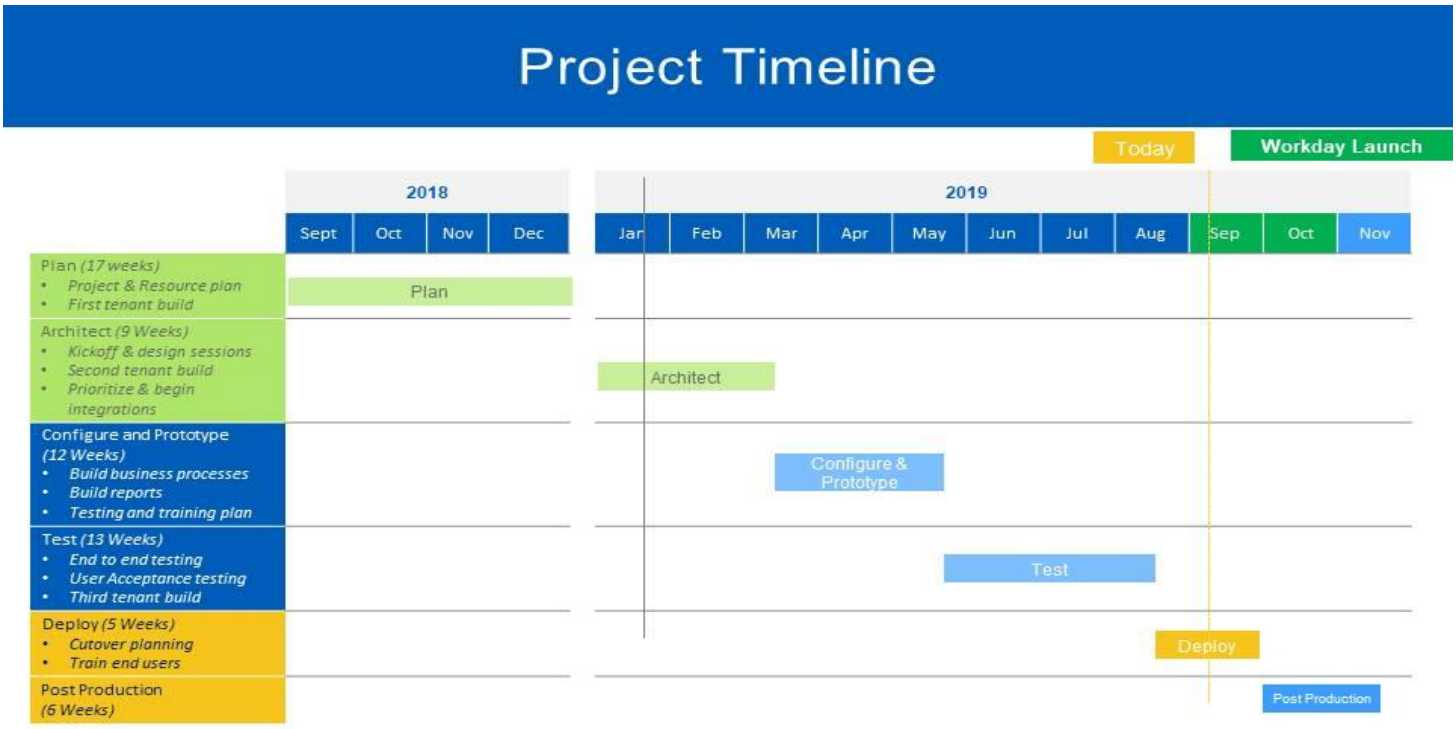
Information Services

All five San Jose Medical Group clinics have converted to the Epic platform with continued on-site support provided to physicians and staff. Multiple applications such as the Verity Legacy EMR and Managed Care applications are now available from ECH devices to support patient care processes.

Our electronic health record upgraded to v.May 2019 on 9/15/19, to stay current with Epic's software build. Based on usability data, Epic redesigned the patient's header to tell a patient's story with interactive functionality. El Camino is the first in the Bay area to adopt the new design called Storyboard.

Workday ERP Project go-live is scheduled on October 1. Workday will be the second largest enterprise system (Epic is the largest) and impacts all employees of the Health System. Workday will include solutions for recruiting, new hire onboarding, payroll and paycheck printing, compensation and benefits, performance reviews, accounting, expense reports, accounts payable, etc. The project timeline is provided below. A robust activation plan including a Command Center and daily debrief meetings, will occur during the immediate go-live support period with measurement, tracking, and communication of Key Performance Indicators.

El Camino Health



Community Stewardship

The hospital sponsored a health fair for older adults organized by the Saratoga Area Senior Coordinating Council, part of the "Age-Friendly" initiative that many cities in Santa Clara County have joined. Staff provided health, service, and Community Benefit information, and an auxiliary member talked about ECH volunteer opportunities. ECH also had a booth at a "Good Neighbor" fair next to our Los Gatos hospital which was hosted by Hope Community Church.

Chinese Health Initiative collaborated with a community service agency that serves low-income families in Sunnyvale. CHI provided 5 Mandarin interpreters for 40 Chinese participants who enrolled in the Challenge Diabetes program, hosted an introductory workshop for 80 participants in preparation for the launch of the Diabetes Prevention Program, and collaborated with Asian American Community Involvement to organize a diabetes prevention workshop conducted in Chinese and English by a registered dietitian with 35 seniors attending the event.

South Asian Heart Center submitted the South Asian Heart Center's Stop Diabetes program/curriculum to the Centers for Disease Control for certification. Community Benefit Director served as a contributing member of the Santa Clara County Oral Health Policy Leadership.

Community Benefit grant partners, including Community Services Agency, Mountain View and Pathways Home Health & Hospice, participated in the Post-Acute Network Vendor Fair hosted by El Camino Health.

El Camino Health honored by Community Benefit grant partner West Valley Community Services Agency at their annual Chefs of Compassion event. ECH received the "Champion of Compattion" award, recognizing commitment to supporting the needs of low-income and homeless community residents.

A Women's Health Fair was held on Saturday, September 28 in Los Gatos with 300 attendees, two health lectures featuring endometriosis treatment and endocrinology disorders, 21 participating physicians, and 11 health fair tables featuring El Camino Health services. A community sneak peek was also held for the new Los Gatos Cancer Center.

Scrivner Center for Mental Health & Addictions Services' sponsored the Maternal Outreach Mood Services (MOMS) Symposium on Friday, September 20, which hosted over 200 people.

Philanthropy

During period 2 of fiscal year 2020, which ended on August 31, El Camino Health Foundation secured $468,689.

Completed Sevathon 2019, a walk/run event organized by India Community Center, with 91 registrations and $1500 raised to be used for South Asian Heart Center patient care, community outreach events, etc.

The 24th annual El Camino Heritage Golf Tournament will be held on Monday, October 28, 2019 at Sharon Heights Golf & Country Club and will benefit the Peter C. Fung, MD Stroke Center.

The Taube Pavilion opening festivities for donors will be held on Thursday, October 24, 2019 and the Sobrato Pavilion Opening Celebration is planned for Sunday, November 17, 2019. These events are in the final planning stages, and additional information will be provided to Board members as it becomes available.

Auxiliary

The Auxiliary contributed 6,301 volunteer hours in September 2019.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: November 4, 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, Patient Care and Patient Experience Committee meeting, the Hospital Board met once and the District Board met once. In addition, since the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee, those approvals are also noted in this report.

A. ECH Board Actions: October 10, 2019

- Approved FY20 Periods 1 & 2 Financials
- Approved FY19 Audit (to ECHD on 10/22/19)
- Approved FY19 Organizational Goal Score
- Approved FY20 Organizational Goal Metrics
- Approved $24.9 Million Partial Funding for MV Campus Completion Project (To ECHD on 10/22/19)
- Approved FY20 CEO Base Salary
- Approved FY19 CEO Incentive Payment
- Approved FY19 CASO Incentive Payment
- Approved Cardiology Call Panel (LG) Renewal

B. ECHD Board Actions: October 22, 2019

- Approved FY19 Audit
- Approved FY19 Year End Consolidated and Stand-Alone Financials
- Approved FY20 YTD (P2) ECHD Financials
- Approved $24.9 Million Partial Funding for MV Campus Completion Project
- Approved FY19 Community Benefit Report
- Re-Elected Julie Kliger, RN and Bob Rebitzer to the El Camino Hospital Board of Directors for a second 3-year term effective July 1, 2020

- Appointed Julia Miller as Chair and Peter Fung as a member of an Ad Hoc Committee tasked with bringing back recommendations regarding the ECHD Community Benefit Grant Program to the Board for consideration

C. Finance Committee Actions: September 23, 2019

- Approved Employee Wellness & Health Professional Services Agreement
- Approved Maternal Child Health Professional Services Agreement
- Approved NICU Consulting Agreement

D. Compliance and Audit Committee: None since last report.

E. 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 Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cheryl Reinking, RN, Chief Nursing Officer
Date: November 4, 2019
Subject: Voice of the Patient – Patient Letter

Purpose:

To update the Board on an example of a patient letter that reflects many of the HCAHPS domains that the organization has been focusing on over the past year.

Summary:

1. Situation: Staff was asked to provide a letter that reflects patient feedback that addresses the areas of the HCAHPS domains on which the organization has been focused, including communication, responsiveness, cleanliness, and discharge information.

2. Authority: The patient letter is reflective of the domains that the Board requested to be included.

3. Background: This patient was present at the MV campus for 19 days and provided this letter after discharge, which touches on areas that indicate efforts are being made by staff to address the areas of the HCAHPS domains of focus within the organization. The patient states, "removing IV's and mid line, and making sure I had clear instructions" relates to the discharge information domain in HCAHPS. There were several quotes that related to the HCAHPS nursing communication domain, "tenderness and empathy in placing the NG" and "kindly giving [name] a pillow and blanket." The letter mentions teamwork among the staff, "Liz and the other nurses helped each other out so willingly and dropping in to see how things were going," specifically the responsiveness domain. Finally, the mention of the "cleaning experts" who kept the room so nice relates to the cleanliness domain.

4. Assessment: The organization reviews these letters in many venues and provides feedback to staff to assist them with connecting their caring behaviors to the desired HCHAPS results.

5. Other Reviews: None

6. Outcomes: We will continue to monitor patient communication as sources for opportunities for improvement and will make adjustments and improvement plans based on the feedback.

List of Attachments:

1. Patient Letter

Suggested Committee Discussion Questions:

1. Are there any other statements in the letter that relate to other HCAHPS domains?
2. What else do you do with patient communication to assist with performance improvement?

October 2019

Thank you to the World's Best Nurses– El Camino 4A

I fear that I have forgotten the name of a friend that has helped me so much. How you all encouraged me to walk and walk and walk and gave me freedom to do things and care for myself too.

Niniel, you were with me for well over an hour "checking" me in September 1, calming me, and getting me to settle down, and then how fittingly, "checking" me out sixteen days later, taking such good care, removing the IVs and mid line, and making sure I had clear instructions. You made it so easy for me.

Brie, not only a great nurse but what a great party monitor you are. How you helped raise my spirits.

Stephanie, Monique, Nancy, Michelle, and Evangelina - Those days of such caring you gave me. Monique, such tenderness and empathy in placing the NG! I felt you

were hurting more than me. Kathy, so right on, starting me on deep breathing exercises, ten every two hours. "John, give me ten more" Keeping Dr. Tran informed on my up and down moments

Kris and Matt made nights bearable. And how Liz and the other nurses helped each other out so willingly, Reina with Monique in placing the NG, and Kevin, Meghan, and Kim helping out when others were busy and Molly dropping in to see how things were going.

Jana, thank you for seeing if a mid line would be ok and then placing it without causing any pain, and also for the helpful running info for me and [redacted].

Thank you, Gloria, for sharing the Santa Cruz sunset and telling me about the Redwood City and San Mateo Peruvian restaurants that I hope to visit soon; Cumba for your warm smile and care, and also kindly giving [redacted] a pillow and blanket; Laurie, you drove an hour and a half back to Lodi at night after caring for me, and [redacted] Thank you to the expert cleaning crew who kept my room so nice!

So many thanks to Doctor Fuentes for arranging me to be admitted and caring for me, and especially for getting me Dr. Koi Tran.

Words fail me here Dr. Tran. Thank you again for everything.

Thank You, Thank You, Thank You!

I made it because I had the best doctors and nurses. I was so happy to see some of you the day I left, your smiles and hugs. I will never forget the loving care you gave me and the kindness you gave my wife [redacted].

Love,

[redacted]

PS. Enjoy the chocolates and the movie and

CARRY ON NURSES!

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: November 4, 2019
Subject: Annual Performance Improvement Reports

Purpose:

To provide information and evidence on the Hospitals' annual performance improvement reports for all services to the Board through the Quality Committee.

Summary:

1. Situation: CMS Conditions of Participation 482.21 on Quality Assurance and Performance Improvement states that, "The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program."

2. Authority: CMS Conditions of Participation 482.21 states that, "The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services, and focuses on indicators related to improved health outcomes and the prevention and reduction of errors."

3. Background: Each department of the Hospital completes these reports on an annual basis. They are presented on a rotating schedule of a few departments each month to the Medical Staff's Quality Council and this Quality Committee.

4. Assessment: See attached reports.

5. Other Reviews: The Quality Council of the Medical Staff reviews these reports as well.

6. Outcomes: To provide information and evidence on the hospitals' annual performance improvement reports for all services to the Board through the Quality Committee of the Board.

List of Attachments: Annual Reports and Dashboards

1. Heart & Vascular Institute (HVI)
2. Care Coordination
3. Pharmacy
4. Nutrition Services

Suggested Committee Discussion Questions: None.

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Annual Performance Improvement Report

Department/Service Line: Heart & Vascular Institute
Prepared by: Amy Maher
Date: 10/02/2019
Reporting Period: (FY 2019)

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

HVI Mortality and Readmissions Report:

MORTALITY

- ***Acute Myocardial Infarction (AMI) Mortality***
  - *Per Premier data, there is marked improvement in AMI mortality O/E over the course of fiscal year 2019 as compared to the previous fiscal year 2018. Cases are reviewed concurrently with Medical Director and the STEMI panel physicians that attend case review meetings.*

Baseline FY18	***FY19***
O/E = .98	*O/E = .73*

  - *Data from American College of Cardiology NCDR (Chest Pain/MI Registry) indicates that in Calendar Year 2018 ECH's AMI mortality for top decile performing hospitals was higher than the NCDR top decile (90th).*

ECH Baseline CY17	***ECH CY18***	***NCDR Top Decile***
2.58%	*2.92%*	*2.64%*

- ***Isolated Coronary Artery Bypass Graft (CABG) Mortality***
  - *Per Premier data, CABG mortality year over year has improved slightly, with the same number of deaths each year (n=2) and slightly higher case volume in FY18.*

Baseline FY18	***FY19***
O/E = 1.30	*O/E = 1.28*

  - *Data from the Society of Thoracic Surgeons national registry indicates significant improvement year over year with no mortality in CY2018 as compared to 4 deaths in calendar year 2018.*

ECH Baseline CY17	***ECH CY18***	***Benchmark STS***
2.5%	*0%*	*1.8%*

- ***Heart Failure Mortality***
  - *Per Premier data, HF mortality has improved year over year with lower case volume in FY19 (n=569) as compared to FY 18 (n=589)*

Baseline FY18	***FY19***
O/E = .96	*O/E = .92*

READMISSIONS

  - *Premier data indicates AMI readmissions has increased slightly year over year*

Baseline FY18	***FY19***
O/E = 1.06	*O/E = 1.19*

  - *Premier data indicates CABG readmissions has increased slightly year over year*

Baseline FY18	***FY19***
O/E = .66	*O/E = .77*

  - *Premier data indicates Heart Failure readmissions have improved significantly year over year*

Baseline FY18	***FY19***
O/E = 1.04	*O/E = .84*

Describe improvements made in the areas of focus or outcome

Opportunities identified for improvement:

- **Mortality Reduction Strategy**
  - The strategic initiative for Fiscal Year 2020 to address mortality concerns is to implement and extracorporeal membrane oxygenation (ECMO) program. Having this program will allow HVI physicians to stabilize patients in cardiogenic shock and transfer them to a facility that has transplant and left ventricular assist device (LVAD) capabilities. A steering committee has been assembled for implementation of the ECMO program by the end of the calendar year 2019.

- **Readmission Reduction Strategies**
  - To address the issue of readmissions, several of the HVI Advanced Practice Nurses attend the Readmissions Task Force Committee meetings and are reviewing cases concurrently to identify any possible process improvement issues.
  - HVI APN's are also identifying patients at high risk for readmission and calling them within one week of discharge to ensure patients are following up with a physician, taking their medications and following an appropriate nutrition plan.
  - The Cardiopulmonary Wellness Center has also implemented comprehensive one-on-one nutrition and stress management consultations for patients who have discharged with these diagnoses.
  - Heart Failure rounds occurring weekly with the Medical Director, APN and 3B nurses in attendance

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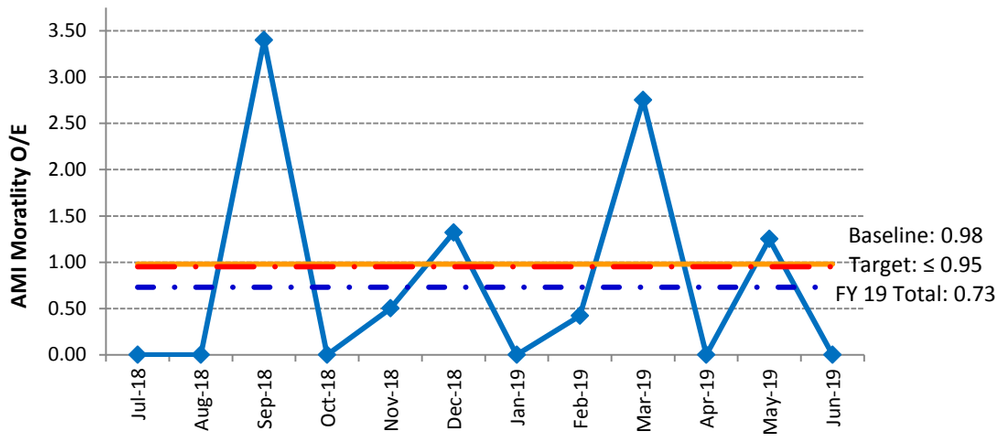
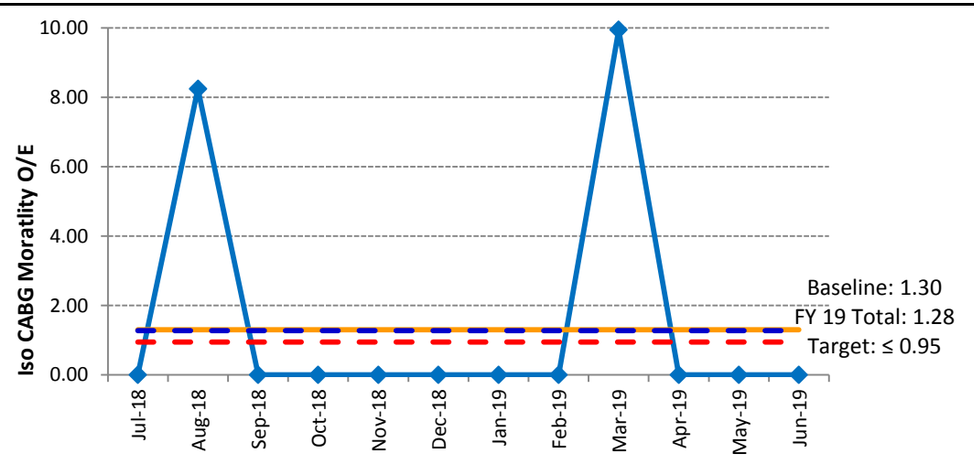
Heart and Vascular Institute Dashboard for FY 2019 - enterprise

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Enterprise Target FY 2019	Trend Graph
	Latest Month	FY 19 Total				
Acute Myocardial Infarction Mortality O/E *Reporting Period: July 2018 - June 2019* *Lower is better*	O/E= 0.00 n= 0/25	O/E= 0.73 n= 8/260	O/E= 0.98 n= 13/280	O/E < 1.00	O/E ≤ 0.95	
Isolated CABG Mortality O/E *Reporting Period: July 2018 - June 2019* *Lower is better*	O/E= 0.00 n= 0/10	O/E= 1.28 n= 2/101	O/E= 1.30 n= 2/113	O/E < 1.00	O/E ≤ 0.95	

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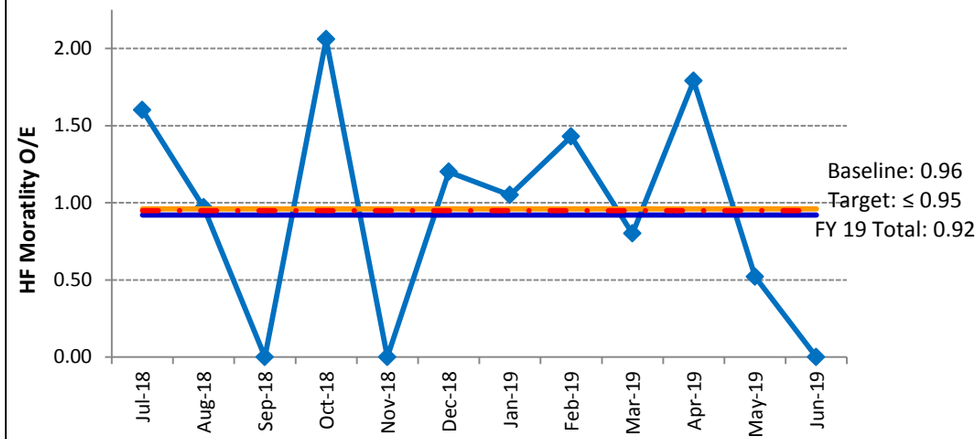
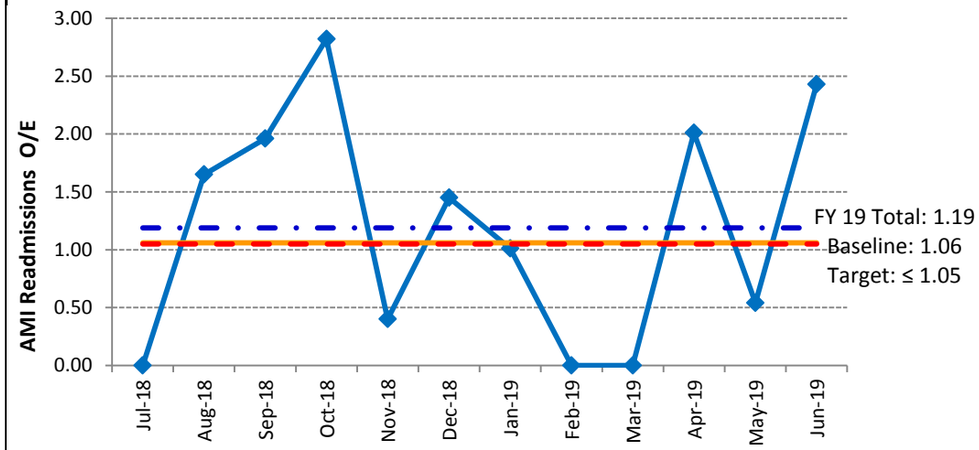
Heart and Vascular Institute Dashboard for FY 2019 - enterprise

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Enterprise Target FY 2019	Trend Graph
	Latest Month	FY 19 Total				
Heart Failure Mortality O/E *Reporting Period: July 2018 - June 2019* *Lower is better*	O/E= 0.00 n= 0/54	O/E= 0.92 n= 16/569	O/E= 0.96 n= 17/589	O/E < 1.00	O/E ≤ 0.95	
Acute Myocardial Infarction Readmissions O/E *Reporting Period: July 2018 - June 2019* *Lower is better*	O/E= 2.43 n= 5/25	O/E= 1.19 n= 23/251	O/E= 1.06 n= 21/266	O/E < 1.00	O/E ≤ 1.05	

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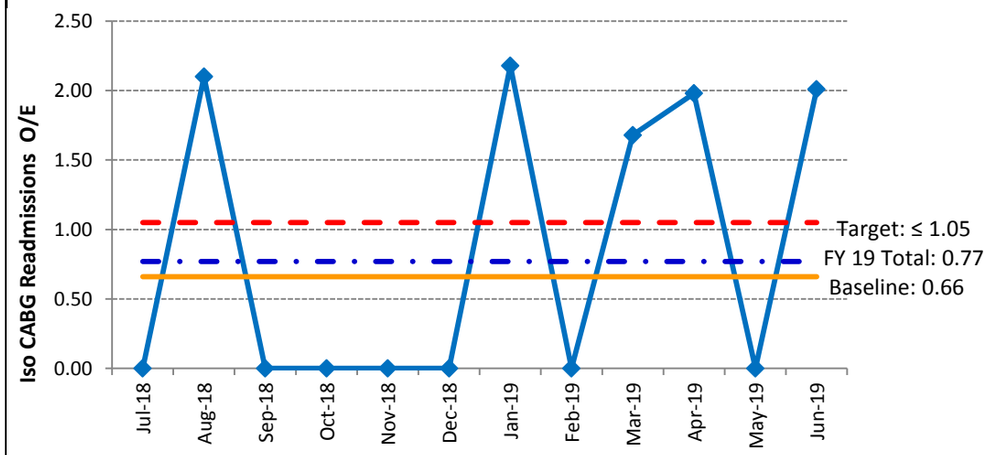
Heart and Vascular Institute Dashboard for FY 2019 - enterprise

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018 Actual	Target FY 2019	Enterprise Target FY 2019	Trend Graph
	Latest Month	FY 19 Total				
Isolated CABG Readmissions O/E *Reporting Period: July 2018 - June 2019* *Lower is better*	O/E= 2.01 n= 1/10	O/E= 0.77 n= 5/99	O/E= 0.66 n= 5/111	O/E < 1.00	O/E ≤ 1.05	

Annual Performance Improvement Report

Department/Service Line: Care Coordination
Prepared by: Grace Benlice
Date: 9/25/2019
Reporting Period: FY 2019

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

Share your data analysis and conclusions after review of the previous Data Dashboard for the reporting period. Use bullet points:

- *Organizational Goal: Mortality Index(O/E)Target:0.95, FY 2019 Performance:0.97*
- *Organizational Goal: Readmission Index (O/E) Target:1.05, FY2019 Performance:0.99*
- *Length of Stay: Baseline 2018: 4.53, FY 2019 Performance: 4.6*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- **Mortality Index**: lack of expansion to Los Gatos of GIP program, lack of MD engagement in GIP, lack of GIP education
- **Readmission Index:** Doing well but continuing work on Readmission prevention such as weekly Root Cause Analysis, continuing Post-Acute Collaboration, Discharge information, etc, New: aligning outpatient referral processes to prevent ED visits and readmissions, timely identification of malnutrition as a co-morbidity that contributes to readmissions
- **Length of Stay**: lack of care coordination staffing (total of 7 medical leaves from November 2018-June of 2019), long ICU stays, long LOS cases mostly oncology (i.e: 128 days stay of a multiple melanoma patient, full code 80+yo, with complex wounds, 60 + days Stage 4 pancreatic CA also Risk case, 60+ days of Medulloblastoma, etc), lack of early goals of care discussion by Oncology.

Describe quality improvement actions taken to address the data and outcomes:

Use bullet points to list actions taken:

- ***Mortality index:*** GIP program officially started on April 2019, Labor Committee approved 1 social work FTE for ECH LG to expand Palliative Care, then expand GIP to ECH LG, continue Physician Academy for next year, continue education for GIP.

- ***Readmission Index:*** Ongoing work group for Readmissions, GIP Program started in April 2019, added Placement Specialists in February 2019 to schedule follow up MD appointments, working with outpatient departments to support efforts on preventing readmissions and unnecessary ED visits, Imaging has shared their referral process, which we then shared with SNFs, Infusion Center doesn't have the capacity to accept new referrals. Endoscopy is pending.

- ***Length of Stay:*** Fully staffed now and expanded weekend coverage for ECH LG, also hired 1 FTE for LG to help with the increased volume since 2018, placement specialists added in February 2019 to help facilitate discharges, Post Acute Network has accountability to support ECH goals for lowering LOS and are working cooperatively with Care Coordination to place difficult patients, discussed with Dr. Adams to possibly have ICU LOS as goals of CCU Medical director and Oncology Medical Director.

Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

Use bullet points to describe improvement:

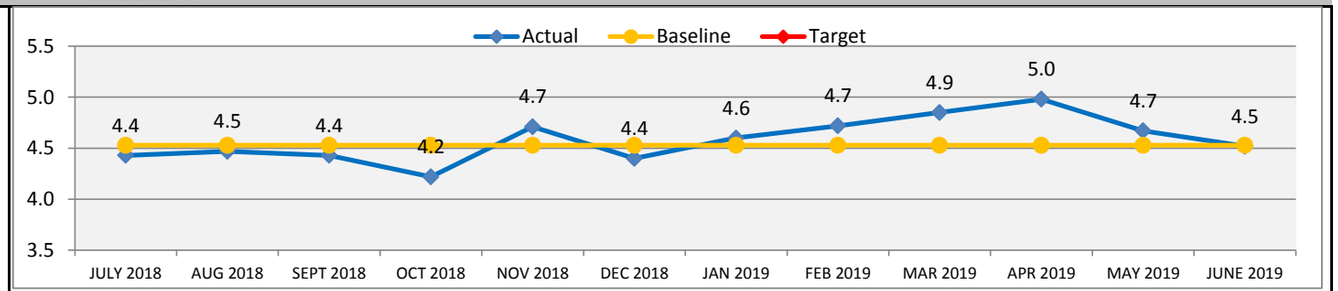
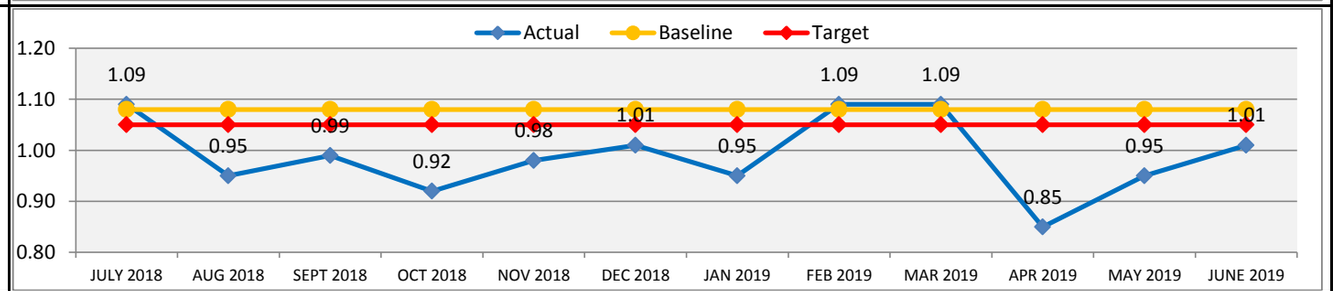
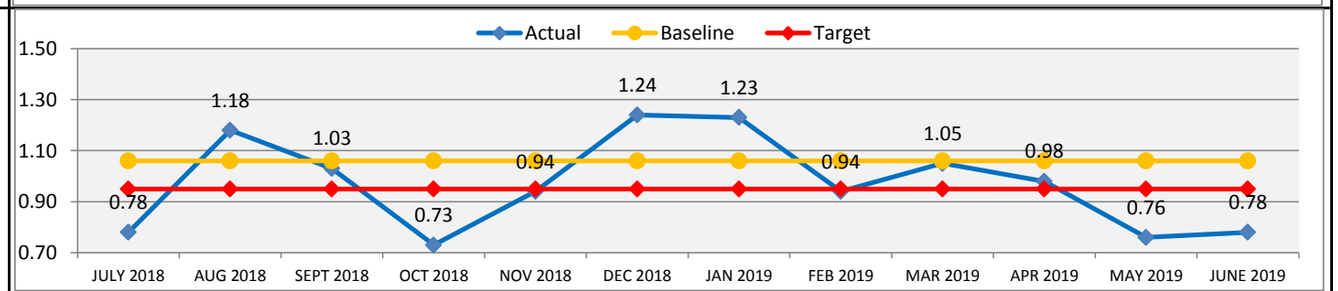
- ***Mortality Index:*** July 2019 data showing O/E: 0.73

- ***Readmission Index:*** July 2019 data showing O/E: 0.98

- ***Length of Stay:*** YTD: 4.14 days

El Camino Health

Care Coordination Dashboard - FY 2019 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Latest Month	FYTD			
METRICS					
Length of Stay (LOS) Inpatient (ex: Psych & Acute Rehab) Payor : Medicare Source : Epic Clarity Report (iCare) *Latest Data Month* : June 2019	4.52	4.60	4.53	-	
Readmission Index (O/E) *(Observed Rate / Expected Rate)* Source : Premier Quality Advisor *Latest Data Month* : June 2019	1.01	0.99	1.08	1.05	
Mortality Index (O/E) *(Observed Rate / Expected Rate)* Source : Premier Quality Advisor *Latest Data Month* : June 2019	0.78	0.97	1.06	0.95	

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Annual Performance Improvement Report

Department/Service Line:
Prepared by: Andre Rossi, Pharm.D., Mojgan Nodoushani, Pharm.D. Poopak Barirani Pharm.D.
Date: October 2, 2019
Reporting Period: FY 2019

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

Share your data analysis and conclusions after review of the previous Data Dashboard for the reporting period. Use bullet points:

- ***MV Controlled Substances Audits:*** *Performed from the Pyxis stations transactions covering from stocking to removal for administer and waste in all areas including anesthesia. (FY 2018 reflects only anesthesia Pyxis stations).The rates have been remained well below 1%.*

- ***MV Reversal Agents Usage:*** *Overall, naloxone and flumazenil usage have decreased from a total of 66 events in FY 2018 to a total of 46 events in FY 2019. About 25% of the events were non-responsive to the reversal agent, highly indicating another cause for the event. The primary risk factors identified for overmedication include older age and renal dysfunction. D50 usages are only level 3 and none were on patients who were receiving insulin drip.*

- ***MV Near misses (errors caught prior to the medication leaving the pharmacy):*** *Near misses continued to be at a low rate. The staff is encouraged to report all near misses. Also, use of automation has helped to catch more errors prior to dispensing.*

- ***LG Controlled Substance Audits:*** *Random audits of the controlled substance are performed tracing the Pyxis transactions from removal to administration, and/or waste, including anesthesia. Falls outs are reported to nursing and anesthesia for follow up.*
  The fall out rates (number of fall outs/total number of transactions audited) remain well below 1%. Concurrent reports made to anesthesia and nursing management on fall outs as well as quarterly aggregate report to identify any repeat offenders.

- ***LG Reversal Agents****: Three reversal agents (Dextrose 50%, Flumazenil and Naloxone) usage is tracked and reported to P&T as part of aggregate Adverse Drug Reaction report. Level 3 is defined as holding the offending medication plus treatment (naloxone, flumazenil, dextrose 50%).All were level 3 and none required the patient to be moved to higher level of care.Total raw numbers remain low. 2 of the D50 cases were on insulin drip.*

- ***LG Pharmacy Near Misses (errors caught prior to the medication leaving the pharmacy)****:*
  Data collected based on errors caught in Pyxis refills, doses issued out of the pharmacy and IV preparation errors. Data is normalized to the number of doses dispensed
  Rates remain well below 1%

- ***Enterprise Clinical Intervention and Monitoring Documentation-*** *Pharmacists documentation of interventions for the various clinical functions they perform (including but not limited to pharmacy driven protocols, antimicrobial stewardship, renal dosing, IV to PO conversions) demonstrate their level of clinical involvement in providing best practice pharmaceutical care to our patients and pharmaceutical services to our physicians and nurses. The number of these clinical interventions per 1000 patient days remains consistent for FY2019 compared to the baseline of FY2018.*

Areas of Concern or Opportunities for Improvement:

Bullet point issues and opportunities identified for improvement:

- ***Controlled Substance Audits***
  - *Continued effort to strive for very low fall outs for controlled substances by collaboration with the anesthesiologists and nursing.*

- ***Reversal Agents Usage***
  - *Continued awareness of the impact of age (75% of patients >65yo) and renal function (50% of patients with renal dysfunction) with the use of opioids and benzodiazepines.*
  - *Continued monitoring for appropriate dosing of the opiates*

- ***Pharmacy Near Misses***
  - *Opportunities for sufficient training and staff education to follow all steps involved in proper medication preparation by looking into the trend of errors and through root cause analysis.*

- ***Pharmacists' Clinical Functions***
  - *Need for continuous staff education and development as we expand the scope of our pharmacy driven protocols.*

  - *With introduction of new regulatory requirements (i.e., National Patient Safety Goal around use of anticoagulants), there will be more clinical functions/protocols for pharmacists to perform on a daily basis.*

Describe quality improvement actions taken to address the data and outcomes:

Use bullet points to list actions taken:

- ***Controlled Substances Audit***
  - *Pharmacy's close collaboration and communication with nursing unit managers and continuous staff education are the elements of achieving high success.*

- ***Reversal Agents Usage***
  - *Revised the opioid standalone orders by reducing the dose and frequency buttons – initiated around 11/2018. Implemented the ED opioid free policy and ED non-opioid order set – initiated around 12/2018. EPIC is working on the development of an opioid risk factor assessment that will be available with opioid orders. Staff education on opioids and risk factors for overmedication*
  - *Monitoring for trends in the use of reversal agents for procedural sedation.* Bring awareness to the anesthesiology department on the use of reversal agents for procedural sedation

- ***Pharmacy Near Misses***
  - *Encouraging staff to report own near misses. Monitoring and looking into trends of error and applying related education and modifying training accordingly.*

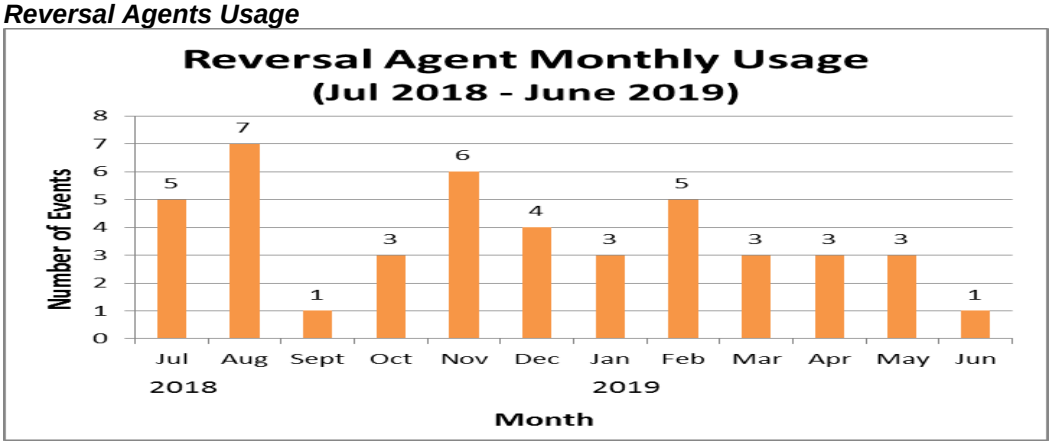
Use bullet points to list actions taken:

- ***Education***
  - *As there is new pharmacy driven protocols implemented, there needs to be sufficient education provided to staff. All the competency modules developed on the various pharmacy driven protocols require a 100% passing score.*
  - *Enterprise wide presentation of Clinical Pearl Huddles for pharmacists.*
  - *Providing education to pharmacists, physicians and nurses on the updated best practice guidelines.*

Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

Use bullet points to describe improvement:

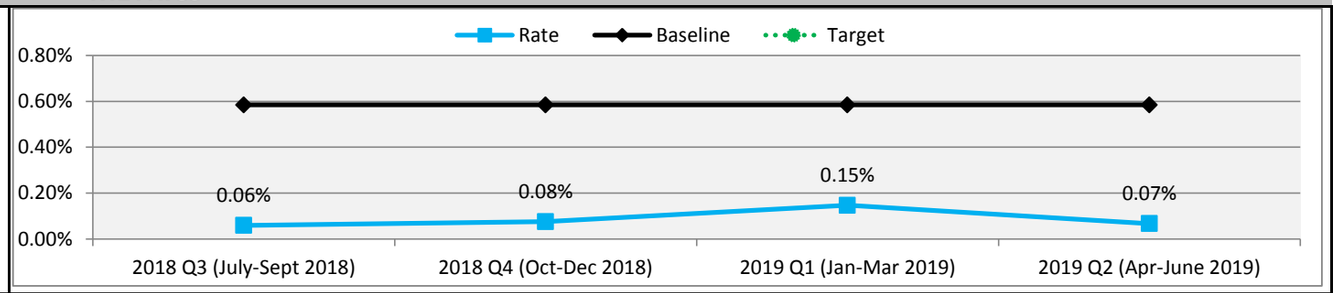
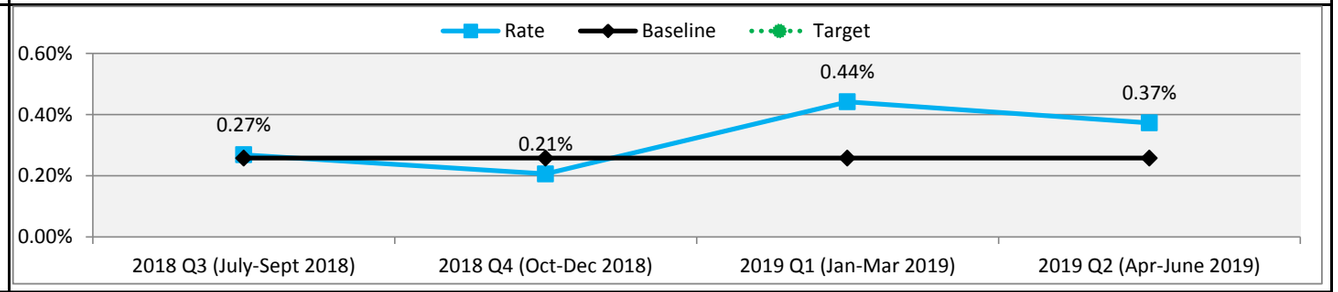
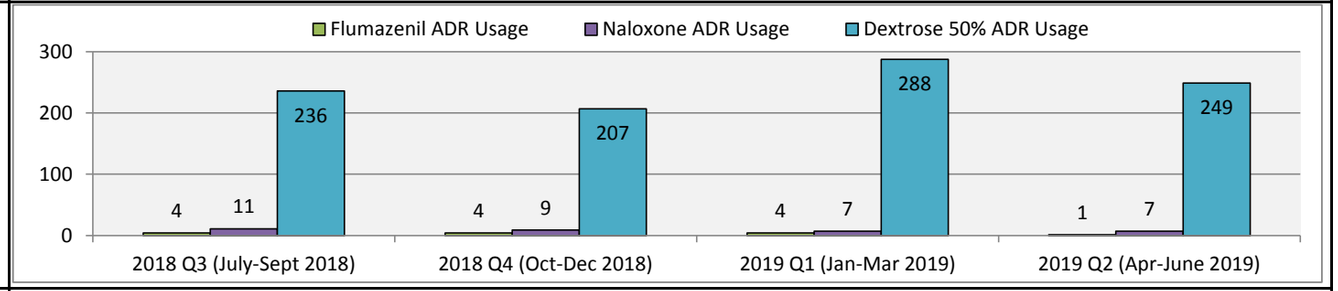
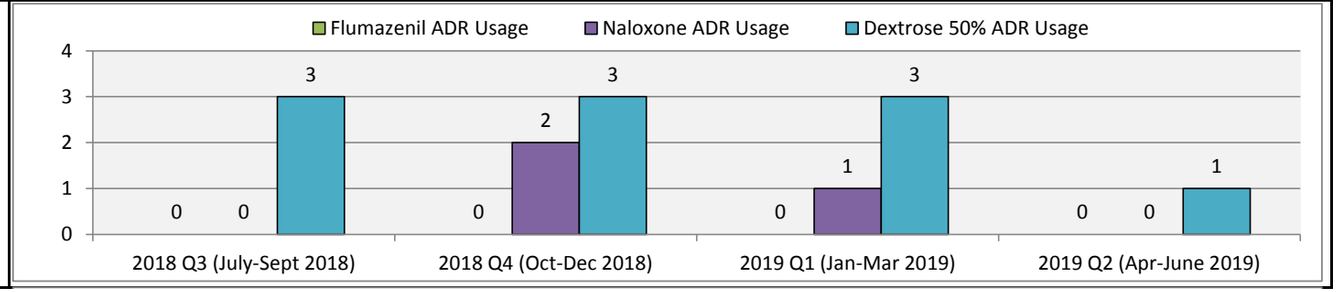
- ***Controlled Substances Audit***
  - *Continued effort to strive for very low fall outs for controlled substances by collaboration with the anesthesiologists and nursing.*
- ***Reversal Agents Usage***



- ***Pharmacy Near Misses***
  - *Expected improvement in med error reduction on medications being dispensed through close monitoring of near misses trend.*
- ***Pharmacists Clinical Interventions-*** *The number of clinical interventions are expected to rise with intorduciton of more pharmacy driven protocols and new clinical services.*

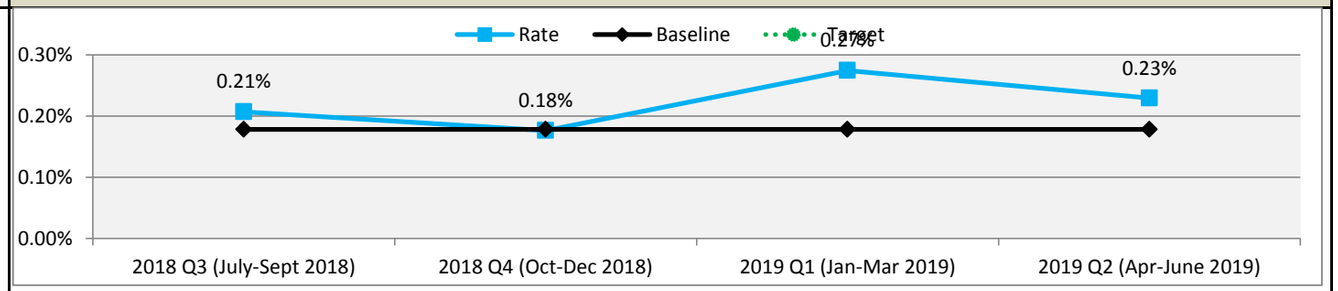
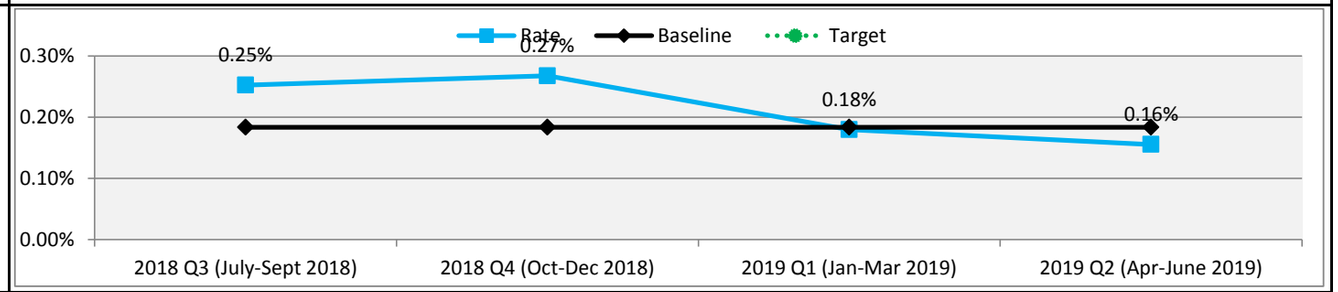
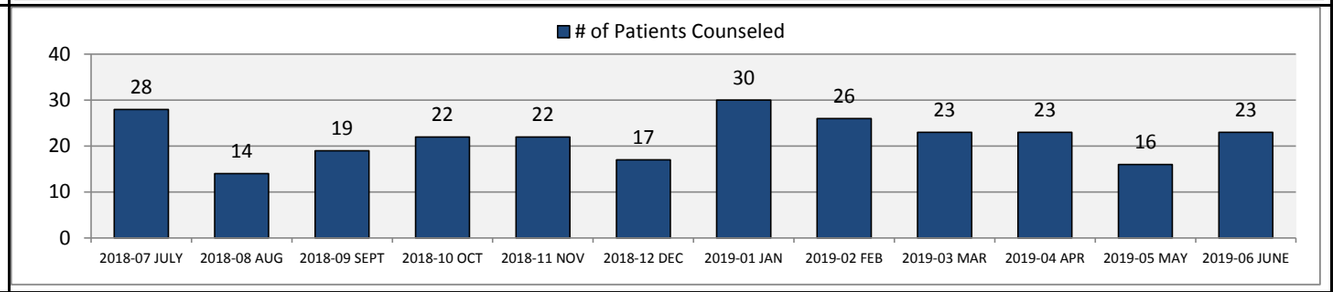
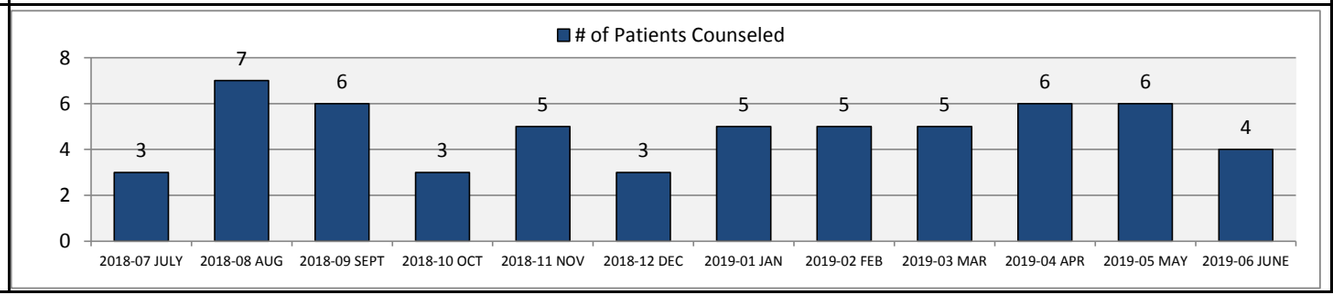
El Camino Health

Pharmacy Dashboard - FY 2019 (July 2018 - June 2019) Performance

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Latest Quarter	Fiscal Year Avg			
METRICS					
Controlled Substance Audits **- ECH MV -** *Latest Data Quarter : 2019 Q2*	0.07%	0.09%	0.58%	-	
Controlled Substance Audits **- ECH LG -** *Latest Data Quarter : 2019 Q2*	0.37%	0.33%	0.26%	-	
Reversal Agent Usage **- ECH MV -** *Latest Data Quarter : 2019 Q2* *Note : All Cases in FY19 were Level 3 cases*	**Total Count** Flumazenil - 1 Naloxone - 7 Dextrose 50% - 249	**Total Count** Flumazenil - 13 Naloxone - 34 Dextrose 50% - 980	**Total Count** Flumazenil - 24 Naloxone - 42 Dextrose 50% - 992	-	
Reversal Agent Usage **- ECH LG -** *Latest Data Quarter : 2019 Q2* *Note : All Cases in FY19 were Level 3 cases*	**Total Count** Flumazenil - 0 Naloxone - 0 Dextrose 50% - 1	**Total Count** Flumazenil - 0 Naloxone - 3 Dextrose 50% - 10	**Total Count** Flumazenil - 2 Naloxone - 9 Dextrose 50% - 10	-	

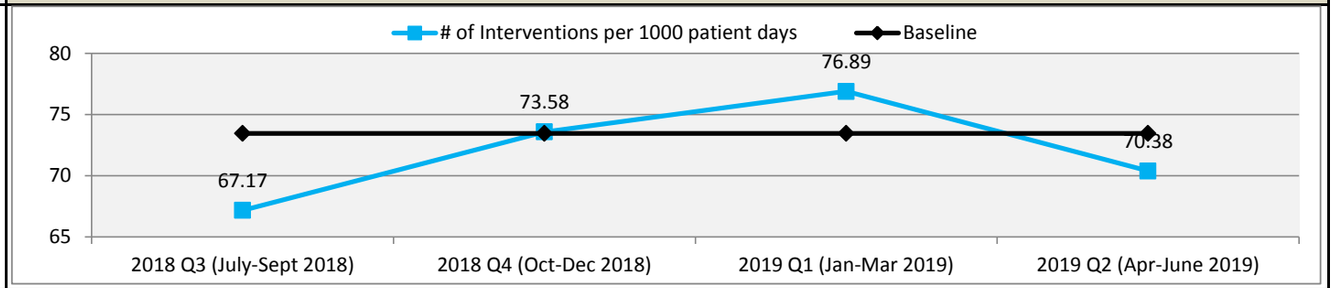
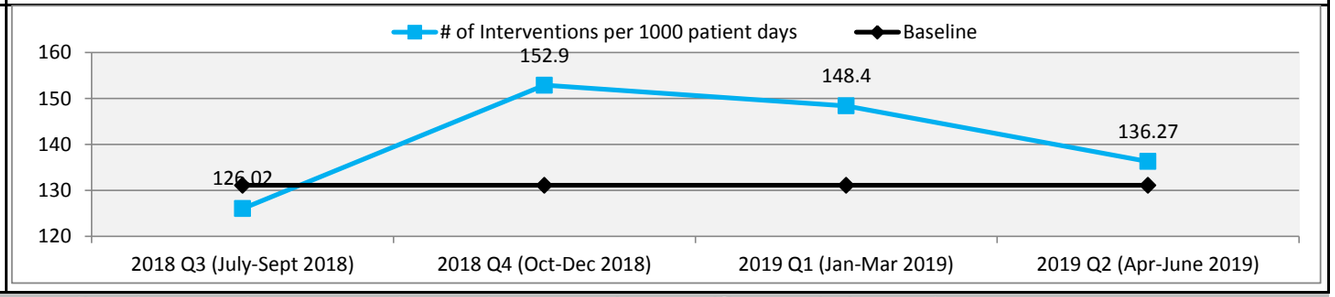
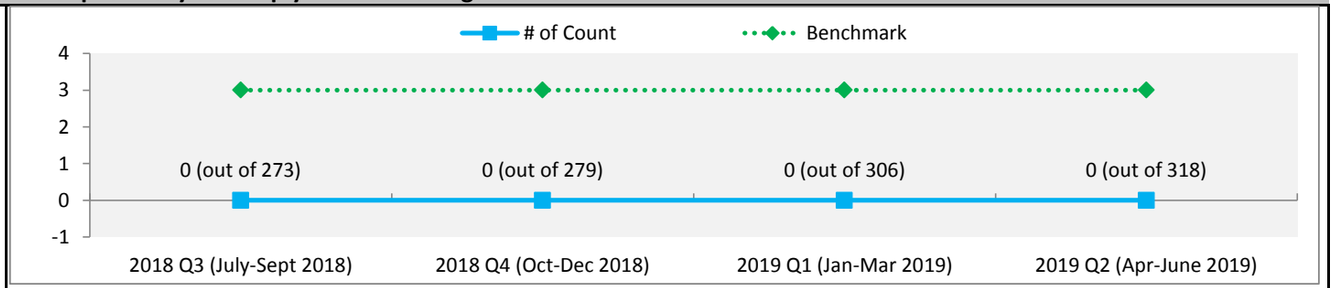
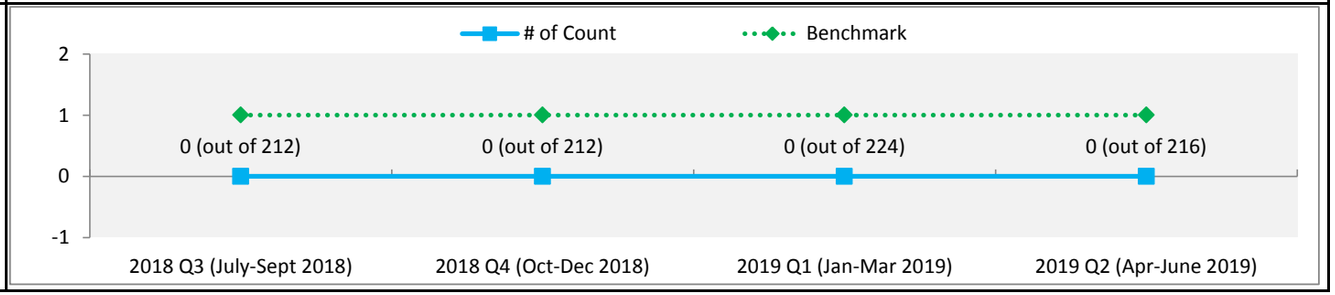
El Camino Health

Pharmacy Dashboard - FY 2019 (July 2018 - June 2019) Performance

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Latest Quarter	Fiscal Year Avg			
Pharmacy Near Miss Report **- ECH MV -** *Latest Data Quarter : 2019 Q2*	0.23%	0.22%	0.18%	-	
Pharmacy Near Miss Report **- ECH LG -** *Latest Data Quarter : 2019 Q2*	0.16%	0.21%	0.18%	-	
Pharmacist Medication Counseling Program - Pre-Operative Classes - **# of Outpatients (Hip/Knee Patients) counseled** **- ECH LG Only -** *Latest Data Quarter : 2019 JUNE*	**Total Count** 23	**Total Count** 263	**Total Count** 312	-	
Pharmacist Medication Counseling Program - Pre-Operative Classes - **# of Outpatients (Spine patients) counseled** **- ECH LG Only -** *Latest Data Quarter : 2019 JUNE*	**Total Count** 4	**Total Count** 53	**Total Count** 66	-	

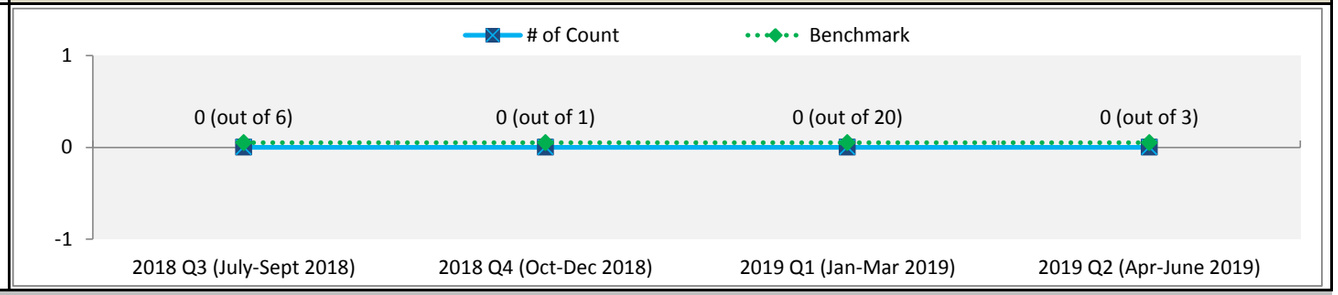
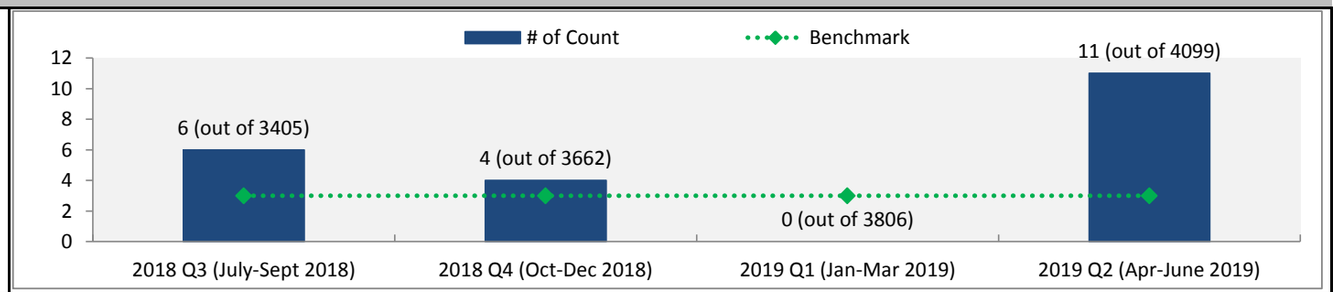
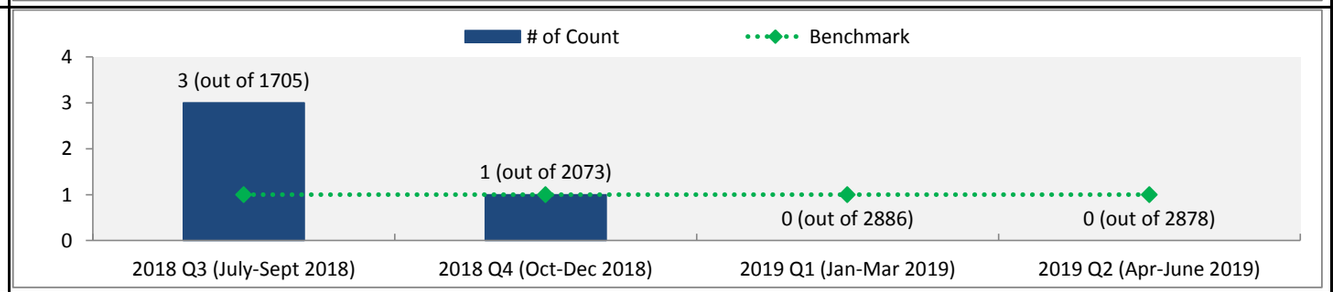
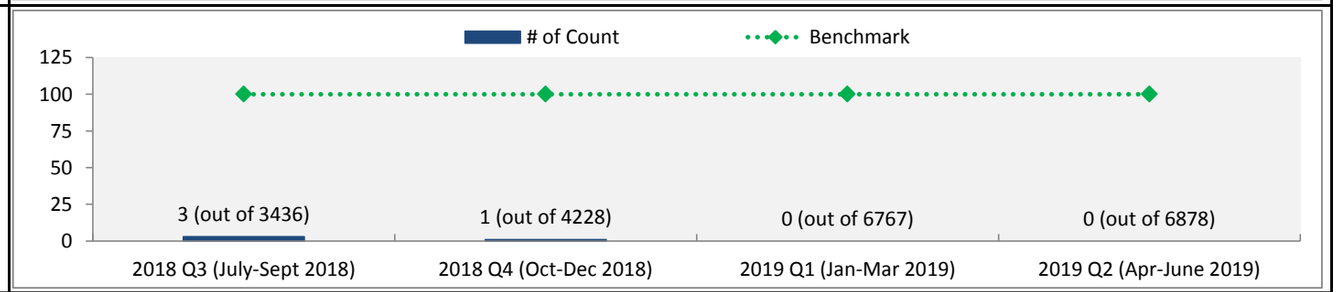
El Camino Health

Pharmacy Dashboard - FY 2019 (July 2018 - June 2019) Performance

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Latest Quarter	Fiscal Year Avg			
Clinical Interventions per 1000 Patient Days **- ECH MV -** *Latest Data Quarter : 2019 Q2*	70.38	72.01	73.45	-	
Clinical Interventions per 1000 Patient Days **- ECH LG -** *Latest Data Quarter : 2019 Q2*	136.27	140.90	131.10	-	
503A facilities are referred to by the FDA as a traditional compounding pharmacy that compounds accordance to patient specific prescriptions and is required by the state boards of pharmacy to comply with USP and guidelines					
503A-CAPS Personnel: Gloved Fingertips and thumb (test is done weekly, benchmark finding is less than 3 cfu) *Latest Data Quarter : 2019 Q2*	**Total Count** 0 (out of 318)	**Total Count** 0 (out of 1176)	-	<3	
503A-CAPS Air Bioburden : (ISO class 5 workstation, testing done weekly, benchmark is equal or less than 1 cfu per plate) *Latest Data Quarter : 2019 Q2*	**Total Count** 0 (out of 216)	**Total Count** 0 (out of 864)	-	≤ 1	

El Camino Health

Pharmacy Dashboard - FY 2019 (July 2018 - June 2019) Performance

KEY PERFORMANCE INDICATORS & METRICS	FY 2019 Performance		Baseline FY 2018	Target or Benchmark	Trend Graph
	Latest Quarter	Fiscal Year Avg			
503A-CAPS **Media Fill :** (low/med risk. Test is done e annually. Benchmark is zero growth) *Latest Data Quarter : 2019 Q2*	**Total Count** 0 (out of 3)	**Total Count** 0 (out of 30)	-	0	
503B facilities are referred to by the FDA as an outsourcing facility that may produce large batches with or without prescriptions to be sold to healthcare facilities, non-patient specific					
503B-CAPS **Personnel:** **Gloved Fingertips and thumb** (test is done weekly, benchmark finding is less than 3 cfu) *Latest Data Quarter : 2019 Q2*	**Total Count** 11 (out of 4099)	**Total Count** 21 (out of 14972)	-	<3	
503B-CAPS **Air Bioburden :** (ISO class 5 workstation, testing done weekly, benchmark is equal or less than 1 cfu per plate) *Latest Data Quarter : 2019 Q2*	**Total Count** 0 (out of 2878)	**Total Count** 4 (out of 9542)	-	≤ 1	
503B-CAPS **Particle Counts Non-viable :** (ISO class 5 workstation, test done daily. Benchmark: equal or less than 100 particles per cubic foot growth) *Latest Data Quarter : 2019 Q2*	**Total Count** 0 (out of 6878)	**Total Count** 4 (out of 21309)	-	≤ 100	

Annual Performance Improvement Report

Department/Service Line: Nutrition Services
Prepared by:
Date: 9/25/19
Reporting Period: FY 19

The purpose of this Performance Improvement Report is to share the work of this department/service line as part of ECH's hospital-wide, data driven, quality assessment and performance improvement program.[1]

Data Analysis & Conclusions:

- **Clinical Chart Audit**
  - MV- overall improvement ↑2.1% over prior year for assessments completed per policy
  - LG- overall improvement ↑1.3% over prior year for assessments completed per policy.

- **Enterprise food safety audits**
  - met threshold expectations of ≥95% compliance
  - no change in score for MV from prior year
  - LG ↑0.8% from prior year

- **Patient Engagement Overall Food Score**
  - decreased from previous year
  - MV ↓0.8 points
  - LG ↓4.2 points YTD

- **Malnutrition Diagnoses by Dietitian**- formal implementation FY19 (December). Data demonstrates increased diagnoses with identification from Clinical Dietitian.

Areas of Concern or Opportunities for Improvement:

- **Chart Audit** - non-compliant assessments related to insufficient staffing, policy not followed for assigning risk (oversight)

- **Food Safety Audits** - findings include equipment repair needs, water leaks, missing dates, food stored too high on shelves

- **Patient Engagement Food Score** - temperature and quality scores decreased, feedback from patients with mixed reviews on offerings, staff workflow deficiencies identified and production areas evaluated for inefficiencies

- **Malnutrition Diagnoses** - continued education and training for clinical dietitians and physicians to improve overall identification of patients with moderate to severe PCM

[1] Comprehensive Accreditation Manual for Hospitals, LD.01.03.01 EP6, and CMS Condition of Participation 482.21.

Describe quality improvement actions taken to address the data and outcomes:

- **Clinical chart audit**- prioritization of assessments includes consults, high risk patients, patients identified with malnutrition and PI's. Reviewed assessment policy with clinical dietitians.

- **Food Safety Audits**- timeliness of work orders, continued education on food rotation, labeling and temperature documentation. Evaluated if all necessary tools available for staff to complete work properly. Purchasing new equipment to improve temperature control.

- **Patient Engagement Overall Food Score**- team collaboration for menu updates (working on recipe development, product sourcing, nutritional analysis, CBORD diet/restriction compliancy), new equipment on order to better maintain hot food temperatures upon delivery, staff education of goals, tray audits and random quality/temperature inspections

- **Malnutrition Diagnoses**- CEU opportunities for dietitians to increase their level of knowledge and practice, including training on Nutrition Focused Physical Exams for improved identification of malnutrition (fat loss, muscle wasting, decline in strength, nutrient deficiencies); physician newsletter article on Dietitians role in identification of malnutrition

Describe improvements made in the areas of focus or outcomes (one page of graphic display may be attached):

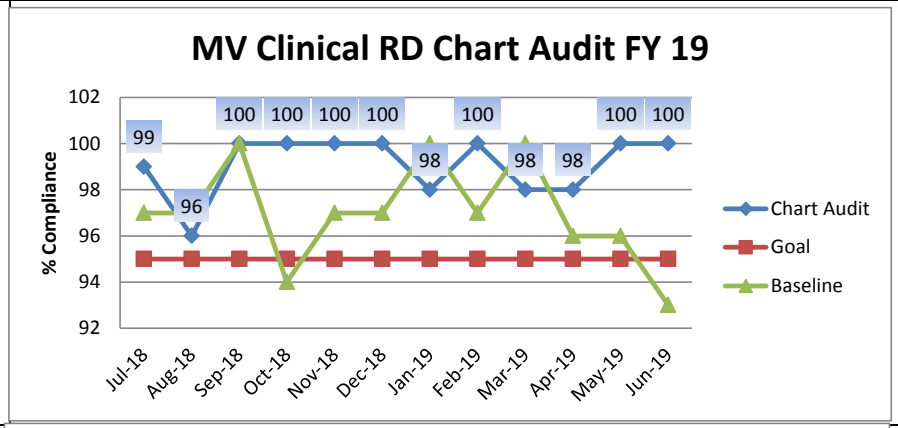
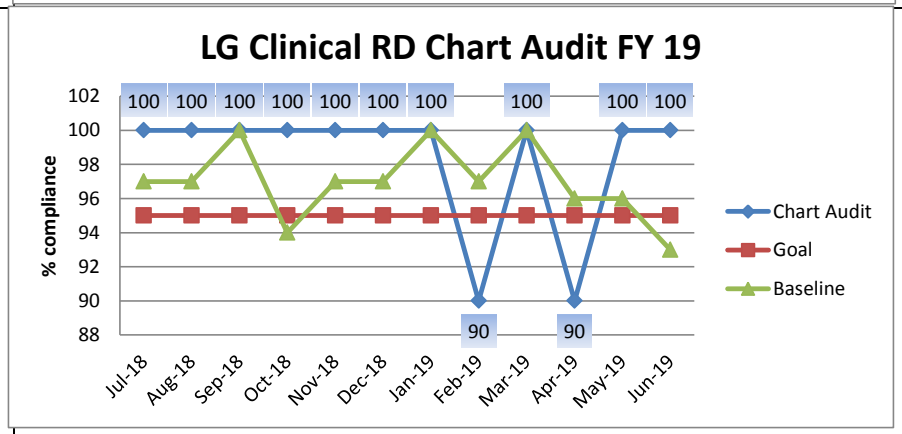
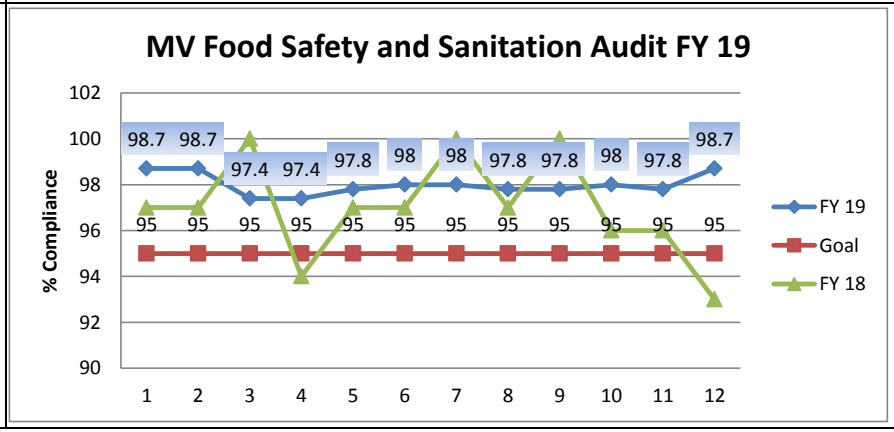
- **Clinical Chart Audit- FY 20 YTD**
  - MV overall compliance score 99% for July and August; continues to meet threshold
  - LG overall compliance score 100% for July and August; meeting threshold

- **Food Safety Audits**
  - MV FY 20 YTD overall compliance score 97%, continues to meet threshold
  - LG FY 20 YTD overall compliance score

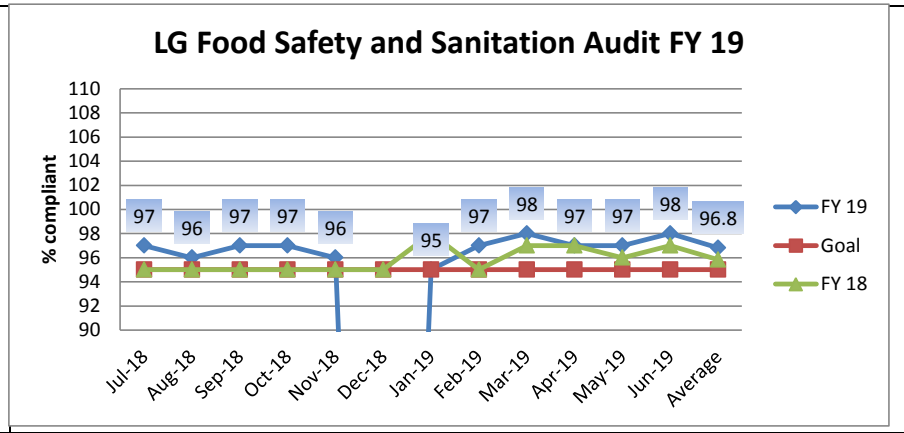
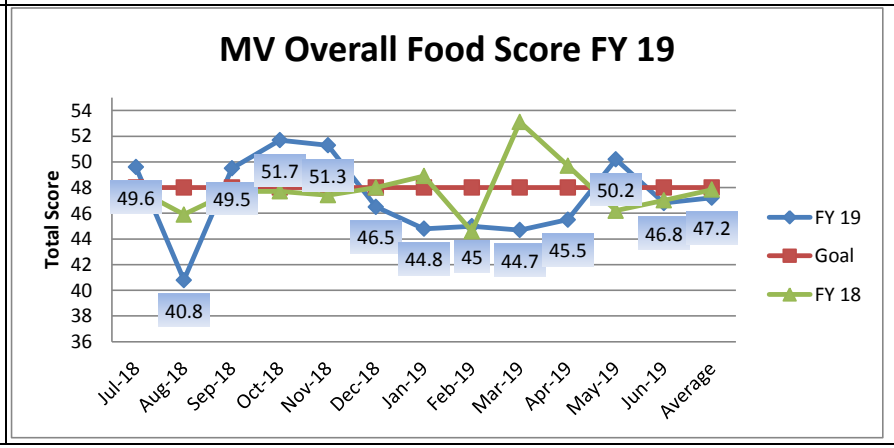
- **Patient Engagement**- drill down focus on quality score for FY 20. Some improvement in MV with July score above goal of 31.2; LG no improvement in score, goal 34.0. Due to timely process of menu development and awaiting equipment arrival, anticipate scores to show sustained improvement by mid fiscal year.

- **Malnutrition Diagnoses**- continued work with staff and collaboration with CDI department for data collection and reporting. Overall trend upward since Dietitian engagement in process of identifying patients meeting malnutrition criteria.

El Camino Health

KEY PERFORMANCE INDICATORS & METRICS	FY 19 Total	Baseline FY 2018 Actual	Target FY 2019	Trend Graph
RD Assessment Chart Audit MV *Reporting Period: July 2018 - June 2019*	99.1%	97%	95%	
RD Assessment Chart Audit LG *Reporting Period: July 2018 - June 2019*	98.3%	97.00%	95%	
Food Safety Compliance Audit MV *Reporting Period: July 2018 - June 2019*	98%	98%	95%	

El Camino Health

KEY PERFORMANCE INDICATORS & METRICS	FY 19 Total	Baseline FY 2018 Actual	Target FY 2019	Trend Graph
Food Safety Compliance Audit LG *Reporting Period: July 2018 - June 2019*	96.80%	96.00%	95%	
Overall Food Score Patient Satisfaction MV *Reporting Period: July 2018 - June 2019*	47.2	47.8	48.0	

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: November 4, 2019
Subject: Strategic Quality and Safety Plan

Purpose:

To review and discuss the long term Strategic Quality and Safety Plan.

Summary:

1. Situation: While El Camino Health has a financial strategic plan and an operational strategic plan there has not been a long term quality and safety strategic plan.

2. Authority: The Committee and the Board requested to see, discuss and give feedback on the plan.

3. Background: The Quality Committee is tasked with overseeing the quality and safety activities and outcomes of the organization on behalf of the Board. To achieve top tier quality and safety, a long term quality and strategic plan is necessary to achieve this goal.

4. Assessment: This plan has been developed over the past several months with extensive input from many parts of the organization. The plan identifies five strategic opportunities for improvement.

5. Other Reviews: N/A

6. Outcomes: Obtain feedback from the Quality Committee regarding the plan and review the timeline with deliverables.

List of Attachments:

1. Executive Summary
2. Roadmap

Suggested Committee Discussion Questions: Does the Committee see any major gaps in the Plan? What is the Committee's role in overseeing the implementation and success of the Plan?

Agenda Item Name Here
October 10, 2018 [Meeting Date]

El Camino Quality Safety Strategic Plan

Executive Summary

In January 2019, El Camino Health engaged Progressive Healthcare, Inc. to prepare an enterprise-wide, long-range Strategic Plan for Quality and Safety and to create a "next generation" quality management program and aspirational vision for quality and safety excellence. This represents an executive summary of the final report of this work.

An initial deliverable for this work was to assess El Camino Health's Current State by viewing it through both external and internal lenses. El Camino's external metrics showed generally average performance on publicly reported measures for quality and safety. The most recent examples are the Spring 2019 Leapfrog scores that show no consistent trend in El Camino's system performance when compared to last year's scores, i.e., Mountain View's score declined from an overall B to a C, while the Los Gatos score improved from a C to a B. Similarly, the 2019 Watson Top 100 Report shows a negative performance trend in most measures other than financial performance. This reinforces that small declines in quality performance metrics, or no/little positive change in metrics when compared with peers (that are improving faster), has negative consequences to the external view. Internal benchmarks (not publicly reported) are similarly average in comparison to leading practices.

El Camino Health has several cultural challenges that must be addressed to achieve its desired quality and safety transformation. These include but are not limited to 1) the evolution of the Board's role to support quality and safety across the rapidly expanding enterprise that includes a new employed medical group this year, expanded behavioral and maternal health facilities that are soon to open and addressing seismic compliance issues at our Los Gatos Campus; 2) engaging a medical staff that is very large for the size of the enterprise, shows polarity between the current two hospital campuses and includes many physicians who are relatively unfamiliar with the organization's quality processes

Fortunately, the El Camino team widely aspires to be a "top tier" organization, one that management and multidisciplinary Quality / Safety Workshop participants described as empowered to achieve an enterprise vision "to consistently deliver the highest quality care with zero preventable harm." El Camino has many excellent staff, medical staff, and leaders at all levels who are energized to provide an increasing scope of leading-edge healthcare offerings and service excellence to address the health care needs of the area's aging, multicultural community, while simultaneously engaging the market's many large, high-tech employers in exciting innovation work.

To accomplish this "top tier" organizational performance vision, five (5) essential strategic opportunities must be addressed:

1. Revise the current Governance, Leadership, and Management structures for quality to meet the needs for alignment and coordination of quality efforts across the growing El Camino Health enterprise that, by definition, involves a myriad of stakeholders. Of the five strategic opportunities presented this one will be most relevant to the work of the Board. It will be addressed in part by:
    a. Establishing an Enterprise Quality Committee that reports to the Board Quality Committee and is responsible for:

i. Establishing the annual quality plan, and

ii. Designing, prioritizing, and resourcing quality initiatives to fulfill the plan

b. Establishing an Office of the Quality Executive that is responsible to facilitate, coordinate, integrate, and communicate quality and safety throughout the enterprise

c. Creating a Board development plan for quality and safety that includes endorsing the vision statement and managing the various knowledge and skills gaps

d. Developing a longitudinal plan to achieve a top decile performance designation, thereby addressing all measures in addition to quality

e. Ensuring the overall organizational structure fully supports a "quality / safety first" culture and achievement of top tier performance. This includes a thorough review of organizational charts with specific attention to all leadership roles, including physicians, e.g., medical staff leaders, department chairs, and medical directors; as well as structural and functional organization of both hospital campus medical staffs.

2. Enhance the operational organization of the quality department and committees by ensuring adequate multidisciplinary participation by physicians, nurses, administration, staff, patients/families, etc. This will be addressed by:

3. Similar to leading organizations, establish a rigorous continuous performance improvement "business system" to focus efforts and accelerate quality improvement, creating greater efficiency and more consistent outcomes. This will be addressed by:

4. Begin the journey to become a high reliability organization by adopting and managing the enterprise to the final "roadmap". This will be addressed by:

5. Develop a self-propagating culture of quality and safety to ensure a successful and sustained transformation to top-tier designation for quality and safety. This will be addressed through:

El Camino has attempted to "reboot" a central quality and patient safety focus several times during the past 5 years. Therefore, it is important for El Camino's leadership to demonstrate a highly visible and sustained commitment to quality and patient safety via culture change from the top. A single, powerful change in structure, process or protocols can signal to all stakeholders the importance of the start of El Camino's quality and high reliability journey and set the stage for renewed organizational focus and enthusiasm for each individual to internalize the quality vision. El Camino leaders must select and implement at least one significant change that can be rapidly designed and implemented. Many examples of such "low-hanging fruit" surfaced during the current state assessment.

Leadership, through the Enterprise Quality Committee, must also immediately lay the groundwork for several intermediate (6-9 month) projects that demonstrate sustained and visible efforts and lead to FY20 goal achievements. While these projects will take additional time to plan and resource, they will demonstrate a meaningful commitment to sustainment while inspiring organizational excellence.

This strategy was developed using a highly inclusive and consensus-driven approach in an effort to create a viable and sustainable transformation plan. To ensure that planning and initial execution are successful, several critical factors must be actively and skillfully managed in support of the roadmap.

These include but are not limited to appointing an owner, engaging MEC leadership, investing in Board and c-suite development, maintaining a sense of urgency, and ensuring resource availability.

Through targeted reorganization, communication, and multidisciplinary integration of people, processes, and technology, El Camino will achieve its aspirational top tier quality and zero preventable harm (True North) goals.

	Task Name	Start Date
		09/01/19
1.	**Leadership, Governance, and Management**	10/29/19
	Establish Enterprise Quality Committee (EQC)	10/29/19
	Clarify the roles of existing enterprise quality-related committees	10/29/19
	Ensure Organizational Structure and Function Support of "Quality and Safety First" Culture	10/29/19
	Create and Manage Board Development Plan for Quality and Safety	12/06/19
	Design Annual Quality Plan with Broad Stakeholder Input	01/01/20
	Implement a longitudinal plan to achieve top decile performance	03/03/20
2.	**Quality Organization Integration**	10/29/19
	Create, present, and periodically update required quality and safety training for all stakeholders	10/29/19
	Develop, implement, and maintain a longitudinal Medical Staff Leadership Development Program	10/29/19
	Align Quality and Safety Goals of the Enterprise (Leaders, Providers, Staff) with Annual Quality Plan	12/10/19
	Align and Enhance Process Improvement (PI) support to Support Enterprise-wide Quality - Safety Transformation	12/10/19
	Enhance Project Management Structure and Resources to Support Enterprise-wide Quality - Safety Transformation	12/10/19
	Optimize Resource Distribution and Reporting Structures via project management, etc.	06/09/20
3.	**Performance Improvement Methods and Metrics**	09/01/19
	Create Triad Leadership Teams (Physician, Nurse, Admin or PI) for all Quality / Safety Committees / Teams	09/01/19
	Create / Leverage Existing Structures to Promote Innovation, Best Practice Use, & Engagement with Ext Leading Quality Orgs	10/01/19
	Institute / Train on Standard Quality / High Reliability Improvement Methods, e.g., ACA, RCA, CCA, FMEA, etc.	10/01/19
	Establish & Maintain Ongoing Proactive Identification of Improvement Opportunities via multi-stakeholder input & tools	02/04/20
	Manage Prioritization of Quality Initiatives through Service Lines / other Multidisciplinary Teams	03/17/20
	Use Structured Process to Allocate Analytic / Reporting Resources; Implement Dashboards / Scorecards	06/02/20
4.	**Journey to become a High Reliability Organization**	09/01/19
	Redefine the "Daily Huddle" to focus on Safety and Train / Implement Safety Leadership Behaviors	09/01/19
	Define Safety as a Core Value and the "Burning Platform" for the Quality / Safety Transformation	09/01/19
	Develop / Implement / Maintain Safety Communication Tools / Dashboards / Recognition Programs, e.g., SSER	10/29/19
	Establish Key Safety Leadership Roles, e.g., Medication Safety Officer and Chief Surgeon (or "Surgeon of the Day")	10/29/19
	Develop / Implement a Series of Error Prevention Behavioral Tools and Expectations for all Stakeholders	11/01/19
	Enhance Environment Reliability and Emergency Preparedness	06/02/20
5.	**Culture of Quality and High Reliability**	10/29/19
	Demonstrate Meaningful Leadership Commitment to a Self-Propagating Culture of Quality and Safety	10/29/19
	Refine HR / Med Staff Recruiting / Credentialing / Peer Review to emphasize Quality Values / Cultural Fit	10/29/19
	Optimize Meaningful Quality and Safety Reward and Recognition Programs for all Stakeholders	10/29/19
	Implement and Promote "Fair and Just Culture" Practices	11/01/19
	Increase Transparency of Quality and Safety Outcomes	02/11/20
	Increase Stakeholder Involvement in Quality / Safety Activities, especially by Patients / Families / Caregivers	02/11/20

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Ken King, CASO
Date: November 4, 2019
Subject: FY19 Annual Evaluation of the Environment of Care and Emergency Management

Recommendation(s):

To recommend Board Approval of the FY19 Annual Evaluation of the Environment of Care & Emergency Management Report.

Summary:

1. Situation: The Annual Evaluation of the Environment of Care provides an overview of the six fundamental elements that ensure a safe and secure physical environment for the care of patients, staff and the public. These elements include the Management of Safety, Security, Hazardous Materials, Fire Safety, Utilities and Emergencies (Disaster Preparedness). The attached report provides both an Executive Summary and detailed information for each element.

2. Authority: The Annual Evaluation of the Environment of Care is required by Joint Commission standards to be reviewed and approved by the Board of Directors. It is the organizations policy that requires a recommendation from the Quality Committee.

3. Background: This is a routine annual report that is prepared by the Manager of Environmental Health & Safety and the Director of Safety and Security. Responsibility for each fundamental element is shared with subject matter experts and is reviewed and approved by the Central Safety Committee.

4. Assessment: As the report indicates we have had a successful year that with a decrease in work related injuries compared to the prior year, along with a very successful outcome with the triennial Joint Commission survey relative to the EOC.

5. Other Reviews: The hospital's Central Safety Committee and Emergency Management Committee have reviewed and approved of this report and recommend approval by the Quality Committee and Board of Directors.

6. Outcomes: Detailed within the report.

List of Attachments:

1. FY19 Evaluation of the Environment of Care & Emergency Management Report

Suggested Committee Discussion Questions:

1. Are there any trends or risks that could affect the organizations provision of care?

El Camino Health

FY-2019 Evaluation of the Environment of Care and Emergency Management

Prepared by:

Steve Weirauch
Manager, Environmental, Health & Safety

Matt Scannell
Director, Safety and Security

Created: 08/22/2019

Table of Contents

Executive Summary

The Safety Program for Managing the Environment of Care is to inform the Hospital Board of Directors of the status of key measurement criteria for the Hospital's safety program implementation that meets Injury and Illness Prevention Program OSHA requirements, and The Joint Commission (TJC) standards.

Safety Management

- The safety program indicators showed a decrease in the rate of all work-related injuries compared to FY-18.
- A significant factor in this decrease is attributed to the Safe Patient Handling program. Patient handling injuries continued to decrease for the 4th straight year.
- Bloodborne pathogen exposures decreased over FY18. One third of the exposures were due to needle sticks. Investigation found a wide variation in the types of needles used across the enterprise which could be a factor in the number of exposures. Work will continue to standardize syringes and ensure staff are trained.

Security Management

- Efforts continued to decrease the number of workplace violence incidents. New procedures and tracking of violence-prone patients has helped decrease the number of incidents by 16% over the FY18 numbers. Efforts are ongoing to continue this trend.
- Code Gray events (aggressive or threatening person) increased during the year. Contributing factors were determined to be:
  - Staff awareness to call for assistance early if patient appears threatening; a positive outcome to ensure staff safety.
  - Multiple incidents involving the same patient. A task force is developing procedures to address and minimize these events.

Hazardous Material Management

- No citations from the Santa Clara County Environmental Resources Agency
- One waste water violation occurred – monthly samples were not collected for a period. This has been corrected.
- Five recordable hazardous materials incidents
  - 2 chemo – MV Infusion center and MV Patient room (no exposure or injuries reported)
  - 3 Formalin – LG OR, MV Imaging, MV OR (one exposure, but no injuries reported)

Fire Safety Management

- One reported fire incident – a patient on oxygen ignited paper causing a small fire. Patient had minor injuries. Mountain View fire responded. Minimal damage, room back in service the same day.

Utility Management

- Two reportable utility incidents – brief power outages

Emergency Management

- Three events requiring the activation of the Hospital Incident Command System (HICS)
  - The Joint Commission tri-annual survey (12/2018)
  - PG&E Power Outage in Mountain View (02/28/2019)
  - CMS Validation Survey (06/2019)

Program Overview

The Joint Commission (TJC) standards provide the framework for the Safety Program for Managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Safety Work Group, and representatives from Infection Control, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends (See Attachment 2a). The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2019. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management

Work Group Chair: ***Mari Numanlia-Wone***

Scope

Safety Management is the responsibility of hospital leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

- Employee Wellness & Health Services
- Education Services
- Quality and Patient Safety
- Infection Prevention
- Security Management
- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

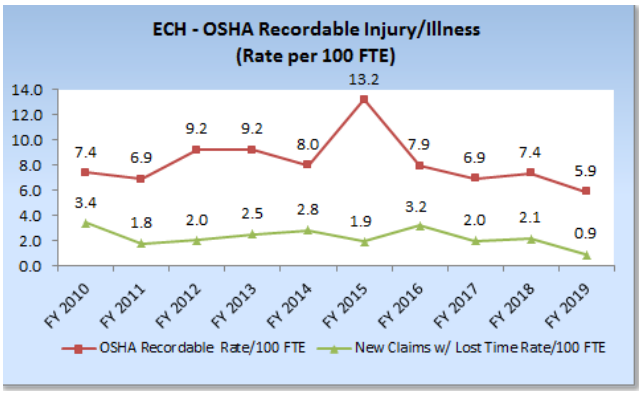
Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-19. This includes data from both the Mountain View and Los Gatos campuses.

[See Attachment 1 for a definition of terms and formulas used to calculate in this report.]

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE decreased in FY-19 to 5.9 as compared to 7.4 in FY-18. The total *number* of recordable incidents decreased to 145 compared to 176 in FY-18. This is the lowest rate in the last ten years!



The rate of injuries for lost work days for all open claims (per 100 FTEs) decreased significantly to 0.9 in FY-19 from 2.1 in FY-18. Again, this is the lowest rate in the last ten years!

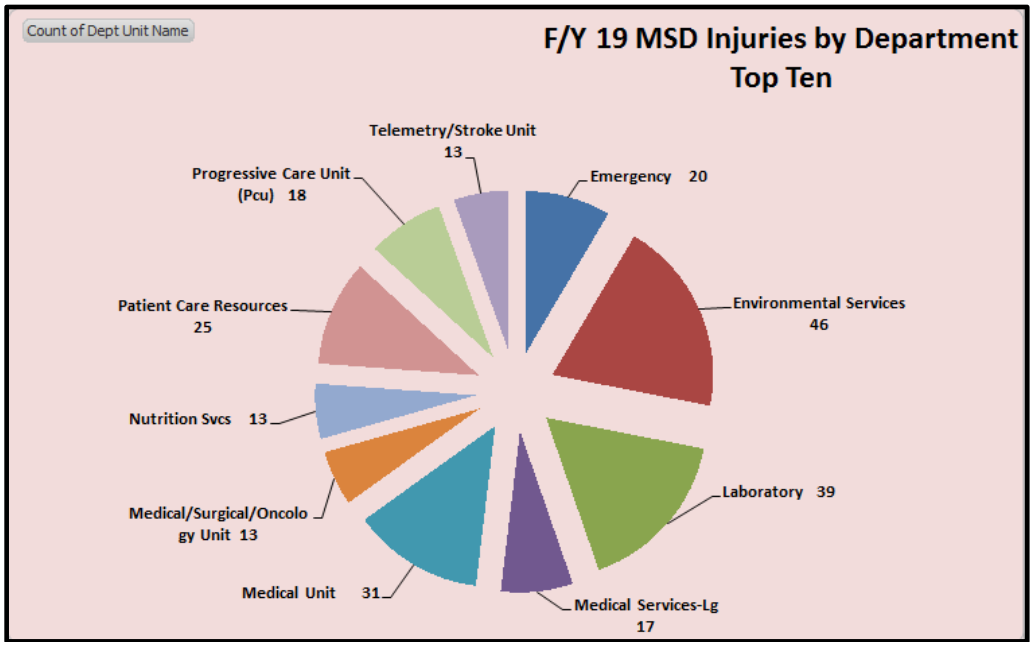
Analysis

- In FY-19 we had a 19% reduction in OSHA recordable injuries compared to FY-18.
- In FY-19 loss time days were reduced by 85% compared to FY-18. In FY-18 we had 1,654 days of loss time compared to 255 in F/Y19. This number directly contributes to the Organization's productivity as we keep our employees at work.
- The decreased in injuries and loss time days are in part due to another great year we had with our Safe Patient Handling Program. This will be explained in detail in the section below.
- Injury Rates: The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were Musculoskeletal Disease (MSD)-not related to patient handling at 38%, exposures at 23% followed by slips/trips/falls at 14%.

EC 1.0 - Safety Management

Improvement Strategies:

We had a total of 235 MSD injuries not related to patient handling in FY-19 (total injuries). Improvement strategies for FY-20 are to target MSD injuries not related to patient handling. The graph below depicts the departments with the highest numbers of MSD injuries not related to patient handling. It is not a surprise that our Environmental Services (EVS) due to the nature of the work they do has the highest incident of this type of injuries.



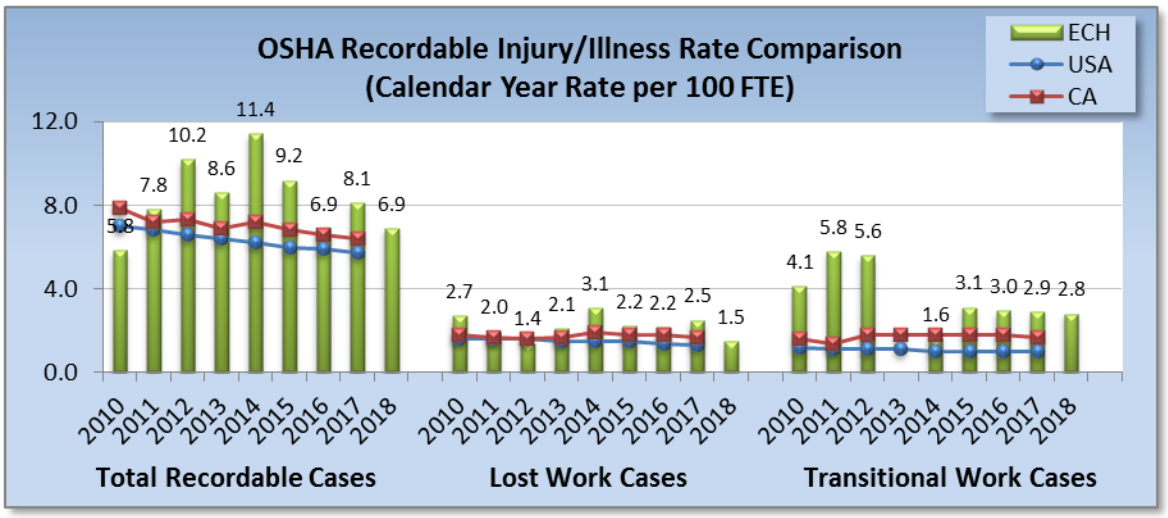
We are partnering with the EVS Department in efforts to reduce MSD injuries. We are conducting an initiative in collaboration with an outside vendor that will include the following deliverables:

1. Complete a musculoskeletal injury risk analysis for primary tasks (job roles or codes may also be used) within the Environmental Services department. The purpose of the analysis is to identify key musculoskeletal risk factors in each job/task. For each job/task reviewed, a mitigation plan using a standard hierarchy of control will be proposed including, when available, engineering, administrative, and work practice controls. Each task analysis will be delivered as a standalone document.
2. Review pertinent injury data, provided by the client, related to sprain/strain or other musculoskeletal injuries sustained in the environmental services department over the past 3 years.
3. Using data, pictures, and information collected in the analysis, will create a PowerPoint based training deck that details job/task specific musculoskeletal risk potential, risk reducing controls and employee expectations. This training may be delivered in person or made available for use in your existing online learning management system.

EC 1.0 - Safety Management

B. OSHA Recordable Injury/Illness Rates as Compared to U.S. & CA Hospitals

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[1].

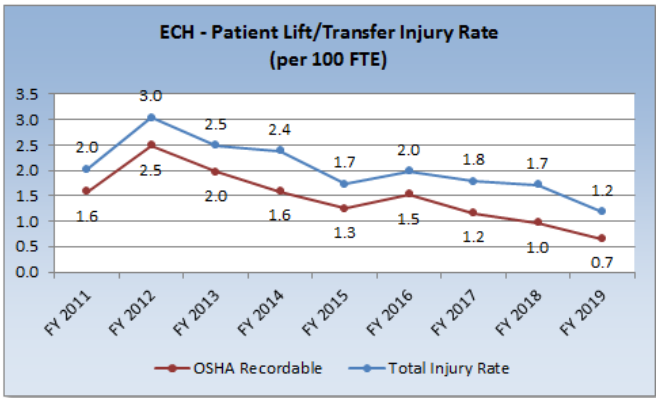


The ECH injury/illness rate in calendar year 18 was 6.9 a little higher than the state and national averages in 2017 (the most recent year available from the BLS). The ECH lost work cases rate was 1.5 close to the national average but a little lower than the state average. Among other reasons, our lower rate in loss time cases is due to ECH robust Transitional Work Assignment Program, showing a commitment to getting people back to work as quickly as possible after an injury or illness. This explains our above average transitional work cases compared to the national and state averages.

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- Injury Rates: The rate of OSHA recordable patient lift/transfer injuries per 100 FTEs decreased to 0.7 in FY-19 compared to 1.0 in FY-18. <u>This is the lowest injury rate due to patient handling ever!</u>



[1]The BLS data is calculated by calendar year. Data for the last full year is typically not available until fall.

EC 1.0 - Safety Management

- Total Injuries: There is a persistent downward trend in the total number of patient handling injuries reported, including a record low number of OSHA recordable injuries:

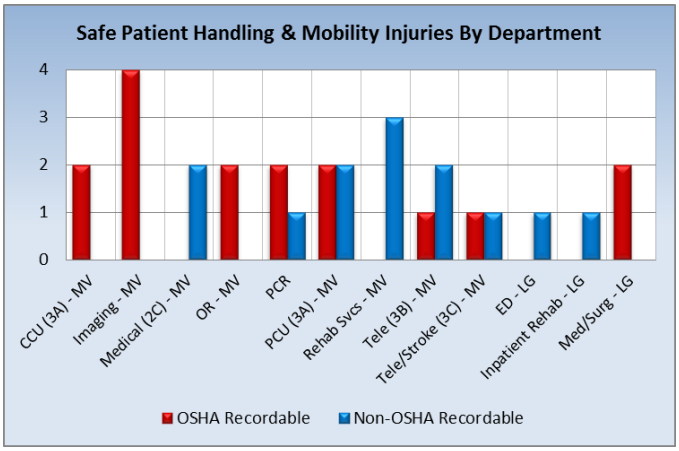
	Total # Injuries	# OSHA Recordable
FY-16	48	34
FY-17	44	29
FY-18	41	23
FY-19	29	16

- Lost Days due to Patient Handling Injuries: There were a record low number of lost days incurred during FY-19 (5 lost days); 98% fewer than in FY-18.
- Injury Types:

Safe Patient Handling & Mobility Injuries by Type

Activity	2015	2016	2017	2018	2019
Combined Transfer	6	8	6	5	5
Cumulative Patient Handling	5	1	5	4	0
Lateral Transfer	8	6	8	1	5
Misc. Patient Handling (e.g., fall, car extraction)	5	6	5	9	8
Patient Holding	2	3	2	3	2
Turning/Pulling	12	12	12	16	5
Vertical Transfer	5	12	5	3	4
Grand Total	43	48	43	41	29

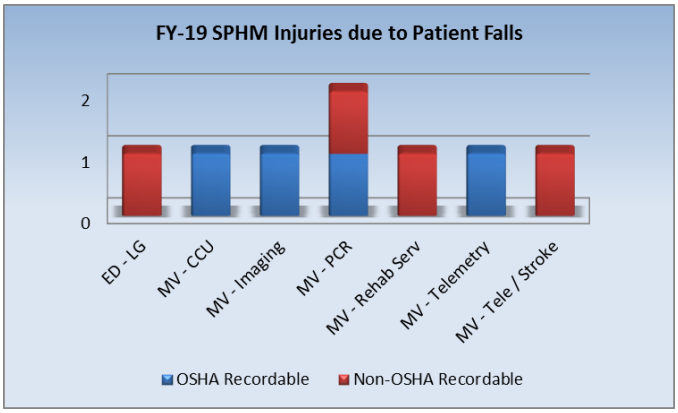
- Injuries by Department
  - CCU had been in the top three departments with SPHM injuries. Partnership with their educator, coaching, plus the trial and introduction of repositioning sheets and a sit/stand/walk aid that promotes early mobility reduced the number of injuries to 2.



  - Inpatient Rehab suffered from the highest incidence of injuries in FY-18. Collaboration with the manager and contracted on-site therapy group to advocate for appropriate use of equipment/training has achieved success reducing the number to 1 non-reportable injury.
  - The Women's Hospital was on an upward trend of injuries until EWHS and an OHN/MSN student performed a needs assessment, equipment trials, and introduction of Sara Stedys and HoverMats with Manager and Educator support. In FY-19 there were no patient hand ling injuries recorded.

EC 1.0 - Safety Management

- Historically, repositioning patients had been the most common cause of SPHM injury, and those from patient falls were among the least.
  - In FY-19, 29% of the injuries were due to patient's falls.



Improvement strategies:

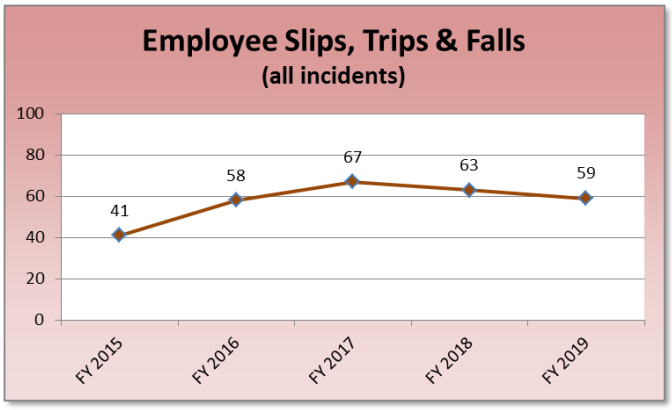
- The Patient Fall Prevention and Employee Fall Prevention Committees have partnered to identify opportunities to decrease risk in both populations.
- Renewed training and mandatory PMAT (Patient Mobility Assessment Tool) documentation is planned to encourage appropriate use of SPHM equipment. This will require robust SPHM committee involvement with collaboration among Nursing, Employee Health, Education, Facilities, Supply Chain, Biomed and Auxiliary.
- SPHM unit champions and shift peer leaders engaged on every unit
- Use of SPHM equipment is the norm; embedded in the culture whereby every lift is a safe lift
- Provide lifts and slings together near the point of care.
- Ensure accessible, appropriate bariatric equipment on-site.
- Include dedicated time for training with hands-on practice off-shift.
- Standardize the method of product trials/evaluation.

EC 1.0 - Safety Management

D. Slips, Trips, Falls Injuries

Analysis

- Injury Rates: The number of slips, trips and falls in the hospital has risen dramatically in the last five years. Last year we started efforts to understand and prevent these injuries. In FY-19 we promoted two enterprise-wide campaigns to encourage staff to cover the cups to prevent spills as contaminants is one of the top two cause of slips/trips/falls.



- Injury Types:
  - 25% of the injuries occurred outside the buildings.

Activity	FY-19
Injury occurred due to contaminant and/or slippery floor	12
Injury occurred due to cords or tubing, bodily reactions, surface irregularities	22
Objects in path	9
Falling from a chair or stool	6
Involving steps or handrails	8
Other *(e.g., tripping on carpeting, lighting, etc.)*	2

Improvement Strategies:

- The task force is meeting monthly, to investigate all accidents. The manager of each department reporting an injury is encouraged to attend to review the cause and strategize prevention efforts.
- Continue initiatives and awareness campaigns.
- Evaluate the possibility to implement slip-resistant shoes (e.g., Shoes for Crews) for specific departments such as Nutrition Services and EVS.
- Partner with Facilities for ongoing exterior grounds inspections to improve lighting, landscape and stair safety.

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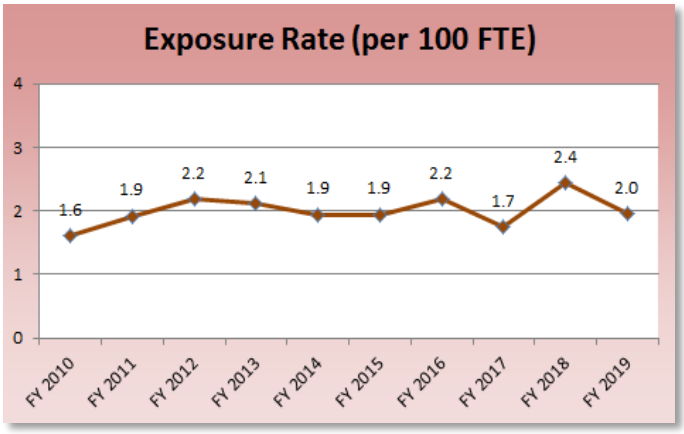
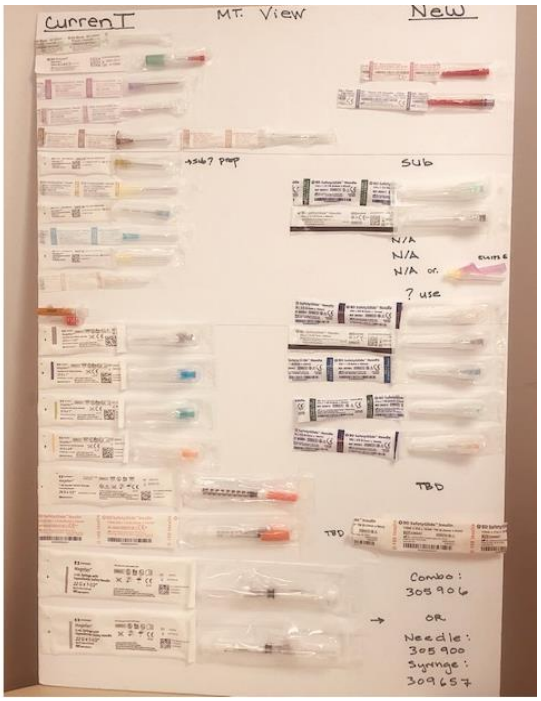
E. Bloodborne Pathogen Exposures

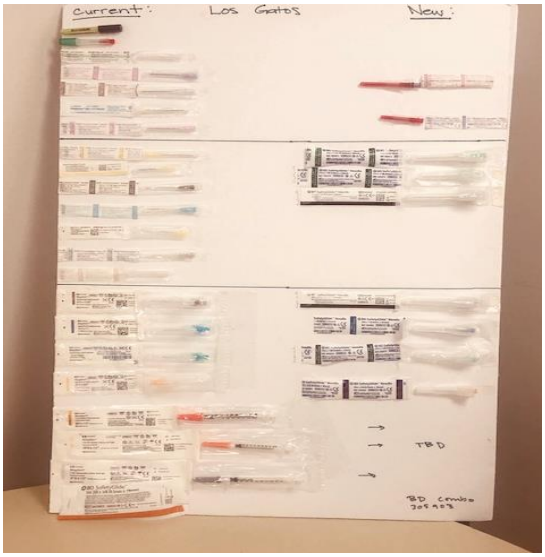
The rate of Blood borne pathogen exposures per 100 FTE decreased to 2.0 in FY-19 compared to 2.4 in FY-18. The total number of exposures for both campuses decreased to 48 exposures in FY-19 compared to 58 in FY-18. Of these, 30 were percutaneous exposures and 18 were body fluid exposures due to splashes.



Analysis:

- 33% of exposures due to needle sticks were the result of handling subcutaneous needles mostly insulin syringes.
- Among the most common root causes failure to engage safety devices immediately after use (recapping) was widespread.
- Switching hand to activate safety mechanism was another prevalent cause
- In FY-19 we established a Sharps Taskforce to look into the insulin syringes and found a variation among floors and between campuses that could directly contribute to staff difficulty engaging the safety device in some instances.
- An insulin syringe trial was completed with the purpose of selecting one product that will be used across the Enterprise.
- In the process we found significant variation among different kinds of needles and other syringes (see images below).





- Bloodborne Pathogen Needle Stick/Sharp by Job Type

Job Title	# Exposures
Behavioral Health Worker	1
Clinical Nurse II	16
Clinical Nurse III	3
Clinical Support (CNA)	1
CT Specialist	1
Lab Tech Support Specialist I	2
Lead Respiratory Therapist	1
Sterile Processing Tech II	1
Supervisor – Environmental Services	1
Surgical Tech I	1
Surgical Tech II	1
Unit Support	1
Total	30

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO.
- New insulin syringe to be deployed in October 2019. One product to be use across campuses & units.
- Full needle conversion to be completed by October 2019.
- Continue to identify causes and how exposure or injury could have been prevented by asking exposed employee what action they will take in the future to prevent the exposure from occurring again should a similar situation arise

F. TB Conversions

There were no known occupational exposure conversions at either campus during FY-19.

G. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-based training is required for all employees. The Life Safety courses required for all employees and provided as on-line modules on topics including fire, evacuation, hazardous materials, and other safety topics. These are:

- New employee orientation: 100% (Target: 100%)
- Life Safety - Non-Clinical: 93.8% (Target: 95%)
- Life Safety - Clinical: 96.0% (Target: 95%)

EC 1.0 - Safety Management

H. Safety Inspections

Safety inspections (Environmental Tours) are conducted monthly. Clinical departments are inspected twice per year, once by the Safety Inspection team, and once by the unit. Nonclinical areas are inspected annually by the Safety Inspection team. Problems noted are documented and delegated to the department manager and remain open until corrected.

The most noted problems in calendar year 2018 involved:

Problem Type	Category
• Damaged or stained ceiling tiles	*General Safety*
• Damaged walls	*General Safety*
• Isolation and Crash carts stocked and clean (tops of crash carts were dusty)	*Infection Prevention*
• Improper storage of clean linen (not in closed cart or cabinet)	*Hazardous Material/Waste*
• 18" vertical clearance to fire sprinkler heads	*Fire Safety*
• Electrical panels not locked	*Utility Management*
• Paper signage in clinical areas (should be laminated or in plastic sleeves)	*Infection Prevention*

I. Environmental Monitoring

All scheduled environmental monitoring was completed and results were below exposure limits as set by the appropriate regulatory agencies.

Monitor	Location	Results
Anesthetic Gases ○ Nitrous Oxide ○ Sevoflurane	OR, PACU, L&D	 Below Cal OSHA PEL Below NIOSH REL[2]
Formaldehyde	Cytology, Histology	Below Cal OSHA PEL
Lead/Cadmium	Radiation Oncology (MV)	Wipe Samples in all areas except the lid of the molding pot and the surface of the molding board were below the recommended surface contamination levels [3]
Noise	Facilities Personal Monitoring (MV)	Below Cal OSHA Action Level
	Central Plant (MV)	Several locations exceed the action limit (85dBA). "Hearing Protection Required" signs are posted in these areas.
Xylene	Cytology, Histology	Below Cal OSHA PEL

[2] OSHA has not established a Permissible Exposure Limit (PEL) for Sevoflurane.

[3] OSHA has not established regulatory quantitative surface limits for lead and cadmium. As a best management practice, the lead and cadmium surface sample results were compared to the Brookhaven National Laboratory's acceptable surface contamination level.

EC 1.0 - Safety Management

Effectiveness

Key indicators were identified to establish goals for FY-19 with opportunities to improve Safety Management within the Environment of Care.

FY 19 Goals

1) Reduce BBP exposures related to splashes due to the lack of Personal Protective Equipment (PPE)

   Measurement of success: Reduce BBP exposures related to splashes by 5%

   This goal was accomplished. In FY-19 we reduced splashes related to the lack of PPE by 15% compared to FY-18.

2) Expand the incident investigation and corrective action process

   Measurement of success: Seek assistance from an outside consultant to review our "as is" process and help us develop a "future state" with the tools and resources we already have. The deliverable from this process will be a policy outline for incident investigation and action tracking.

   This goal was not accomplished. Due to other priorities during the fiscal year such as preparation for Joint Commission visit and aggressive Enterprise safety goals among others we were unable to secure the adequate time from stakeholders needed to evaluate the current process. We have made some small changes in the documentation utilizing our current AIER System to improve corrective actions documentationFY-18 Goals

EC 2.0 - Security Management

Work Group Chair: ***Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism

Workplace Violence Prevention Plan

Workplace violence (WPV) prevention has been a focus of the health care community for many years. In 1993 the California Health and Safety Code adopted Sections 1257.7 and 1257.8, requiring hospitals to conduct annual security and safety assessments and implement a security plan to protect employees, patients and visitors from aggressive and violent behavior at work. The laws require hospitals to report injuries sustained by personnel to law enforcement, and to provide training to hospital employees regularly assigned to the emergency department and other high-risk areas, as identified by the hospital.

In October, 2016, an additional health care workplace violence prevention regulation, Section 3342 of Title 8 of the California Code of Regulations, was adopted with full compliance required by April 1, 2018. A task force was created to oversee the implementation of the hospital's Workplace Violence Prevention Plan. All required elements of the program have been implemented. The task force has disbanded and oversight and update has been given to the Workplace Violence Committee.

Plan Element: Written Plan	**Status: COMPLETED**
• The written plan has been completed and approved. • The plan requires annual review / update by the Workplace Violence Committee. The plan was reviewed, revised and approved by the Workplace Violence Committee in June of FY 2019.	

Plan Element: Response: Investigate violent incidents	**Status: Completed**
• This is being completed through the Workplace Violence Committee. The plan includes a comprehensive violent incident investigation process.	

Plan Element:	**Training (annual)**	**Status: ONGOING**

- The hospital has developed two levels of training.
  1. AVADE – Computer based training module assigned to most staff.
  2. Nonviolent Crisis Intervention (NCI) training – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
     - Behavioral Health
     - Emergency Department
     - Facilities Engineering
     - Assistant Hospital Managers (Hospital Supervisors)
     - Security
     - Course is also available as an option to all staff.

EC 2.0 - Security Management

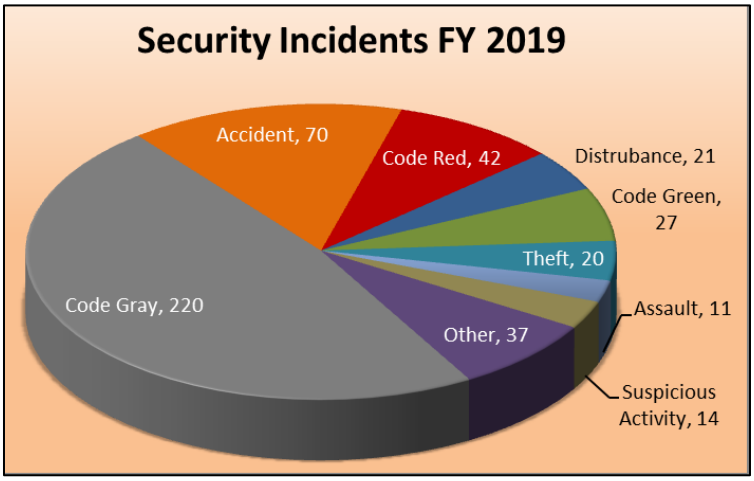
Plan Element: **Reporting:** All physical assaults against staff to OSHA	**Status:** **ONGOING**

- An ongoing WPV Reporting team is ensures reporting is completed as required.
- In FY-19, 51 incidents were reported to OSHA.
  - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
- 41% (21) of incidents resulted in no injury. The remaining events were minor injuries with over half (51%) being bruises or abrasions. No major injuries were reported.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY-19. The data includes activity from both campuses.

There were a total of 462 reported security incidents for FY-19 requiring immediate response. This is an increase from the FY-18 total of 449.



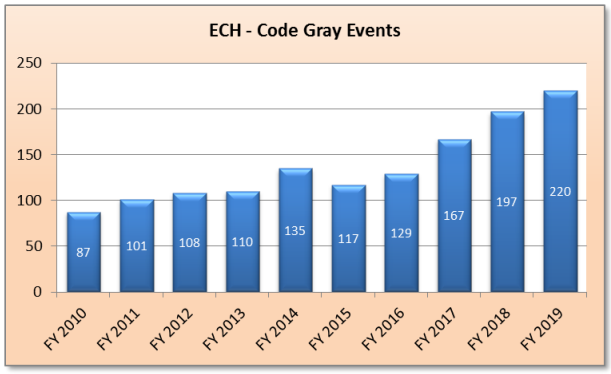
Review of the major FY-19 incidents showed:

- There were 51 Workplace Violence (WPV) incidents reported to CA-OSHA. This is a 16% reduction from FY18. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
  - Monthly Workplace Violence Committee meetings.
  - "Stop Signs" placed on the outside of patient's rooms to alert staff that have been or have the potential to be combative.
  - Adding a "flag" in EPIC to alert staff of the patents potential to be combative during the length of their care and the next time they come back to the Hospital.
  - Formalized and documented rounding by Security to ensure both the Security team and the patient care team are aware of any patient that has the potential to be combative.
- In December of FY 19 we had our Joint Commission accreditation survey. There were no findings in the Security Management portion of the survey.

EC 2.0 - Security Management

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY-19 was 220 compared to 196 in FY-18.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- MV Medical Unit (2C) – 18%
- MV Progressive Care unit (PCU) – 17%
- MV Emergency Department (ED) – 15%
- MV Telemetry/Stroke (3C) *[**Note** reduced from 17% to 10% of total.]*

Responses are tracked through the Code Gray critique form and monitored to help identify possible improvements to the process.

The Hospital utilizes the **Non-violent Crisis Intervention® (NCI)** training program for all staff who deals with angry or agitated persons. This is part of the Workplace Violence Prevention program and is required for staff in designated high-risk areas. Staff in other departments are encouraged to take this training as an optional course.

B. Bulletins, Alerts & Presentations

Security Services issued 3 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 4,635 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 1667 patient watches, standbys and restraints. This was a significant increase over FY 18 which was 965. Hospital Supervisors notify Security of these events which can last several hours. They primarily occur in the Emergency Department, Behavioral Health and on the Medical Units. Patient watches are also handled by the ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 118 fire drills and are 100% up-to-date. A total of 12 fire watches were performed in FY 19.

F. General Assistance

Security Officers performed 94,378 service requests including but not limited to main lobby greeter assistance, directional requests, door locks/unlocks, escorts, issuance of one-day passes.

G. ID Badges

Security Services issued 2,038 Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 2,425 temp badges were issued.

EC 2.0 - Security Management

H. Investigations & Audits

Security Services performed 57 investigations and audits including but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost And Found

Security Officers performed 515 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 14,901 (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 210 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 149 vehicle-related services including jump-starts, door unlocks and tows. 706 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 48 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

EC 2.0 - Security Management

N. Statistics –Police Department Crime Data

2018 MVPD Annual Report		
Square Miles:	12	11.25
Population:	80,800 (County of Santa Clara 1,937,570)	30,724
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics ***UCR data includes attempts and actual crimes***		
Part I UCR:	2274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2497	Not Collected
Previous Year	2800	Not Collected
Arrests-Misdemeanor:	1235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2199	Not Collected
Indexes ***Per 1,000 current year population***		
Violent:[4]	2.11	0.35
Previous Year	2.33	0.48
Property:[5]	26.29	15.53
Previous Year	24.46	18.98

Effectiveness

Key performance indicators were identified in the FY 19 to improve Security Management within the Environment of Care.

FY19 Goals

1) 90% non-medical emergency security response time less than 3 minutes- **This goal was accomplished.**

2) 20% reduction in number of reportable workplace violence incidents- In FY 19 there was a 16% reduction in the number of Workplace Violence reports submitted to CAL-OSHA. **This goal was not met.**

[4] Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery
[5] Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson

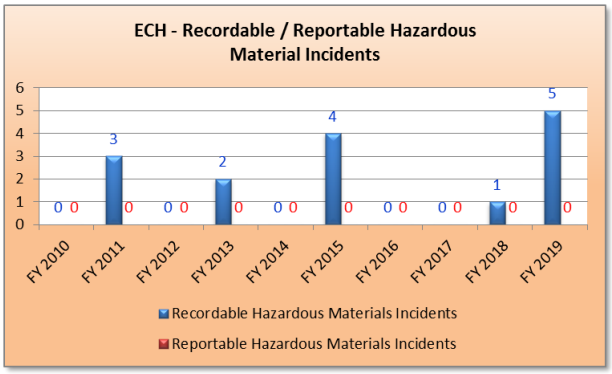
EC 3.0 - Hazardous Materials & Waste Management

Work Group Chair: ***Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Hospital. The work group chair serves as the central contact point for the reporting and documentation for the Hazardous Materials & Waste Management work group and provides regularly scheduled reports to the Central Safety Committee.

Performance



A. Hazardous Material Incidents

Facilities Services maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

- **Recordable Hazardous Material Incidents[6]:**

  1) Spill in MV Infusion Center – tubing improperly attached causing small spill of chemo agent. Cleanup was handled safely.

  2) Formalin spill in Los Gatos OR – Employee spilled quantity of Formalin while pouring. Employee was contaminated by spill and was decontaminated with no injury. Spill was cleaned up. Reviewed procedures for Formalin handling and recommendations made to improve process.

  3) Small Formalin spill in MV OR – spill was cleaned up by staff in area. Code Orange activation was not necessary.

  4) Small Formalin spill in MV Imaging - spill was cleaned up by staff in area. Code Orange activation was not necessary.

  5) A chemo patient pulled out IV while attempting to use restroom. Cleanup handled safely.

- **Reportable Hazardous Material Incidents[3]** – No reportable spills.

B. Waste Water Discharge Violations:

1 – missed 3 monthly sample collections in July 2018. Correcitve measures taken to ensure compliance.

[6] Reportable and recordable hazardous material incidents are defined by state and federal regulations and are determined based on the quantity and hazard of the spill.

EC 3.0 - Hazardous Materials & Waste Management

C. Monitoring and Inspections

- **Hazardous Waste Inspections**-No Inspections for FY-19
- **Santa Clara County Annual Medical Waste Inspections**
  - **Los Gatos**: April 22, 2019: Two minor issues identified. All were corrected and accepted on the date of the inspection
    1) Coached Staff to cover all Bio Barrels completely and snap shut.
    2) Replaced fading signs on Bio Waste storage outside.
  - **Mountain View**: May 29, 2019: Several minor issues identified. All were corrected and accepted on the date of the inspection
    1) Mother-Baby and PACU/OR - Observed a missing absorbent pad in a pharmaceutical waste container in the mother baby unit med room.
    2) Endoscopy - Replace the torn biohazard label on door of the interim storage room.
    3) A container found without lids or a red bag liner. Overfilled secondary container in OR staging area –all corrected immediately
    4) Observed an overfilled pharmaceutical waste container in the Pharmacy Department. Adjacent to the overfilled container, there was a good supply of empty pharmaceutical waste containers. Pharmacy supervisor coached to educate staff to utilize storage of empty containers to prevent overfilling.
- Continued monitoring and education to ensure waste segregation compliance :
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors
  - Monthly Safety Rounds that include observation of waste segregation practices
  - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly.

EC 3.0 - Hazardous Materials & Waste Management

E. Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[7] training course.

Key indicators were targeted to establish goals for FY-18. The following goals presented opportunities to improve hazardous materials & waste management.

FY-19 Goals:

1) 15% increase in the number of HAZWOPER[2]-certified staff
   - **Measurement of success**: Increasing the total number or HAZWOPER certified employees.
   - ***This goal was accomplished.***
     - Conducted on-site classes April 1 – April 5th, 2019.
     - Results: FY18: 18, FY19: 23; at 28% increase
2) 30% reduction in number of NISOH items that sent to Guaranteed Returns for Enterprise by Pharmacy
   - ***Measurement of Success:*** Implement a check system in the pharmacies to reduce number of NISOH items that had been sent to guarantee return
   - ***This goal was accomplished.*** This goal was accomplished. There was a 55% reduction in the total number of returned items. There were a total of 71 items returned in FY-19 compared to 159 in FY-18.

[7] HAZWOPER: Hazardous Waste Operations and Emergency Response

EC 4.0 - Fire Safety Management

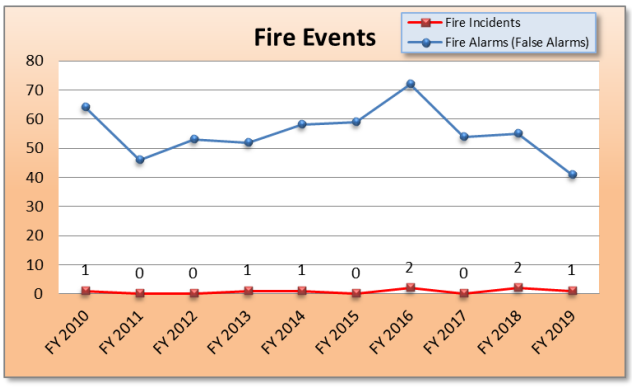
Work Group Chair: ***John Folk***

Scope

The Fire Safety Management Plan is designed to assure appropriate, effective response to a fire emergency situation that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY-19.



A. Fire Incidents

There was 1 reported fire incidents in FY-19.

- On Tuesday, September 18th 2018 at approximately 4:35 PM, a smoke detector activated in patient room 3120. Upon responding the alarm, it was found that the room was filled with smoke and a patient had been burned. It was found that the patient, who was on supplemental oxygen, had activated a lighter. The enhanced oxygen atmosphere around the patient intensified the fire, causing burns to the patient's face, chest and arm. Staff quickly and appropriately responded to obtain a fire extinguisher and turn of the oxygen. Upon shutting off the oxygen, no further fire was noted and the extinguisher was not used.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All cases are evaluated for potential opportunities for improvement.

The total number of events in FY-19 (41) was significantly lower compared to FY-18 (56). There were 36 events in Mountain View and 5 in Los Gatos. This was accomplished despite heavy construction activity at both hospitals during FY-19. The reduction can be linked to the development of an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.

Fire Drills Completed / Scheduled- All required fire drills (total of 120) were completed in FY-19. For all drills, there were 24 required actions by staff. All issues were fully corrected either on the spot or with further education by the dept. Manager.

EC 4.0 - Fire Safety Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 19 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new IMOB and BHS buildings.

   Ongoing- Training for all Engineering staff is ongoing as the buildings become closer to completion.

2) Identified supervisory staff will attend NFPA code classes to further their knowledge and applications of fire safety codes.

   This goal was accomplished. 3 Engineers have received the recommended high rise training.

3) Develop an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.

   This goal was accomplished. Ongoing monitoring is in place to ensure compliance with the Life Safety and NFPA codes.

4) Increase oversight an improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities.

   This goal was accomplished. Ongoing monitoring and education of contractors is in place.

EC 5.0 - Medical Equipment Management

Work Group Chair: ***Jeff Hayes***

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-19.

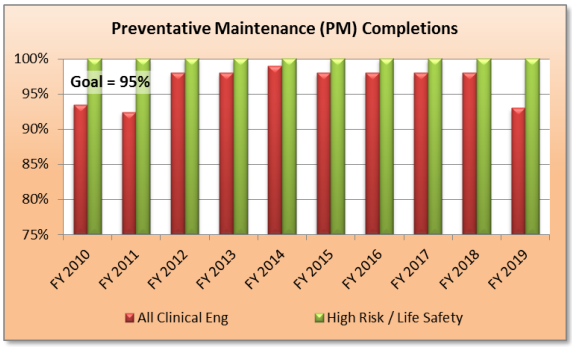
A. Reports to the FDA –

There were 16 reports through the Medwatch[8] system in FY-19. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% in all areas.

- The completion rate for Clinical Engineering achieved 93% for FY-19.
- All high risk, life safety equipment was maintained at 100% completion rates



C. Product Recalls Percentage Closed / Received

For FY-19, there were 83 recorded product recalls; 14 still open.

Effectiveness

Key indicators are targeted to established goals for the fiscal year. Due to multiple changes in Clinical Engineering management a continuum of focus on the indicators was not obtained in FY-19.

[8] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

EC 6.0 - Utilities Management

Work Group Chair: ***Nick Stoliar***

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

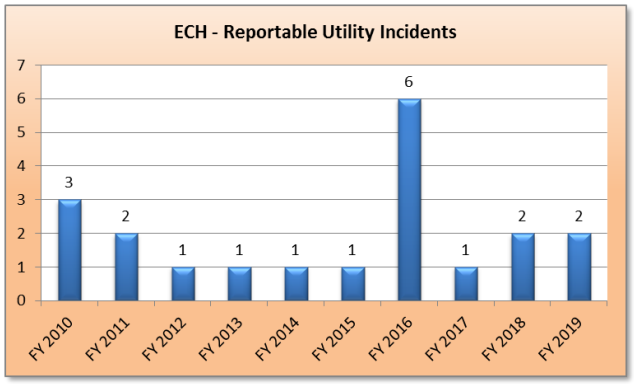
Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-19.

A. Utility Reportable Incidents

There were 2 reportable incidents in FY-19. Both were electrical outages.

1) July, Los Gatos - momentary loss of electrical utility (PG&E) campus wide.
2) September, Mountain View - Loss of electrical to equipment branch at Mountain View Women's Hospital in September due to a mechanical malfunction of an automatic transfer switch



B. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was 97%, which the goal of 95%. Critical systems were maintained as required for the facility operations.

C. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

EC 6.0 - Utilities Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 19 Goals

1) Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.

   In progress **-** Ongoing education and familiarization for all engineering staff will occur over the course of the next few months as the new buildings come on line.

2) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

   This goal was accomplished. Process in place for access control, ongoing monitoring for effectiveness is in place.

3) Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.

   In progress **-** There is still some equipment that needs to be added to the renovation and or replacement plan for both sites.

FY 20 Goals

1) Work with PG& E to improve communication related to Planned/Unplanned utility disruption events
2) Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.
3) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.

EM – Emergency Management

Committee Chair: ***Steve Weirauch***

Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee ensures an effective response to these events. The hospital actively participates with state and local emergency management entities to coordinate community planning efforts and response. Emergency Management is a separate chapter under The Joint Commission; however the annual reporting is being combined with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported through the monthly committee meetings. Significant events are presented quarterly to the Central Safety Committee. The following Emergency Management indicators were reported in FY-19.

A. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY-19 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. **The Joint Commission (TJC) Survey (12/2018)** – the tri-annual TJC survey occurred in December, 2018. During the survey, the HCC was operational during daytime hours to coordinate and provide needed resources.
2. **Power Outage – Mountain View Campus (02/28/2019)** – A PG&E power failure occurred in the early morning of February 28th. Emergency power activated as designed and provided all power to the hospital. The HCC was opened at the beginning of the day shift. Elective surgeries were put on hold pending restoration of power as a precaution. Power was restored about 08:30, and the HCC was closed.
3. **CMS Survey (06/2019)** – CMS conducted a 4-day survey in response to complaints. The HCC in Mountain View was activated during business hours to coordinate and provide resources.

B. Events / Emergencies

The hospital responded to several additional emergency incidents that did not activate the Hospital Command Center. These included:

1. **Code Red (fire) in patient room – Mountain View (09/18/2018)** – A patient on supplemental oxygen activated a cigarette lighter. The enhanced oxygen atmosphere around the patient intensified the fire, causing minor burns to the patient's face, chest and arm. Staff responded and quickly extinguished the fire. The Mountain View Fire Department responded and assisted with ventilating the room.
2. **Hazardous Exposure Incident – Mountain View (09/03/2018)** – Patient presented with exposure to organophosphate. ED staff decontaminated the patient utilizing decon procedures.

3. **Code Orange (chemical spill) – Los Gatos (01/09/2019)** – a spill occurred in the OR while staff was pouring Formalin contaminating them with the chemical. The employee utilized a shower to remove the chemical. No injuries were reported. The spill was cleaned up. An investigation recommended several procedural changes to prevent a future occurrence.
4. **Hazardous Exposure Incident – Mountain View (02/14/2019)** – Law enforcement presented to the hospital with exposure to possible Fentanyl. Staff decontaminated officers prior to admission to emergency department. Follow-up meeting held with agencies to review and improve future responses.
5. **Code Silver (person with weapon) – Mountain View (05/02/2019)** – patient with known aggressive tendencies had several Code Gray (angry/violent person) activations. During one event, patient pulled metal bar from gurney and threatened staff. Team responded appropriately and called for police. Incident was resolved with no physical injury to staff or patient.

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY-19, this requirement was met through the Statewide Medical & Health Exercise in November, 2018 (see below), and a spring exercise in June. These are summarized below. Action items were created in both exercises to improve future responses.

a. **Statewide Medical & Health Exercise (11/15/2018):** Both campuses participated in the statewide exercise. The scenario involved a widespread emerging infectious disease. Caring for infected patients while maintaining the safety and security of the facility provided challenges to both campuses.

b. **Spring Functional Exercises (06/2019)** – A functional exercise was conducted at both campuses involving response to an earthquake. HICS was activated and the HCC opened at both sites. All departments were requested to complete a self-evaluation and report of unit status to the HCC.

- Los Gatos - the scenario included a full evacuation of the Rehab Center. Staff physically evacuated “patients” from the building to test procedures. This also assisted in compliance with CARF requirements for the unit.
- Mountain View - a full evacuation of the Behavioral Health unit and NICU was required. The BHS evacuation was conducted as a tabletop exercise to determine how this would be handled in a real event. The NICU team tested new evacuation equipment and moved “patients” out of the affected areas.

Additional Exercises were conducted to assess and test our preparedness to other emergency events

c. **Active Shooter Drills – Los Gatos (01/11/2019)** – Tabletop drills were conducted in each department to test staff ability to respond to an active shooter type event. The exercise was designed to be low-stress for staff to foster discussion and learning. Based on feedback from the Los Gatos drill, changes are being implemented prior to conducting these drills at the Mountain View campus.

d. **Code Pink Drills – Mountain View & Los Gatos (09/2018)** - Exercises were conducted at both campuses to test staff’s ability to respond to an infant security band alert.

e. **Decontamination Team Training (04/2019) -** Training and functional exercises were held several times to train and test the ED staff and decontamination teams on proper response to the arrival of contaminated patients to the hospital.

D. Emergency Management Training

- **New hire orientation** (100% for all employees)
- **Safety coordinator meetings** (44% attendance overall for the quarterly meetings). Safety Coordinators unable to attend the meetings are provided with detailed notes and information and are expected to complete all assignments.
- **Advanced HICS Training** – three classes were held for managers to learn/review the operation of the Hospital Incident Command System during emergency events affecting the hospital.

E. Community Involvement

The hospital continues to be an active participant in the Santa Clara County Hospital Emergency Preparedness Partnership (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives of all Santa Clara County hospitals and the county EMS. The goal is to establish a collaborative county-wide emergency response and disaster plan. The group also organizes and facilitates county-wide disaster exercises in which the hospital actively participates.

The EPHC expands many of the same elements of the SCCHEPP to all healthcare facilities in the county including clinics, skilled-nursing facilities and dialysis clinics. This group meets quarterly and shares information and provides training to help all healthcare facilities prepare for emergencies. Steve Weirauch is currently the chair of the SCC-EPHC and has participated in several conferences sharing the experiences and benefits of developing regional coalitions.

F. Hazard Vulnerability Assessment (HVA)

The HVA is an assessment of each facilities risk for various emergency situations. The HVA is reviewed and revised annually. Separate HVA's are completed for the Los Gatos and Mountain View campuses to account for physical differences in the locations and facilities. Efforts are then focused on attempting to minimize the highest risks during the fiscal year.

- There were several changes to the HVAs at both campuses in FY-19. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Person with Weapon	(2) Communication System Failure
(3) Flood - Internal	(3) Information System Failure
(4) Communication System Failure	(4) Electrical Power Failure
(5) Information Management System Failure	(5) Dam Failure

EM – Emergency Management

Effectiveness

Key indicators were targeted to establish goals for FY-19. The following goals presented opportunities to improve emergency management.

FY-19 Goals

1. Continue the replacement of Evacuation litters and chairs with Med Sleds at in Los Gatos and other buildings, as needed.

   This goal was accomplished. Additional Med Sleds were purchased and are being deployed in Los Gatos and other buildings. Plans are in place to add units to the new Taube and Sobrato Pavilions.

2. Expand the use of mass notification system (Everbridge)
   a. Investigate adding users to system to notify more staff of events
   b. Train key staff to be able to use/send alerts

   This goal was not accomplished. Investigated the options for increasing the use of Everbridge notifications by all staff. To utilize the system effectively requires major assistance from IS to network and automate the database maintenance and the additions of additional licenses and modules to our existing contract. This required a major budget request which was submitted for FY20. The additional funds were approved, so this goal will be continued in FY20. Training will also be conducted as the expanded capabilities are brought on line.

FY-20 Goals

1. Expand the use of mass notification system (Everbridge) to all employees
   a. Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
   b. Evaluate and set up logical groups and rules for notifications.
   c. Train key staff to be able to use/send alerts
2. Revise and distribute the Emergency Management Guides for both campuses.
   a. Revision of content to include latest information.
   b. Roll out of app for the guide on Android and iOS devices in addition to wall-mounted guides.
3. Train staff on emergency procedures in new Taube and Sobrato Pavilions.

Attachment 1 - Employee Health Services Definitions

1. OSHA Recordable Injuries / Illnesses per 100 FTEs	Number of injuries/illnesses multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# of OSHA recordable injuries ∗ 200,000 / Productive Hrs.]
2. Lost Work Day NEW cases per 100 FTEs	Total number of new injuries occurring in this fiscal year quarter multiplied by 200K divided by the number of Productive Hours* during the reported quarter. [# new cases in qtr. w/ lost work days ∗ 200,000 / Productive Hrs.]
3. Patient Lift / Transfer Injuries per 100 FTEs	Number of OSHA recordable injuries resulting from a specific event involving the lifting and transferring of patients and/or pulling up in bed multiplied by 200K and divided by Productive Hours*. Does not include pushing patients in beds, gurneys, wheelchairs, or other transport devices. [# patient lift injuries ∗ 200,000 / Productive Hrs.]
4. Exposures to Blood and Body Fluids per 100 FTEs	Number of exposures to blood/body fluids during a quarter or year x 200K divided by Productive Hours*. [# BBPs ∗ 200,000 / Productive Hrs.]
5. Productive Hours	Total number of hours worked for the quarter or year by all organizational employees. Includes overtime but does not include education, vacation, PTO, ESL, or other non-productive time. This does not include outside labor.

Attachment 2a - Safety Trends

	Indicators	FY 13	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19
E.C. 1.0 - SAFETY MANAGEMENT								
Employee Safety								
1.	Total Injury/Illness Incident Reports	349	458	618	428	470	411	439
2.	OSHA Recordable Injury/Illness (Total)	173	171	306	193	164	176	145
	a. Lost Time	59	61	38	78	45	51	22
	b. No Lost Time	114	110	268	113	119	125	133
3.	Patient Lift/Transfer Injuries (OSHA Recordable)	33	36	27	37	28	23	16
4.	Patient Lift/Transfer Injuries	42	54	37	48	43	41	29
5.	Trip/Slip/Fall	43	50	41	58	67	63	60
Infection Control								
8.	TB Conversions (mo.)/qtr. %	0	0	0	0	0	0	0
9.	Blood & Body Fluid Exp.	45	44	45	53	42	58	48
	a. Percutaneous	30	28	38	39	30	36	30
	b. Skin/Mucus Membrane Contact	15	16	7	14	12	22	18
E.C. 2.0 - SECURITY MANAGEMENT								
1.	Code Grey Incidents	110	135	117	129	167	197	222
2.	Security Response Time < 3minutes (Goal: >90%)	N/A	N/A	N/A	N/A	N/A	N/A	82%
3.	Reportable Workplace Violence Incidents	N/A	N/A	N/A	N/A	N/A	61	51
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT								
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	2	0	4	0	0	1	5
3.	Waste Water Discharge Violations	0	0	0	0	0	0	1
4.	Staff ability to locate SDS online	N/A	N/A	N/A	N/A	N/A	N/A	95%
5.	Staff know eyewash rinse time if exposure is 15 minutes	N/A	N/A	N/A	N/A	N/A	N/A	79%
E.C. 4.0 FIRE PREVENTION MANAGEMENT								
1.	Fire Incidents -Actual	1	1	0	2	0	2	1
2.	Fire Alarm Events	52	58	59	72	54	55	41
3.	Fire Drills comp/scheduled	100%	97%	100%	100%	103%	103%	118%
4.	Staff ability to define RACE and PASS	N/A	94%	100%	100%	100%	100%	91%
5.	Staff ability to locate fire extinguishers and pull stations							96%
6.	Staff can define horizontal and vertical evacuations							91%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT								
1.	Reports to FDA	11	2	6	3	6	15	16
2.	PM Completion Rate %							
	a. ECH Life Safety PMs	98%	98%	98%	98%	98%	98%	100%
	b. Vendor/OEM Life Safety PMs	100%	100%	100%	100%	100%	100%	100%
	c. ECH General PMs	99%	99%	99%	100%	100%	100%	03%
	d. Vendor/OEM General PMs	100%	100%	100%	100%	100%	100%	100%
3.	Equipment Unable to Locate	95%	98%	88%	78%	95%	82%	10%
E.C. 6.0 - UTILITIES MANAGEMENT								
1.	Utility Reportable Incidents	0	1	1	6	1	2	2
2.	PM Completion Rate % completed/scheduled	84%	92.7%	90.9%	97%	90%	89%	95%
3.	% of Life Safety Work Order Completions	100%	100%	100%	100	100	100%	90%

Attachment 2b - Safety Trends Definitions

E.C. 1.0 SAFETY MANAGEMENT	
Employee Safety	
1. Injury/Illness Reports	Total number of injuries/illnesses reported on *Report of Accident, Injury, Incident or Exposure*, (Form 309) and followed up by Employee Health Services. Includes first aid cases that do not meet the criteria as OSHA Recordable.
2. OSHA Recordable Injury and Illness	Total number of employee injuries and illnesses meeting the OSHA recordable definition and as recorded on the OSHA 300 log.
a. OSHA Recordable: Lost Time	Number of injuries/illnesses with days away from work.
b. OSHA Recordable: No Lost Time	Number of injuries/illnesses with no lost work time, includes cases with transitional work (modified work) when there is no lost work time.
3. Patient Lift/Transfer Injury (OSHA Recordable)	Number of OSHA recordable injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital. Does not include reported injuries with no specific lift/transfer incident.
4. Patient Lift/Transfer Injury (All)	Total number of injuries resulting from a specific event involving the lifting/transferring of patients. Includes injuries from pulling patient up in bed; does not include pushing patients in beds, gurneys or wheel chairs throughout the hospital.
5. Trip/Slip/Fall (all incidents reported)	Number of Trip/Slip/Fall incidents resulting from the unintended or unexpected change in contact between the feet or footwear and the walking or working surface.(All incidents)
6. TB Conversion Rate (Monthly number/quarterly rate)	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.
a. Percutaneous	
b. Skin, Mucous Membrane Contact	
Infection Control	
1. TB Conversion Rate (Monthly number / quarterly rate)	The number of work related* PPD converters by month and quarterly, total of conversions divided by the number of persons receiving PPDs.*Work related PPD conversion is a HCW PPD conversion after contact with a known TB + active case.
2. Blood & Body Fluid Exposures a. Percutaneous b. Skin, Mucous Membrane Contact	A percutaneous injury (e.g., a needle stick or cut with a sharp object), contact of mucous membranes or non-intact skin (e.g., when the exposed skin is chapped, abraded, or non-intact due to dermatitis), or contact with intact skin when the duration of contact is prolonged, (i.e., several minutes or more) or involves an extensive area, with blood, tissue or other body fluids. Body fluids include: a) Semen, vaginal secretions or other body fluids contaminated with visible blood that have been implicated in the transmission of blood borne pathogens b) Cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids which have an undetermined risk for transmitting HIV.
E.C. 2.0 SECURITY MANAGEMENT	
1. Code Gray Incidents	Code Grey is called when immediate assistance is required to respond to potential or actual violent situations involving visitors, patients, or family members.
2. Security Response Time < 3minutes (Goal: >90%)	The percentage of security responses within 3 minutes of receiving the request for assistance. The goal is >90%.
3. Reportable Workplace Violence Incidents	The number of workplace violence incidents - patient assault of staff that was reported to CA-OSHS during the year.

Safety Trends Definitions

E.C. 3.0 HAZARDOUS MATERIALS MANAGEMENT	
1. Reportable Hazardous Materials Incidents	Any unauthorized discharge which is determined not to be recordable and must be reported to the City of Mountain View (subsection 24.5.0.a.1 (a) of Mountain View Health and Safety Code) or the Town of Los Gatos.
2. Recordable Hazardous Materials Incidents	An unauthorized discharge of hazardous or other regulated material defined as a discharge from a primary to a secondary container, cleanup of a discharge to a secondary container requiring greater than 8 hours, no increase of fire or explosion nor production of poisonous gas or flame, or no degradation of secondary container, the discharge does not exceed one (1) ounce by weight or can be cleaned up in 15 minutes following deterioration of the primary container.
3. Waste Water Discharge Violations	Monthly sampling analysis > than the Maximum Limit (mg/L): Zinc 2.0; Total Toxic Organic 1.0; Single Toxic Organic 0.75; Formaldehyde 5.0; Copper 0.25.
4. Staff ability to locate SDS online	Staff able to demonstrate ability to look up a Safety Data Sheet through the Toolbox and MSDSOnline program.
5. Staff know eyewash rinse time if exposure is 15 minutes	Staff able to state the minimum required time required to flush a person's eyes after exposure to a hazardous chemical. The requirement is a minimum of 15 minutes.
E.C. 4.0 FIRE PREVENTION MANAGEMENT	
1. Fire Incidents	Number of actual fire incidents/month.
2. Fire Alarm Events	Number of fire/smoke alarms activated by an event not classified as an actual fire or false alarm (example: burnt toast, dust, steam, etc.)
3. Fire Drills Completed/Scheduled	Number of fire drills completed/number scheduled.
4. Staff ability to define RACE and PASS	Staff should be able to define RACE (Remove, Alarm, Confine, Extinguish) for responding safely to a fire and PASS (Pull, Aim, Squeeze, Sweep) when using a fire extinguisher.
5. Staff ability to locate fire extinguishers and pull stations	During regularly scheduled fire drills, staff can locate the nearest fire extinguisher and pull station to their normal work area.
6. Staff can define horizontal and vertical evacuations	Staff are able to define the two types of evacuations • Horizontal - evacuate staff to another smoke compartment on the same floor • Vertical - evacuate the building, floor by floor, starting with the upper levels and proceeding until everyone is out of the building.
E. C. 5.0 MEDICAL EQUIPMENT MANAGEMENT	
1. Reports to FDA	Number of reports to FDA as defined by Safety Medical Device Act requirements. Reported quarterly.
2. PM % Completion	Scheduled preventive maintenance completed. Reported quarterly.
a. ECH Life Safety	All critical, life safety equipment PMs completed by ECH Clinical Engineering
b. Vendor/OEM Life Safety PM	All critical, life safety equipment PMs completed by vendors
c. ECH General PM	Other equipment PMs completed by ECH Clinical Engineering Department
d. Vendor/OEM General PM	Other equipment PMs completed by Vendors
3. Equipment unable to locate	The % of equipment on Clinical Engineering's inventory that are not able to be found.
E.C. 6.0 UTILITIES MANAGEMENT	
1. Utility Reportable Incidents	Utility System incidents with actual or potential significant impact on safe patient care, staff health and safety or resource/property loss.
2. PM Completion rate % Completed	Scheduled preventive maintenance completed with 28 days of the prescribed interval/items scheduled for maintenance. Reported quarterly.
3. % of Life Safety Work Order Completions	The percentage of life safety work orders submitted to Facilities that have been completed.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: November 4, 2019
Subject: FY20 CDI KPI Dashboard

Purpose:

To provide the Committee with the Key Process Indicators for assessing ECH's Clinical Documentation Integrity (CDI) program.

1. Situation: Annotation is provided to explain actions taken affecting each metric.

2. Authority: This dashboard provides oversight on compliance with metrics that reflect the quality of the CDI program.

3. Background: The CDI Steering Committee provides guidance to the manager in the selection of these key metrics and in the setting of the metric goals.

4. Assessment:

- The goal to review/cover 85% of all Medicare inpatient admissions is met at 86%
- The goal to review/cover 75% of all payor inpatient admissions is met at 80%
- The response rate to CDI queries by the medical staff is consistently 100%
- The agree rate by physicians to the CDI queries has steadily improved from March 2019 to near the target goal at 83%

5. Other Reviews: The CDI Steering Committee reviews these data monthly and provides guidance aimed at performance improvement.

6. Outcomes: N/A

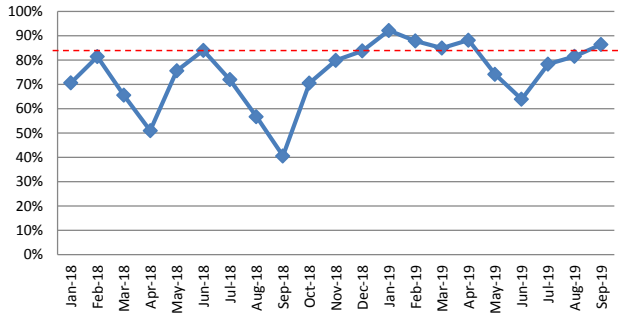
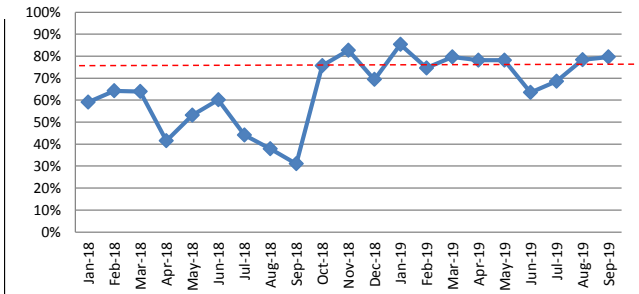
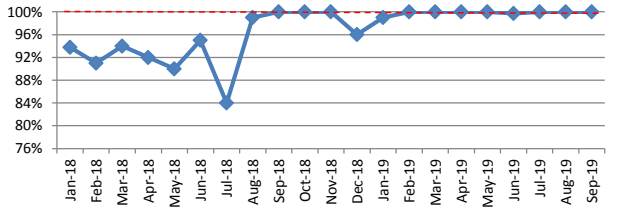
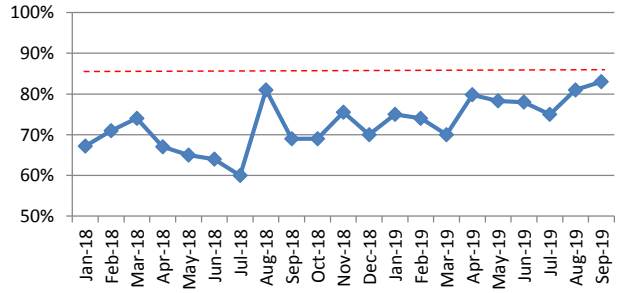
Suggested Committee Discussion Questions: None

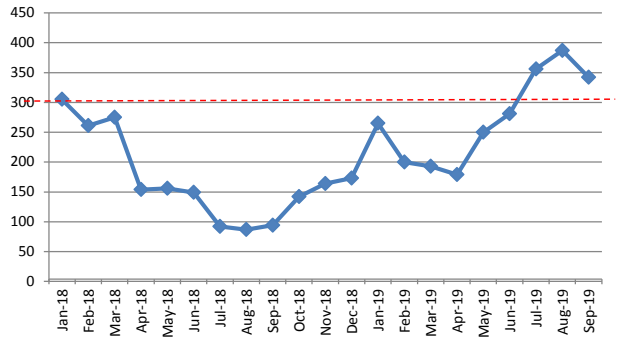
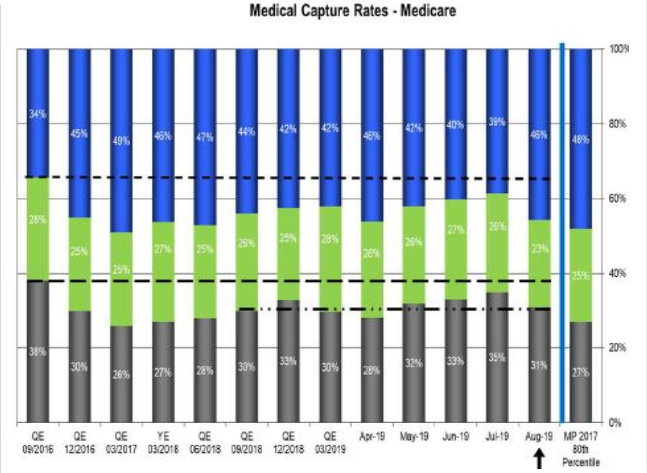
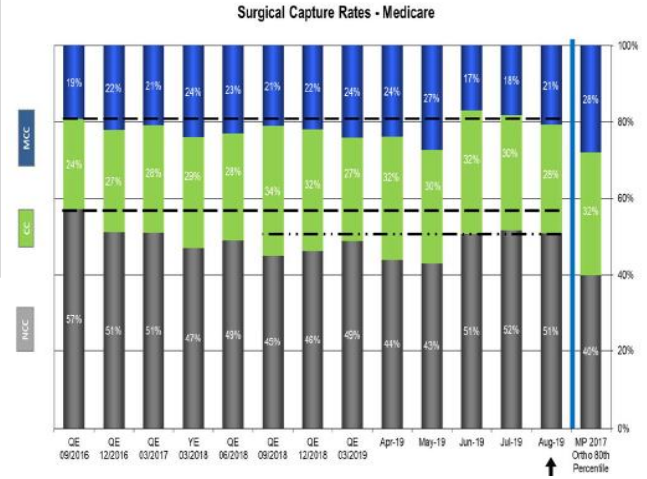
List of Attachments:

1. FY20 CDI KPI Dashboard

El Camino Health

Clinical Documentation Integrity Dashboard (Monthly/ ALL adult, acute care, non-OB inpatient population)

As of Oct 10, 2019			Baseline	FY20 Goal	Trend	Comments
Coverage	Performance		FY2019	FY2020 goal		
1	**Medicare** *Source: iCare CDI Productivity report	Sep 2019 515/445 86% FYTD 82%	75%	85%		Medicare coverage continued to fluctuate due to some factors including higher IN-OBS convertion rate of the patients attributed mainly to a higher troughput in ER department, as well as some minor turnover in the CDS staff (minus 1 FTE begining July). CDI staff continue to prioritize Medicare and Advantage Care cases in their daily review. We also are developing an OBS WQ in iCare that will allow to catch reviewed accounts that have been converted. Also, we are interviewing candidates for last CDS position to be filled.
2	**All Payor** *Source: iCare CDI Productivity report	Sep 2019 974/776 80% FYTD 76%	67%	75%		Focus of review on ALL PAYERS - it is directed towards all ECH population expected mortality optimization. After almost one years we consistently started to cover all financial clases and payers. It started in October FY 2019. FYTD we cover 76% of all patients with a goal of 75% for the FY 2020.
Physician Response	Performance		FY2019	FY 2020 goal		
3	**Query Response Rate** *Source: iCare CDI Query report	Sep 2019 100% FYTD 100%	98%	100%		Consistently 100% after implementing the new Physician Query P&P in August last year. At the highest level ever registered for the existence of the CDI program. With few exceptions, phycians are very engaged in documentation clarification opportunities.
4	**Query Agree Rate** *Source: iCare CDI Query report	Sep 2019 83% FYTD 80%	73%	>85%		Agreement rate steadily increasing, ranging in 80% FYTD, with a target of 85% for FY 2020. Opportunities identified with query outcomes "clinicaly undetermined" and irrelevant commnets to the question adressed. With the new updates to the query forms, reflecting IPPS 2020 documentation guidelines associated with an increase outreach to providers regarding the rationale behind clarification requests started to bring results

#	Queries volume	Performance		FY2019	FY 2020 goal		
5	**Query volumes** **Source: iCare CDI Query report*	**Sep 2019** **342** 47%	**FYTD** **342**	**177**	35% of all reviewed accounts		Query volumes have been trending up at the highest numbers of CDI staff increased. Direct correlation with the number of cases reviewed. Worh noting that despite increased number of queries placed the response rate and agreement rate at all time high. It denotes a high engagement on the clinical practitioners side.
6	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: CLARO report	**Sep 2019** **MCC 46%** **CC 23%** **NCC 31%**	**N/A**	**Nat 80th% CMS 2018** MCC 48% CC 27% No CC 29%	**Nat 80th% CMS 2018** MCC 48% CC 25% No CC 27%		Higher MCC Capture Rate is better. This affects Reimbursement, Expected GMLOS, and CMI in Medicare population. National 80th Percentile is computed by CMS and published annually on 10/1.
7	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: CLARO report	**Sep 2019** **MCC 21%** **CC 25%** **NCC 51%**	**N/A**	**Nat 80th% CMS 2018** MCC 31% CC 32% No CC 37%	**Nat 80th% CMS 2018** MCC 28% CC 32% No CC 40%		Surgical cases make up 20-30% of our Medicare patient volume. The biggest impact in reimbursement, CMI, GMLOS will come from increased Surgical CC/ MCC capture. Working closely with HVI, orthopedic and stroke teams to document comorbid conditions in sugical population is the focus of CDI program begining with FY 2019

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: November 4, 2019
Subject: CY 2019 Core Measure Dashboard

Purpose:

To provide the Committee with the current CMS and TJC required clinical core measure data results.

1. Situation: Annotation is provided to explain actions taken affecting each metric. These core measure results are applied by CMS to several programs: CMS Value-based Purchasing program (VBP), CMS Star Ratings, Leapfrog Safety Grade, and Public Hospital Redesign and Incentives in MediCal (PRIME) program.

2. Authority: The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on compliance with CMS measurements of clinical quality.

3. Background: These metrics are revised annually by CMS and TJC in January, and some are retired or moved to eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program.

4. Assessment:

- Zero occurrence of Early Elective Deliveries prior to 39 weeks (PC-01) since March 2019
- MV performance for Primary C/Section (PC-02) and Exclusive Breast Feeding (PC-05) not at target level.
- Outpatient measures performance meeting targets.
- HBIPS = Hospital-based Inpatient Psychiatric unit measures; all measures at target, except the tobacco use metric.

5. Other Reviews: N/A

6. Outcomes: N/A

Suggested Committee Discussion Questions: None.

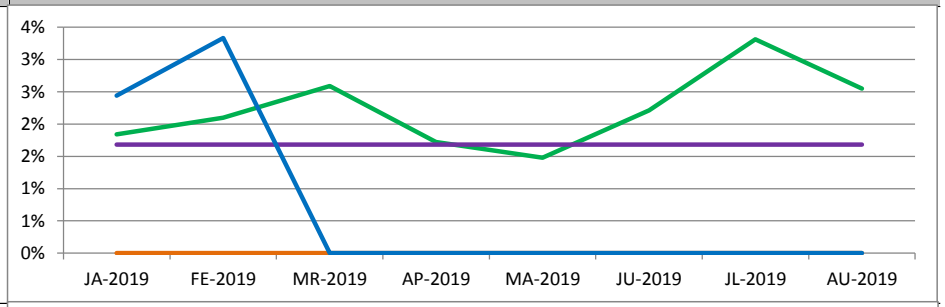
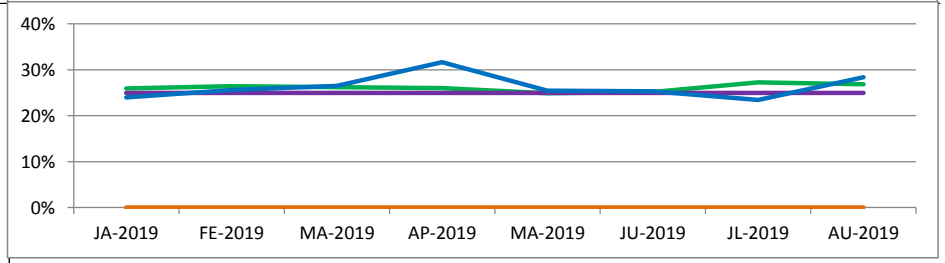
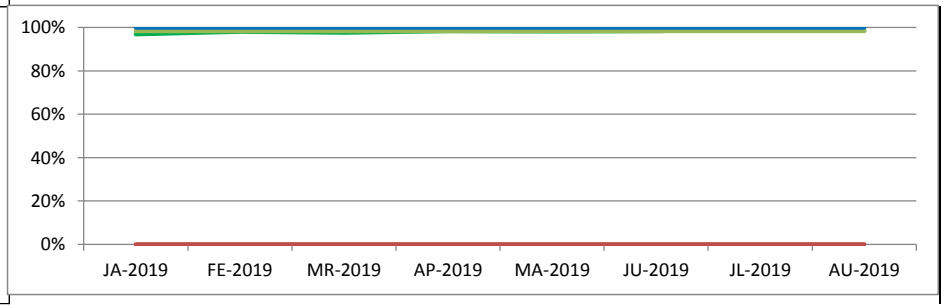
List of Attachments:

1. CY 2019 Core Measure Dashboard through August 2019.

El Camino Health

Core Measures Summary Report

Date Period: August 2019

		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
Perinatal Care Mother		**Month**	**2019 CYTD**			
1	PC01- Elective Delivery Prior to 39 weeks gestation (lower=better) Date Period: August 2019	Ent 0% (0/39) MV 0% (0/32) LG 0% (0/7)	Ent 0.75% (2/267) MV 0.85% (2/235) LG 0% (0/32)	Ent 1.32% (4/302) MV 1.61% (4/265) LG 0% (0/37)	0%	
2	PC02- Cesarean Birth (lower=better) Date Period: August 2019	Ent 28.4% (48/169) MV 29.68% (46/155) LG 14.29% (2/14)	Ent 26.36% (319/1210) MV 27.73% (295/1064) LG 16.44% (24/146)	Ent 24.13% (331/1372) MV 25.20% (309/1226) LG 15.07% (22/146)	<23.90%	
3	PC03- Antenatal Steroids Date Period: August 2019	100%	100%	100%	100%	

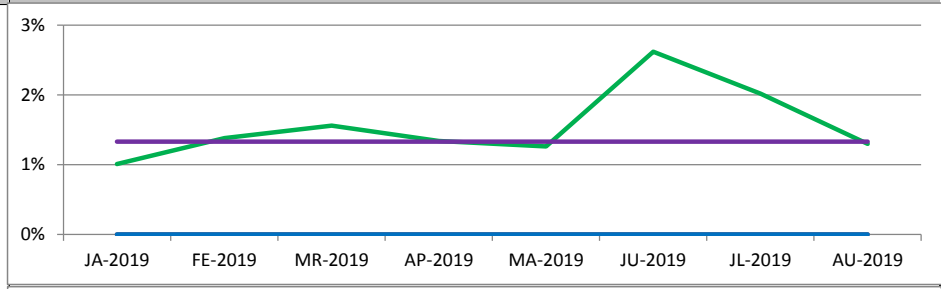
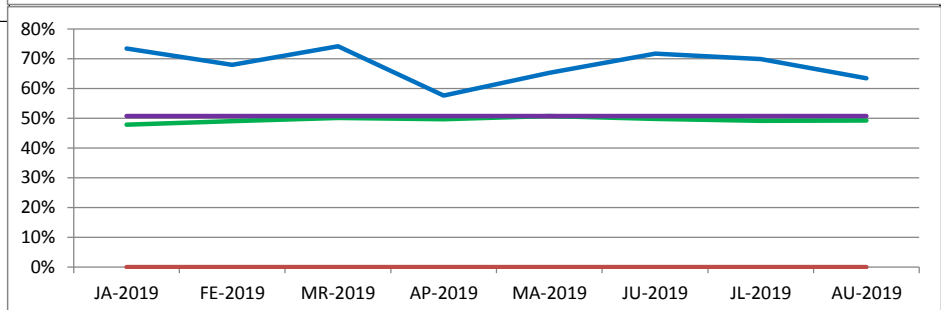
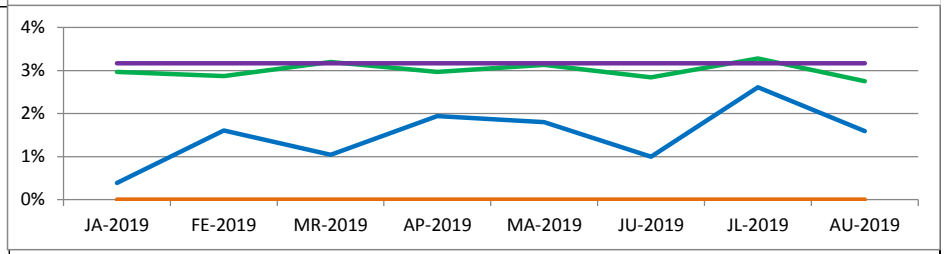
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2020 Definition	Data Source
PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed	Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Target goal is 0%; CYTD 2019 Performance: 0.75% Hospital Compare PC-01 from 10/1/2017 to 9/30/2018 national and state is 2%. Elective Delivery challenges include potentially modifiable factor such as patient preferences, those with prior cesarean section who desires repeat cesarean section and scheduled repeat cesarean section prior to 39 weeks. Outliers had conditions not included in the exclusion criteria e.g. borderline amniotic fluid index (AFI) as well as oligohydramnios and suspected macrosomia with history of shoulder dystocia with previous delivery and advanced maternal age.	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	IBM CareDiscovery Quality Measures
PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth	Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; CYTD 2019 Performance is 26.36%. We've had 2 insurance providers who indicated not sending patients to us if our rate is higher than the target goal. Fallouts are referred to peer review coordinator; the most common indications for primary cesarean delivery included abnormal fetal heart rate tracing, CPD, preeclampsia and suspected fetal macrosomia, arrest of labor and abnormal or indeterminate fetal heart rate tracing. LG has certified nurse-midwife on staff.	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	IBM CareDiscovery Quality Measures
PC-03: Antenatal Steroids Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns	The measure recommends to give a full course of corticosteroids to all pregnant women between 24 weeks and 34 weeks of gestation who are at risk of preterm delivery. Target goal is 100%; CYTD 2019 Performance: 100%. No outliers since 2014.	TJC	No issues	Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed	Numerator Statement: Patients with antenatal steroids initiated prior to delivering preterm newborns Denominator Statement: Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed	IBM CareDiscovery Quality Measures

El Camino Health

Core Measures Summary Report

Date Period: August 2019

		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
Perinatal Care Babies		**Month**	**CYTD**			
4	PCB04- Health Care-Associated BSI in Newborns (lower=better) Date Period: August 2019	0%	0%	0%	0%	
5	PC05- Exclusive Breast Milk Feeding Date Period: August 2019	Ent 63.38% (45/71) MV 56.90% (33/58) LG 92.31% (12/13)	Ent 67.86% (340/501) MV 64.10% (275/429) LG 90.28% (65/72)	Ent 63.58% (473/744) MV 59.97% (385/642) LG 86.27% (88/102)	70%	
6	PC06- Unexpected Complications in Term Newborns (lower=better) *Date Period: August 2019*	1.59%	1.48%	new in 2019	0%	

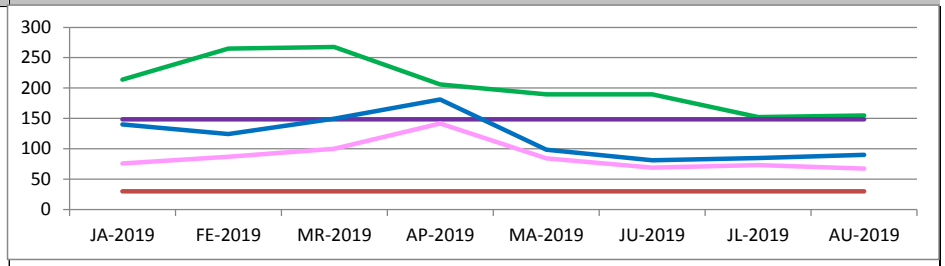
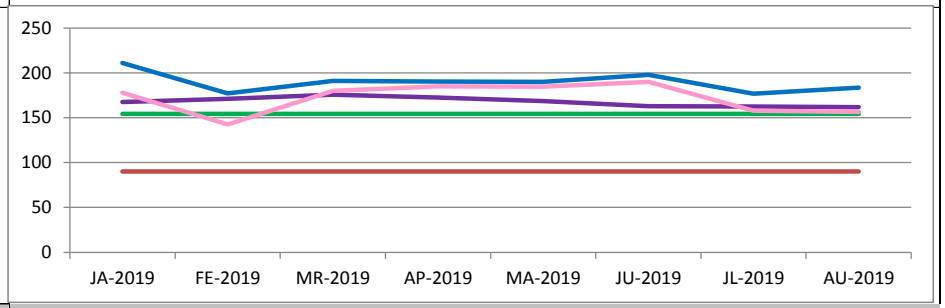
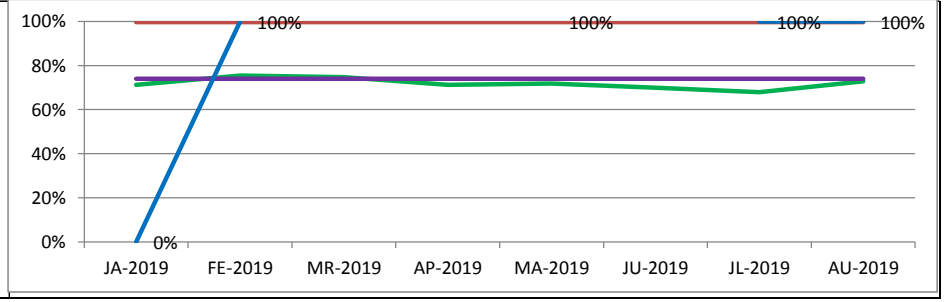
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2020 Definition	Data Source
PCB-04: Health Care-Associated BSI in Newborns Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns	This is aligned with NHSN definition of Health Care-Associated BSI. Staphylococcal and gram negative septicemias or bacteremias in high-risk newborn. Target goal is 0%; CYTD 2019 Performance: 0%	TJC	No issues	Numerator Statement: Newborns with septicemia or bacteremia Denominator Statement: Liveborn newborns	Numerator Statement: Newborns with septicemia or bacteremia Denominator Statement: Liveborn newborns	IBM CareDiscovery Quality Measures
PC-05: Exclusive Breast Milk Feeding during the newborn's entire hospitalization	Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; CYTD 2019 Performance: 68%. TJC is 51% Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration	TJC	Quarterly meeting/emails with L&D nursing leadership	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital		IBM CareDiscovery Quality Measures
PC-06: Unexpected Complications in Term Newborns - The percent of infants with unexpected newborn complications among full term newborns with no preexisting conditions.	The Joint Commission's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; CYTD 2019 Performance: 1.48% This is a new measure and we started to refer and send the fall outs to Peer Review for screening and trending. Severe complications include neonatal death, transfer to another hospital for higher level of care, severe birth injuries such as intracranial hemorrhage or nerve injury, neurologic damage, severe respiratory and infectious complications such as sepsis. Moderate complications include diagnoses or procedures that raise concern but at a lower level than the list for severe e.g. use of CPAP or bone fracture. Examples include less severe respiratory complications e.g. Transient Tachypnea of the Newborn, or infections with a longer length of	TJC	Quarterly meeting/emails with L&D nursing leadership; failure summary cases referred to per review coordinator	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?		IBM CareDiscovery Quality Measures

El Camino Health

Core Measures Summary Report

Date Period: August 2019

		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
ED Throughput		**Month**	**CYTD**			
7	ED2b- Admit Decision Time to ED Departure Time for Admitted Patients (lower=better) Date Period: August 2019	ENT 67.5 mins MV 67.5mins LG 68 mins	ENT 81 mins MV 81 mins LG 82 mins	ENT 95 mins MV 95 mins LG 94 mins	<120 mins	
8	*OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients(lower=better)* *Date Period: August 2019*	ENT 156.5 mins MV 156 mins LG 151 mins	ENT 172 mins MV 172 mins LG 167mins	ENT 183 mins MV 183 mins LG 184 mins	<180 mins	
Outpatient Measures		**Month**	**CYTD**			
10	OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Date Period: August 2019	100% 1/1	80% 4/5	62.50% 5/8	100%	

Definitions and Additional Information

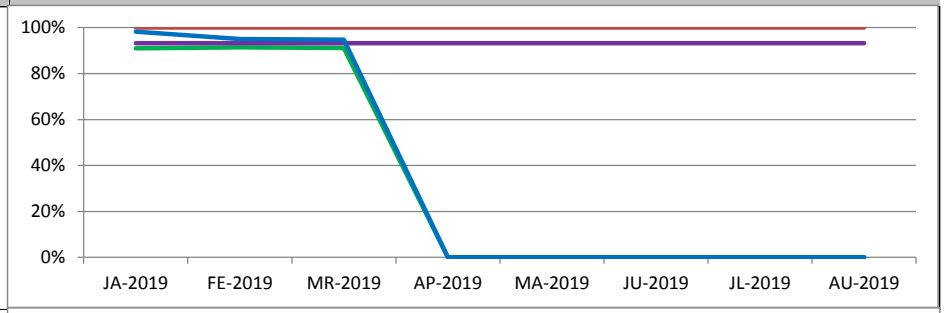
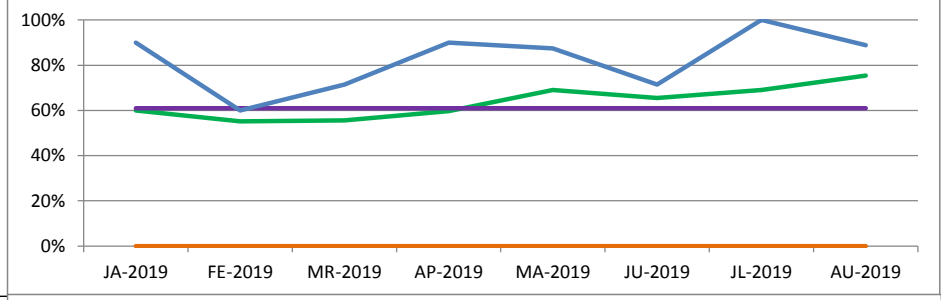
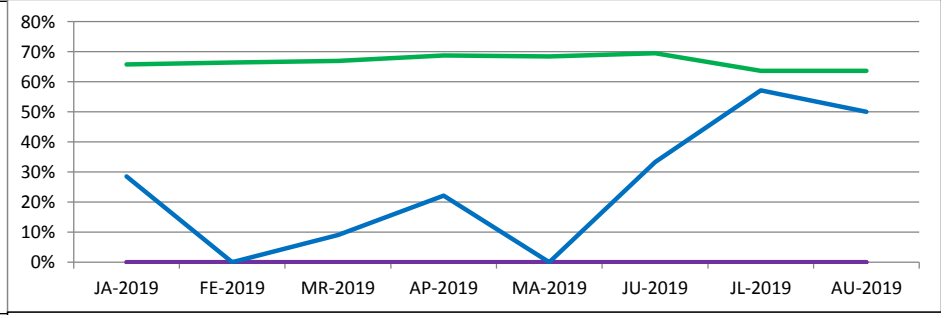
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2020 Definition	Data Source
ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients	Median time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room. Target goal is 120 minutes or less. CYTD 2019 ENT 81 mins, MV 81mins, LG 82mins This measure is focused on admitted patients and depends on bed availability throughout the hospital. Quality collaborated with PI Data Analyst to ensure data definition and collection is meeting CMS standards. TJC median is 149 minutes	TJC	Hospital has multiple mulit-disciplinary committees working on improving bridging orders, nursing hand-off interval, bed flow, etc.	Numerator Statement: Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients Denominator Statement:Any ED Patient from the facility's emergency department. Excludes Patients who are not an ED Patient.	Definition: The documented date the decision to admit to observation or inpatient status occurred. Decision to admit to observation or inpatient status date is the date the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital for continued care in the facility.	IBM CareDiscovery Quality Measures
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients	Median Time from ED Arrival to ED Departure for Discharged ED Patients- Median time patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; CYTD 2019 rate is 172 minutes compared to National: 144 Minutes; California: 206 Minute	Hospital OQR Specifications Manual		Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department		IBM CareDiscovery Quality Measures
OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients who arrive at the ED within 2 hours of the onset of symptoms who have a head CT or	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. Analysis includes CT TAT (ordering, initiating, completing, and interpretation). Target goal is 100%; CYTD 2019 80%. California and national average is 72% Improvement noted after Clinicians' reminder focused on early identification of stroke s/s and use of stroke order sheet. This measure has a very low volume. Outliers are shared with Stroke clinical coordinator for further review and action plan. Challenges include communicating the stroke alert e.g. if radiology is unaware of case being a stroke, the exam would fall into the normal reading queue. Reasons for delay are multi-disciplinary most of the time.	Hospital OQR Specifications Manual	Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)	Numerator Statement: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator Statement: Emergency Department Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the Time Last Known Well with an order for a head CT or MRI scan		IBM CareDiscovery Quality Measures

El Camino Health

Core Measures Summary Report

Date Period: August 2019

Blue = ECH Observed | **Green** = All Core Measures Hospitals benchmark value
Orange = CMS Standard of Excellence - Top 10% of Hospitals | **Purple** = Joint Commission Benchmark

	Hospital Based Inpatient Psychiatric Services (HBIPS)	CY19 Performance Month	CY19 Performance CYTD	Baseline CY18	CY19 Target	
11	IMM-2 Influenza Immunization Date Period: August 2019	Not Flu Season	96%	91%	100%	
12	HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification Date Period: August 2019	89%	84%	76%	80%	
13	PC-TOB Perfect Care - Tobacco Use Date Period: August 2019	50%	25%	82%	80%	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2020 Definition	Data Source
IMM-2: Influenza Immunization	Patients assessed and given influenza vaccination. Target goal is 100%; CYTD 2019 rate is 96%. CMS retired IMM2 beginning January 2019 discharges and is only collected by TJC for BHS HBIPS. Follow through of Influenza immunization nursing process i.e. documentation between October 1 and March 31 whether patient received or refused an influenza immunization. Included BPA in ordering flu vaccine and scheduled it for administration during hospitalization prior to discharge.	CMS/TJC	quarterly meeting/email to BHS team	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	IBM CareDiscovery Quality Measures
HBIPS-5: Patients Discharged on multiple antipsychotic medications with appropriate justification	Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%; CYTD 2019 rate is 84% Reports were created and shared monthly to BHS leadership to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. Education efforts targeted to remind providers that even if they prescribed antipsychotic (e.g. Abilify) to treat depression, it's stil counted as antipsychotic. Also not to bypass or work-around the hardwired discharge documentation of reason for 2 or more antipsychotics by answering NO.	TJC	quarterly meeting/email to BHS team		Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	IBM CareDiscovery Quality Measures
PC-TOB: Perfect Care - Tobacco Use	Target goal is 80% CYTD 2019 rate is 25.42%. Patients who receive even brief advice and intervention from their care providers are more likely to quit than those who receive no intervention. There is a current project focused on this measure since there is a significant drop in our performance rate.Fallouts sent to BHS team for further review and education to providers. iCare modified tobacco order set to increase compliance. Perfect Care-TOB comprises the following: TOB-1 Tobacco Use Screening TOB-2 Tobacco Use Treatment Provided or Offered TOB-2a Tobacco Use Treatment TOB-3 Tobacco Use Treatment Provided or Offered at Discharge TOB-3a Tobacco Use Treatment at Discharge Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of	TJC	quarterly meeting/email to BHS team	Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay within the first three days after admission Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.	Hospitalized patients who are screened within the first three days of admission for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days Patients identified as tobacco product users within the past 30 days who receive or refuse practical counseling to quit AND receive or refuse FDA-approved cessation medications during the hospital stay within the first three days after admission Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication upon discharge.	IBM CareDiscovery Quality Measures

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Core Measures Summary Report

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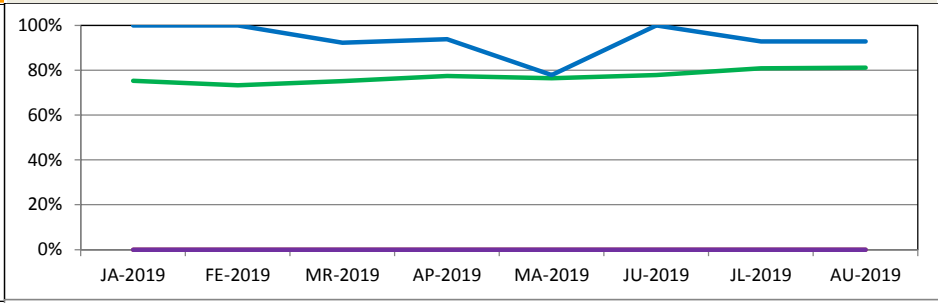
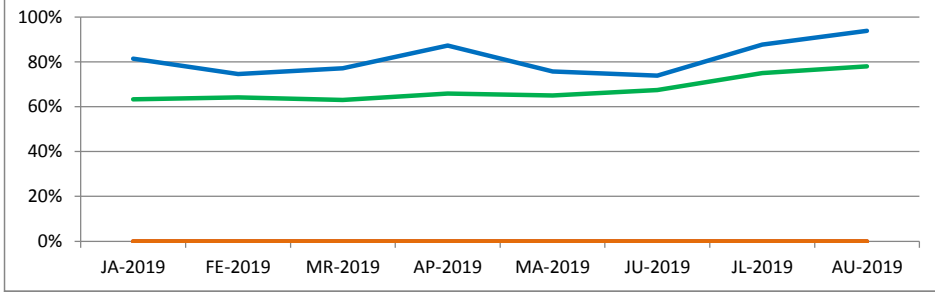
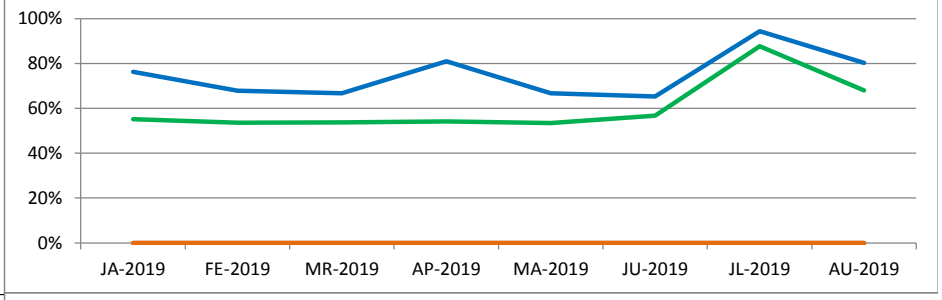
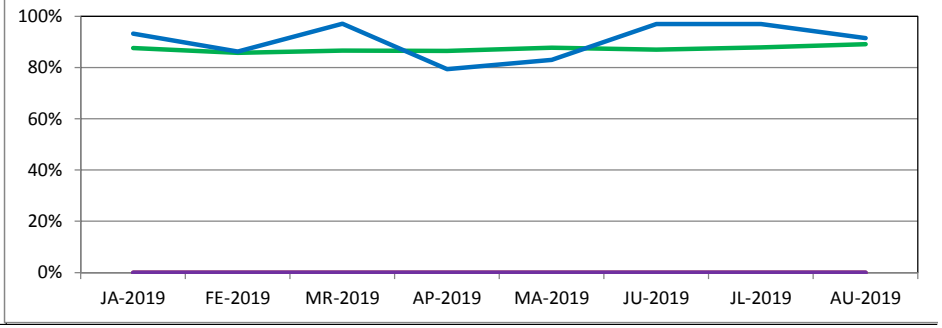
		CY19 Performance		Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark
4	PC-SUB Perfect Care - Substance Abuse Date Period: August 2019	93%	95%	97%	80%	
5	TR-1 Transition Record with Specified Elements Received by Discharged Patients *Date Period: August 2019*	94%	81%	75%	75%	
14	TR-2 Timely Transmission of Transition Record Date Period:August 2019	80%	72%	67%	75%	
15	MET -1 Screening For Metabolic Disorders Date Period: August 2019	91%	90%	97%	75%	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2020 Definition	Data Source
PC-SUB: Perfect Care - Substance Abuse	Target goal is 80% CYTD 2019 rate is 95% Perfect Care-SUB comprises the following: SUB-1 Alcohol Use Screening SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge Brief intervention on Unhealthy Alcohol use was added to education documentation. Patients are referred to facilities that are able to address issues with alcohol and drug use disorder.	TJC	quarterly meeting/email to BHS team	Hospitalized patients who are screened within the first day of admission using a validated screening questionnaire for unhealthy alcohol use Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.	Hospitalized patients who are screened within the first day of admission using a validated screening questionnaire for unhealthy alcohol use Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.	IBM CareDiscovery Quality Measures
TR-1 Transition Record with Specified Elements Received by Discharged Patients	Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% CYTD 2019 rate is 81% The value of integrated care is the main focus of this measure Transition Record improved significantly August 2019 is 94% r/t recent focus on Advanced Directive and also BHS team invited charge nurses, admin assistant and front life staff to the quarterly meetings.	CMS/TJC	quarterly meeting/email to BHS team	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	IBM CareDiscovery Quality Measures
TR-2: Timely Transmission of Transition Record	Timely Transmission of Transition Record- Target goal is 75%; CYTD 2019 rate is 71% When TR is not complete the case not only fails TR1 but also an automatic fail of TR2 measure. Most fallouts are related to patients not having their own PCP. The education is focused on transmitting the TR to the next provider whether it's the patient's pcp or not.	CMS/TJC	quarterly meeting/email to BHS team	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	Numerator: Psychiatric inpatients for whom a transition record, which included all 11 elements, was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge. Denominator: Psychiatric inpatients, regardless of age, discharged from an IPF to home/self-care or any other site of care.	IBM CareDiscovery Quality Measures
MET: Screening For Metabolic Disorders	Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; CYTD 2019 rate is 90% Fallouts r/t mising Blood glucose- documentation that the patient fasted prior to the test is required. If there is no documentation that the patient fasted, that test cannot be used for this data element.	CMS/TJC	quarterly meeting/email to BHS team	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days.	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic	IBM CareDiscovery Quality Measures

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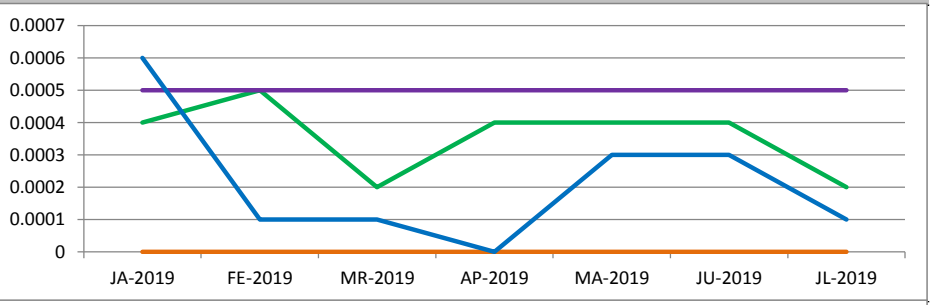
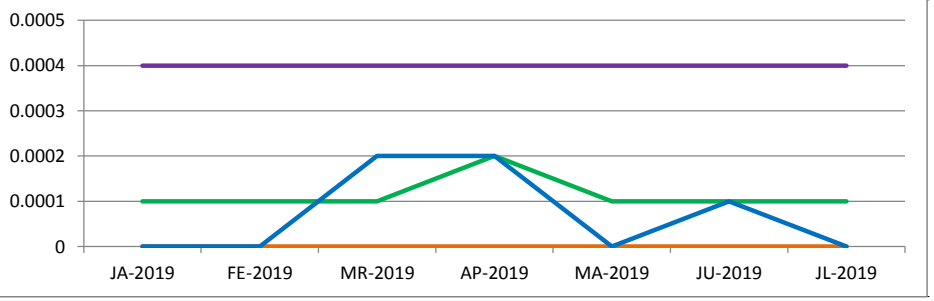
	CY19 Performance	Baseline CY18	CY19 Target	Blue = ECH Observed | Green = All Core Measures Hospitals benchmark value Orange = CMS Standard of Excellence - Top 10% of Hospitals | Purple = Joint Commission Benchmark

Restraints and Seclusions	Month	CYTD			
16	*HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)* *Date Period: July 2019*	0 (0.9167/12984)	0.0002 (22.333/101976)	0.0002 (34.933/169896)	0.0004	
17	HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower=better) Date Period: July 2019 *Event measures (HBIPS-2 and HBIPS-3) are calculated by event occurrence date	0 (0/12984)	0.0001 (7.7/101976)	0.0002 (41.7667/169896)	0.0003	

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2020 Definition	Data Source
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)	ECH is at below ECH-defined goals and TJC rate for both hours of physical restraint and seclusion use. Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	TJC	quarterly meeting/email to BHS team	Numerator : The total number of hours that all psychiatric inpatients were maintained in physical restraint Denominator : Number of psychiatric inpatient days	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	IBM CareDiscovery Quality Measures
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower=better)	ECH is at below ECH-defined goals and TJC rate for both hours of physical restraint and seclusion use. Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.	TJC	quarterly meeting/email to BHS team	"Numerator:The total number of hours that all psychiatric inpatients were held in seclusion Denominator: Number of psychiatric inpatient days"	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	IBM CareDiscovery Quality Measures