El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

Quality, Patient Care and Patient Experience Committee Meeting of the El Camino Hospital Board

Monday, October 30th, 2017, **5:30 p.m.**
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Dr. Jeffrey Davis will be participating via teleconference from 600 Stockton Street, San Francisco, California 94108

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	Dave Reeder, Quality Committee Chair		**5:30 – 5:31pm**
2. ROLL CALL	Dave Reeder, Quality Committee Chair		**5:31 – 5:32**
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Dave Reeder, Quality Committee Chair		**5:32 – 5:33**
4. CONSENT CALENDAR ITEMS: *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair	*public comment*	**Motion Required 5:33 – 5:36**
Approval a. Minutes of the Open Session of the Quality Committee Meeting (October 2nd, 2017) ***Information*** b. Research Article c. Patient Story d. FY18 Pacing Plan e. Progress Against FY 2018 Committee Goals f. Safety Report for the Environment of Care			
5. REPORT ON BOARD ACTIONS **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion 5:36 – 5:39**
6. QUALITY PROGRAM UPDATE: ELECTROPHYSIOLOGY **ATTACHMENT 6**	Shaun Cho, MD, Co-Medical Director, Electrophysiology		**Discussion 5:39 – 5:59**
7. COMMITTEE MEMBER RECRUITMENT	Dave Reeder, Quality Committee Chair		**Discussion 5:59 – 6:04**
8. FY18 QUALITY DASHBOARD **ATTACHMENT 8**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 6:04 – 6:14**
9. PEER REVIEW PROCESS CHANGES IMPLEMENTATION UPDATE **ATTACHMENT 9**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 6:14 – 6:24**

A copy of the agenda for the Regular Committee 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**	Jessica Hatala, Interim CDI Manager		**Discussion 6:24 – 6:34**
11. CORE MEASURES **ATTACHMENT 11**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 6:34 – 6:44**
12. UPDATE ON CULTURE OF SAFETY RESULTS **ATTACHMENT 12**	William Faber, MD, Chief Medical Officer		**Discussion 6:44 – 6:54**
13. UPDATE ON PATIENT AND FAMILY CENTERED CARE **ATTACHMENT 13**	Cheryl Reinking, RN Chief Nursing Officer		**Discussion 6:54 – 6:59**
14. PUBLIC COMMUNICATION	Dave Reeder, Quality Committee Chair		**Information 6:59 – 7:02**
15. ADJOURN TO CLOSED SESSION	Dave Reeder, Quality Committee Chair		**Motion Required 7:02– 7:03**
16. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Dave Reeder, Quality Committee Chair		**7:03 – 7:04**
17. CONSENT CALENDAR *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required 7:04 – 7:07**
Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (October 2, 2017) ***Information*** b. Quality Council Minutes (September 6, 2017)			
18. *Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - Red/Orange Alert and RCA Updates	William Faber, MD, Chief Medical Officer		**Discussion 7:07 – 7:12**
19. *Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - Quarterly Quality and Safety Report	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 7:12 – 7:22**
20. *Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - CMO Report	William Faber, MD, Chief Medical Officer		**Discussion 7:22 – 7:27**
21. ADJOURN TO OPEN SESSION	Dave Reeder, Quality Committee Chair		**Motion Required 7:27 – 7:28**
22. RECONVENE OPEN SESSION/REPORT OUT	Dave Reeder, Quality Committee Chair		**7:28 – 7:29**
To report any required disclosures regarding permissible actions taken during Closed Session.			
23. ADJOURNMENT	Dave Reeder, Quality Committee Chair		**Motion Required 7:29 – 7:30pm**

Upcoming FY18 Meetings

- December 4, 2017
- February 5, 2018
- March 5, 2018
- April 2, 2018
- April 30, 2018
- June 4, 2018

Upcoming Board & Educational Committee Gatherings

- April 25, 2018

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, October 2, 2017
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	**Members Absent**	**Members Excused**
Dave Reeder, Jeffrey Davis, MD; Katie Anderson, Ina Bauman, Mikele Bunce, Wendy Ron, and Melora Simon	Nancy Carragee Peter Fung, MD	

**Melora Simon joined the meeting at 5:36pm*
**Mikele Bunce left the meeting at 7:05pm*
**Ina Bauman left the meeting at 7:25pm*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 2nd of October, 2017 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Chair Dave Reeder at 5:33 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Nancy Carragee and Dr. Peter Fung were absent. Melora Simon joined the meeting at 5:36pm and all other committee members were present during roll call. Chair Reeder welcomed Dan Woods, CEO, and a roundtable of introductions ensued.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member may have a conflict of interest with any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session the Quality Committee Meeting (August 28, 2017) **Movant**: Ron **Second:** Davis **Ayes:** Anderson, Bauman, Bunce, Davis, Reeder, Ron, Simon **Noes:** None	***The Open Session Minutes of the August 28, 2017 meeting were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Abstentions: None **Absent:** Carragee, Fung **Excused:** None **Recused:** None	
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and briefly highlighted the following: • Appointment of new Board Member Neysa Fligor to the Executive Compensation Committee, the Corporate Compliance/Privacy and Internal Audit Committee, and elected to the El Camino Hospital Board of Directors.	***None***
6. QUALITY PROGRAM UPDATE: ROBOTICS	Alpert Pisani, MD, Co-Medical Director of Gyn/Robotics Surgery, updated the Committee on the Gynecologic Oncology Robotic surgery at ECH and reported that this program is the busiest in Northern California, with more than 6,500 cases done here yearly. He further highlighted that the Gyn mortality rate is recorded at 0 with one exception in August 2016; while SSI Rate is recorded at 1 at MV campus and 0 at LG campus and no CAUTIs are identified from July 2016 to Jan 2017. He also noted Gyn/Gyn Oncology 30 day procedure readmission is relatively low. Dr. Pisani explained that ECH is one of only two hospitals from the Bay area to offer bariatric robotic surgery. He described the advantages of Robotic-Assisted Operative Laparoscopy which 33% of patients are less likely to be readmitted, 64% are less likely to experience complications, and financially economical when compared to open direct cost. Dr. Pisani further updated the Committee of the FY17 goals of decrease TPN usage and the goal for FY 18: decrease post-operative opioid use after ERAS (Enhanced Recovery After Surgery) protocol and utilizing order set in iCare. Dr. Pisani asked for feedback and questions from the Committee and a brief discussion ensued.	***None***
7. COMMITTEE MEMBER RECRUITMENT	Chair Reeder informed the Committee of vacant positions available on the committee but not necessary to be filled and of two potential candidates: Dr. Carol Somersille (independent physician) and Julie Kriger (program director). A brief discussion ensued regarding the type of expertise and competencies needed for the Committee. The Committee asked to revisit the topic at the next meeting.	***Agenda item to be added for next meeting on October 30th, 2017***

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Agenda Item	Comments/Discussion	Approvals/Action
8. FY18 QUALITY DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, reviewed the FY18 Quality Dashboard with the Committee. Ms. Carson discussed that the trend is near or at goal for falls in Jan 2017 and this data will be shared with the Falls team. A standardized infection rate from NSHN will be reported quarterly or every 6 months for CAUTI, CLABSI, CDI and SIR. No CLABSI were reported in July and 1 C.Diff infection was reported at the MV campus. Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population is now part of daily huddle. Sepsis Core Measure is based off Early Management Bundle: 1) Sepsis 3-hour window - initial lactate, antibiotic, and blood cultures, 2) Sepsis 6-hour window – repeat lactate, 3) Septic Shock 3-hour window – crystalloid fluids, and 4) Septic Shock 6 hour window – septic shock assessment. She further reported that the ED Physicians are more consistent in ordering fluid resuscitation for Sepsis patients. The Mortality Rate FY18 goal is based on the July 2016 to May 2017 top docile performers, the comparison is not yet available by Premier, and the rate is risk adjusted. The Rate the Hospital HCHAPS score for August exceeds maximum, maintaining that level will be the challenge. Due to the quarterly nature of the Infection metric, this last metric is not reported. Ms. Carson reported that through August, ECH has had 4 occurrences of CAUTI, 0 occurrences of CLABSI, and 4 occurrences of C-Diff. **Items of Note: Catherine Carson will reset Falls Goal to CALNOC top 25% docile and readjust chart to view one year data. Next meeting to provide all Falls data and all Falls data with Harm to the Committee and provide an overview of Medicare's criteria and coverage.*	
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Michelle Gabriel, Director of Performance Improvement, informed the committee on the status of hiring the Patient Experience Manager of which 17 applicants have applied with 3 potential candidates. She explained that the patient experience governance committee had their first meeting in September and is currently reviewing patient experience data to identify opportunities for improvements and piloting a dashboard. She asked the Committee members for feedback and a brief discussion ensued.	***None***
10. FY 17 ORGANIZATIONAL GOAL ACHIEVEMENT	Mick Zdeblick, Chief Operating Officer, shared the final outcomes of FY 17 Organizational Goals. Pain Reassessment has done very well at 89%, Pain Patient Satisfaction reached maximum goal at 76%, and LOS did	***None***

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Agenda Item	Comments/Discussion	Approvals/Action
UPDATE	improve and didn't affect negatively on readmission. While Smart Growth was on target at 96.5%.	
11. READMISSION DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, shared the new format for FY 2018 Medicare 30 Day All-Cause, Unplanned Readmission Dashboard with the committee. She explained how Hospital Readmission Reduction Program will reduce reimbursement for 2,573 hospitals for fiscal year 2018 by Medicare according to CMS data. The latest penalties are based on readmission between July 2013 and June 2016 which affects Medicare payments that CMS makes to hospitals between October 1, 2017 and September 30, 2018. Ms. Carson further reported that CMS withholds up to 3% of regular reimbursement if a hospital has a higher-than-expected number of readmission within 30 days of discharge for 6 conditions: Chronic Lung Disease, Coronary Artery Bypass Graft Surgery, Heart Attacks, Heart Failure, Hips and Knee Replacements, and Pneumonia. The penalties which most affect ECH are for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and Total joints.	***None***
12. PSI-90 ST SAFETY INDICATORS	Catherine Carson, Sr. Director/Chief Quality Officer, explained that the PSI-90 Total Inpatient report is pulled from July 2016 to May 2017. The facility composite value was 0.668412 which is lower than the Premier PSI-90 score at 0.80 but ECH still has room for improvement to meet Premier PSI-90 top decile score of 0.57. She noted 3 out of 8 Patient Safety Indicators had an uptick: Perioperative PE or DVT, Postop Sepsis, and Accidental Puncture or Laceration. The Sepsis Committee reviewed each case for further details, and found a contributing factor due to lack of information from physician notation in medical records cause the uptick for accidental puncture or laceration scores and no trends were noted on Perioperative PE or DVT cases. **The committee noted that PSI-90 Composite graph's data value was not correct, Catherine will recalculate to generate accurate graph.*	***None***
13. CULTURE OF SAFETY SURVEY RESULTS	William Faber, MD, Chief Medical Officer, updated the Committee on the Press Ganey Culture of Safety questions and results. The employee and medical staff's scores were tabulated separately and both aggregate scores were slightly below the national average but showed multiple areas of improvement. Dr. Faber asked the Committee for feedback on specific areas of concern to include: • When a mistake is reported, the focus is on solving the problem, not writing up the person.	

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Agenda Item	Comments/Discussion	Approvals/Action
	• My work unit works well together. • My work unit is adequately staffed. • Senior management provides a work climate that promotes patient safety. • I feel free to raise workplace safety concerns. • I can report patient safety mistakes without fear of punishment. The committee's feedback included providing a breakdown of the results by physician to the department chair in order to improve scores through working together with unit management.	
14. PUBLIC COMMUNICATION	None.	***None***
15. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:05 p.m. **Movant:** Davis **Second:** Simon **Ayes:** Anderson, Bauman, Bunce, Davis, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Carragee, Fung **Excused:** None **Recused:** None	***Adjourned to closed session at 7:05 p.m.***
16. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:26 pm. *Agenda Items 16 – 20 were addressed in closed session.*	
17. AGENDA ITEM 22: ADJOURNMENT	The meeting was adjourned at 7:26 pm. **Motion:** To adjourn at 7:26 p.m. **Movant:** Anderson **Second:** Ron **Ayes:** Anderson, Davis, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Bauman, Bunce, Carragee, Fung **Excused:** None **Recused:** None	***Meeting adjourned at 7:26 pm***

Attest as to the approval of the foregoing minutes by the Quality Committee of El Camino Hospital

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Dave Reeder
Chair, ECH Quality, Patient Care and
Patient Experience Committee

DRAFT

ScienceDaily®
Your source for the latest research news

Catheter ablation better than traditional drug therapies for treating atrial fibrillation

Date: August 27, 2017

Source: University of Utah Health

Summary: New study shows radiofrequency catheter ablation lowered hospitalization and mortality rates by 47 and 44 percent respectively in patients with atrial fibrillation (AF), a contributing factor to heart failure.

FULL STORY

Every year millions of people around the world are diagnosed with heart failure, a chronic, progressive condition where the heart is unable to pump enough oxygenated blood throughout the body. Researchers at the University of Utah Health and Klinikum Coburg, Germany co-led a clinical trial that showed radiofrequency catheter ablation lowered hospitalization and mortality rates by 47 and 44 percent respectively in patients with atrial fibrillation (AF), a contributing factor to heart failure.

"None of the traditional drug therapies are improving the patient's condition, a major medical dilemma when we see these patients in our clinics," said Nassir F. Marrouche, M.D., professor in Internal Medicine and Executive Director of the Comprehensive Arrhythmia Research and Management (CARMA) Center at U of U Health.

The medical community has long debated the ideal treatment for AF, especially for patients who suffer from left ventricular dysfunction, a weakening of the left ventricle that supplies most of the heart's pumping power. Until now, no clinical studies have been conducted that support one definitive treatment.

Marrouche and Johannes Brachmann from the Klinikum Coburg conducted the eight-year CASTLE-AF clinical trial to compare catheter ablation to conventional drug therapies recommended by the American Heart Association and European Heart Society to control the heart's rate.

"The CASTLE-AF clinical trial represents a landmark in the history of cardiovascular medicine because of its potential impact on our patients who are suffering from heart failure," said James Fang, M.D., Chief of Cardiovascular Medicine at the University of Utah Health. "For the first time in a randomized study, the strategy of catheter ablation for atrial fibrillation may be better than the current approach for these patients. It is also one of the many landmark contributions to cardiovascular medicine that the University of Utah has made over the past five decades."

After evaluating more than 3,000 patients from North America, Europe and Australia, researchers selected 363 participants with temporary or persistent AF and heart failure, characterized by heart function at less than 35 percent capacity, for the clinical trial. The patients were separated into two groups, receiving either radiofrequency catheter ablation (179) or a conventional drug therapy (184).

The clinical trial's end point was set at all-cause mortality and worsening of heart failure, resulting in an unplanned overnight hospitalization. Patients in the ablation group experienced lower overall mortality (28%; 51/179) compared to the medication group (46%; 82/184). In addition, catheter ablation resulted in lower cardiovascular mortality (13%; 24/179) compared to the medication group (25%; 46/184).

Special heart cells create electrical signals that cause the heart's upper and lower chambers to beat in the proper sequence to pump blood through the body. Abnormal cells can cause the heart to beat faster or irregularly, resulting in AF.

"Atrial fibrillation prevents the heart from filling and pumping properly," said Marrouche. "When the heart is not synchronized, it hastens heart failure and increases the risk of stroke."

During the ablation process, a catheter is snaked through the patient's body to the site of abnormal heart cells. The doctor delivers a dose of radiofrequency energy, similar to microwaves, to destroy the abnormal cells, which restores the heart's regular rhythm.

All of the participants included in the CASTLE-AF trial had previously received an implantable cardioverter defibrillator (ICD), which allowed for continuous monitoring of heartrate. The ICD may have improved mortality, which Marrouche believes is the primary limitation in this study that may have affected death rates in both groups.

"This clinical trial is the first time we can show with hard data that ablation is saving more lives than arrhythmia medications," said Marrouche. "It also lowers the cost of treating patients by keeping them out of hospital due to lower incidence of worsening heart failure."

The research results were released at the European Society of Cardiology conference in Barcelona, Spain on August 27, 2017 during a session on catheter ablation.

In addition to U of U Health and Klinikum, Germany, collaborating institutions include Kardiologie an den Ev. Elisabeth-Kliniken, Berlin, Germany; Klinik Rotes Kreuz, Frankfurt/Main, Germany; Klinikum Links der Weser, Bremen, Germany; Antonius Ziekenhuis Nieuwegein, Nieuwegein, The Netherlands; The Erasmus University Medical Center, Rotterdam, The Netherlands; Semmelweis Medical Univesity, Budapest, Hungary; State Research Institute of Circulation Pathology, Novosibirsk, Russia; Biotronik SE & Co. KG, Berlin, Germany; Deutsches Herzzentrum Munchen, Munich, Germany; Institute of Medical Statistics and Computational Biology, Cologne, Germany; and KMG Klinikum GmbH, Gustrow, Germany.

This research was supported primarily by Biotronik GmbH.

Story Source:

Materials provided by **University of Utah Health**. *Note: Content may be edited for style and length.*

Cite This Page:

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MEDICALNEWSTODAY

Catheter ablation helps atrial fibrillation patients live longer

By Catharine Paddock PhD | Published Thursday 31 July 2014

A new long-term study suggests that adult patients with atrial fibrillation whose heart rhythm is successfully restored with a minimally invasive procedure called catheter ablation, have a significantly reduced chance of early death from a heart attack or heart failure.

The team, from the University of Michigan (U-M) at Ann Arbor, reports the findings in the journal *Heart Rhythm*.

"The study findings show the benefit of catheter ablation extends beyond improving quality of life for adults with atrial fibrillation," say the researchers.

Atrial fibrillation is an age-related heart rhythm disorder caused by electrical "short-circuits" in the heart that impair its ability to pump blood efficiently and cause fluttering sensations in the chest.

People with atrial fibrillation have a higher risk of stroke and heart attacks, and they also suffer a considerably poorer quality of life.

According to the World Heart Federation, who describe the condition as a "growing and urgent public health concern," atrial fibrillation is the most common sustained abnormal heart rhythm condition worldwide.

In Europe and the US, there are currently estimated to be about 9 million people with atrial fibrillation, and numbers are set to increase.

Catheter ablation led to 60% lower rate of deaths from cardiovascular events

Catheter ablation is a minimally invasive procedure where an electrophysiologist delivers radiofrequency energy to the heart muscle through a specially designed catheter inserted into the left atrium or chamber of the heart.

The intention is to disrupt the short-circuits that are causing the irregular heart rhythm.

The catheter is inserted with a needle into a vein that runs up to the heart from the groin. A three-dimensional mapping system on a computer helps the doctor guide the catheter precisely to the correct location in the heart.

In this latest study, the U-M researchers showed that death from cardiovascular events dropped by 60% among adults who had their normal heart rhythm successfully restored with catheter ablation.

Lead author Dr. Hamid Ghanbari, an electrophysiologist at U-M's Frankel Cardiovascular Center, says:

"The study findings show the benefit of catheter ablation extends beyond improving quality of life for adults with atrial fibrillation. If successful, ablation improves life span."

Even older patients, and those with other conditions benefited

He and his colleagues found that even older patients gained the cardiovascular survival benefits of the procedure, as did those with diabetes or a history of stroke, or who had sleep apnea, or a condition known as low-ejection fraction - an early sign of heart failure where the heart does not pump enough blood.

In an accompanying editorial, that characterizes catheter ablation of atrial fibrillation as "a death-defying endeavor," the authors describe the study results as encouraging for those involved in treating the debilitating heart condition.

For their investigation, Dr. Ghanbari and colleagues examined 10 years of follow-up medical data on over 3,000 adults who had received catheter ablation as a treatment for paroxysmal atrial fibrillation - where the condition comes and goes on its own. Most of the participants, whose average age was 58 when they received the treatment, were men.

The study is thought to be the first and longest to examine the clinical outcomes of catheter ablation.

Meanwhile, *Medical News Today* recently learned how another new study found light may treat atrial fibrillation painlessly. Presenting at a conference in Spain, researchers explained how rather than relying on painful electric shocks, they are studying a new "optogenetic" treatment that uses light to achieve defibrillation in patients with atrial fibrillation.

References

Mortality and cerebrovascular events after radiofrequency catheter ablation of atrial fibrillation, Hamid Ghanbari, et al., *Heart Rhythm*, published online 6 May 2014, DOI: 10.1016/j.hrthm.2014.05.003, Abstract.

University of Michigan news release, accessed 31 July 2014.

Additional information

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Citations

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MLA

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5 Oct. 2017. <https://www.medicalnewstoday.com/articles/280396.php>

APA

Paddock, C. (2014, July 31). "Catheter ablation helps atrial fibrillation patients live longer." *Medical News Today*. Retrieved from https://www.medicalnewstoday.com/articles/280396.php.

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El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Patient Story
Quality Committee of the Board
October 2017

The information below is from an ECH patient who has created a blog about her story. With her permission is her story via the links to her blog part I and part II. Please access the links for her story.

From: Lisa Goldman
Sent: Thursday, August 03, 2017 12:49 PM
To: Charles Lombard
Cc: Shane Dormady
Subject: Blogs about my visit to the ECH Path Lab

Hi Dr. Lombard,

I finally blogged about my visit to your lab. I had so much to say, I had to break it out into two parts (and even then I omitted some things I would have liked to include). I thought you might be interested to see:

(1) http://lisa.ericgoldman.org/lung-cancer-facts/field-trip-to-the-pathology-lab-part-one-of-two

(2) http://lisa.ericgoldman.org/general/pathology-lab-field-trip-a-visit-with-one-of-the-hidden-heroes-part-two-of-two

Thank you again for everything,
Lisa

P.S. Dr. Dormady, I didn't mention you by name, but you do make a cameo in Part One. Thank you also for your part in making this happen!

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan

FY2018 Q1		
JULY 2017	**AUGUST 7, 2017**	**August 28, 2017 (for September's meeting)**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Progress Against FY 2018 Committee Goals (Oct 30, March 5, June 4) ▪ FY18 Pacing Plan ▪ Med Staff Quality Council ▪ Patient Story ▪ Research Article	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 17 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items 1. Committee Recruitment 2. Update on Patient and Family Centered Care 3. FY17 Organizational Goal Achievement Update 4. Review proposed new format for Quarterly Quality and Safety Review 5. BPCI program 6. Appoint Committee Vice Chair	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 17 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda items: 1. Annual Patient Safety Report 2. Pt. Experience (HCAHPS) 3. ED Pt. Satisfaction (Press Ganey) 4. ECH Strategic Framework
FY2018 Q2		
OCTOBER 2, 2017	**OCTOBER 30, 2017 (for November's meeting)**	**DECEMBER 4, 2017**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. FY 17 Organizational Goal Achievement Update 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Culture of Safety Survey Results 6. Committee member recruitment (10/25 – Joint Board and Committee Session)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Peer Review Process Changes Implementation Update 2. Safety Report for the Environment of Care 3. Quarterly Quality and Safety Review 4. CDI Dashboard 5. Core Measures 6. Update on Patient and Family Centered Care 7. Update on Culture of Safety Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Credentialing Process Report 3. Pt. Experience (HCAHPS) 4. ED Pt. Satisfaction (Press Ganey)

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan

<table>
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<tr><th>JANUARY 2018</th><th>FEBRUARY 5, 2018</th><th>MARCH 5, 2018</th></tr>
<tr><td>No Meeting</td><td>Standing Agenda Items:
1. Board Actions
2. Consent Calendar
3. FY18 Quality Dashboard
4. Clinical Program Update
5. Serious Safety/Red Alert Event as needed
6. CMO Report

Special Agenda Items:
1. Update on Patient and Family Centered Care
2. Quarterly Quality and Safety Review
3. Readmission Dashboard
4. PSI-90 Pt. Safety Indicators</td><td>Standing Agenda Items:
1. Board Actions
2. Consent Calendar
3. FY18 Quality Dashboard
4. Clinical Program Update
5. Serious Safety/Red Alert Event as needed
6. CMO Report

Special Agenda Items:
1. iCare Update
2. Proposed FY19 Organizational Goals
3. CDI Dashboard
4. Core Measures
5. Update on Patient and Family Centered Care</td></tr>
<tr><th colspan="3">FY2018 Q4</th></tr>
<tr><th>APRIL 2, 2018</th><th>APRIL 30, 2018
(for May's meeting)</th><th>JUNE 4, 2018</th></tr>
<tr><td>Standing Agenda Items:
1. Board Actions
2. Consent Calendar
3. FY18 Quality Dashboard
4. Clinical Program Update
5. Serious Safety/Red Alert Event as needed
6. CMO Report

Special Agenda Items:
1. Update on Patient and Family Centered Care
2. Proposed FY 19 Committee Goals
3. Proposed FY 19 Committee Meeting Dates
4. Review Committee Charter
5. Proposed FY 19 Organizational Goals
6. Leapfrog Survey Results
7. Value Base Purchasing Report

(4/25 – Joint Board and Committee Session)</td><td>Standing Agenda Items:
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1. Proposed FY 19 Committee Goals
2. Proposed FY 19 Organizational Goals
3. Review Biennial Committee Self-Assessment Results
4. Quarterly Quality and Safety Review
5. Pt. Experience (HCAHPS)
6. ED Pt. Satisfaction (Press Ganey)
7. Update on Patient and Family Centered Care</td><td>Standing Agenda Items:
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Special Agenda Items:
1. Update on Patient Centered Care
2. Approve FY19 Pacing Plan
3. Readmission Dashboard
4. PSI-90 Pt. Safety Indicators
5. Update on Patient and Family Centered Care</td></tr>
</table>

FY18 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is 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, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Quality 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: **William Faber, MD**, Chief Medical Officer

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 may participate in the meetings upon the recommendation of the CMO and at the discretion of the CEO and the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurse, and members from the community advisory councils or the community at-large. The CEO is an ex-officio member of this Committee.

GOALS	TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	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 the Quality, Patient Care and Patient Experience Committee.	• Q1 FY18 – Goals • Q3 FY18 - Metrics	• Review, complete, and provide feedback given to management, the Governance Committee, and the Board. • The Board has approved the FY18 goals and the Committee is monitoring LOS, HCHAPS, GMLOS, and Standardized Infection Ratios.
2. Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the recommendations made through the Greeley peer review process.	• Q2 FY18	• Receive update on implementation of peer review process changes • Review Medical Staff credentialing process
3. Develop a plan to review the new Quality, Patient Care and Patient Experience Committee dashboard and ensure operational improvements are being made to respond to outliers.	• Q1 – Q2 FY18 – Proposal • Q2 FY18 – Implementation • Month Q1 – Q4 FY18	• Receive a proposed format for quarterly Quality and Safety Review; make a recommendation to the Board and implement new format. • FY18 Quality Dashboard is completed and supplemented by 2 additional Quality Metrics reports which are being review at every meeting • Monthly review of FY18 Quality Dashboard
4. Oversee the development of a plan with specific tactics and monitor the HCAHPs scores for Patient and Family Centered Care.	• Q2 FY18	• Review the plan and approve
5. Monitor the impact of interventions to reduce hospital-acquired infections.	• Quarterly	• Review process toward meeting quality

		(infection control) organizational goal • 1st quarter reviewed quality dashboard including standardized infection ratios

SUBMITTED BY:

David Reeder **Chair**, Quality Committee

William Faber, MD **Executive Sponsor**, Quality Committee

Approved by the ECH Board of Directors on June 14, 2017

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

FY-2017 Evaluation of the Environment of Care and Emergency Management Programs

with

Goals for FY-18

Prepared by:

Steve Weirauch
Manager, Environmental, Health & Safety

Created: August 28, 2017

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Executive Summary

The FY-2017 report of the Safety Program for Managing the Environment of Care is to inform the Hospital Board of Directors of the status of the 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.

The safety program indicators showed a decrease in the rate of all work-related injuries compared to previous years. This includes the patient handling and blood borne pathogen injury rates as well as the overall OSHA-recordable work related injury and illness rate. A continued emphasis on training and the use of proper equipment has been credited with this positive trend.

In FY 2017, a new healthcare workplace violence prevention regulation was adopted by Cal-OSHA. The hospital is on track to meet the compliance dates for all elements of this plan.

In FY 2017, there were:

- No citations from the Santa Clara County Environmental Resources Agency
- No waste water violations
- No reportable hazardous materials incidents
- No reported fire incidents.
- One reportable utility incidents
  - 3-hour power outage in Los Gatos
- Four events requiring the activation of the Hospital Incident Command System (HICS)
  - Patient surge at the Mountain View campus
  - Patient surge at the Los Gatos campus
  - Power outage at the Los Gatos campus
  - Potential ransom ware attack at both campuses

Emergency exercises were conducted during the year to test and improve our response capabilities in the event of a real emergency situation. The major exercises for the year were:

- Participation in the Statewide Medical and Health Exercise at both campuses. This was a mass casualty incident that included the activation of HICS and the opening of the Hospital Command Centers (HCC).
- A tabletop evacuation exercise at the Los Gatos campus. This included activation of HICS and the opening of the HCC.
- A functional evacuation exercise of patients from the tower of the Mountain View campus. This exercise focused solely on the procedures and operations for physically evacuating patients from the building. HICS was not activated, nor was the HCC opened for this drill.

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, Emergency Management and Life Safety 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 monthly 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 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 2017. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management (*Interim Work Group Chair: **Tamara Stafford***)

1. 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 Control
- Security Management
- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

2. Performance

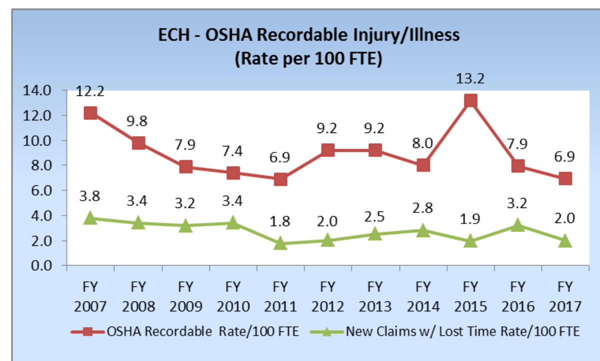
Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-17. 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-17 to 6.9 as compared to 7.9 in FY-16. The total *number* of recordable incidents decreased to 167 compared to 193 in FY-16.

The rate of injuries for lost work days for all open claim (per 100 FTEs) decreased by 40% to 2.0 in FY-17 from 3.2 in FY-16.



Analysis

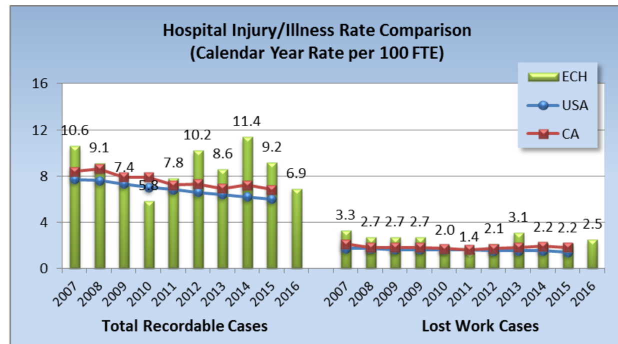
- **Injury Rates:** The two largest injury type contributing to the Cal/OSHA recordable injury and illness rate were strains/sprains (45.28%) and contusions (13.68%).

Improvement Strategies:

Continue the process for early intervention when injuries occur by contacting each injured worker when the Accident/Injury/Exposure Report (AIER) is completed. Encourage the injured employee to be seen in Employee Wellness and Health for an immediate evaluation of the injury and any treatment needed. Minimize late reporting by continuing to educate new hires about safety measures/safety training to take to keep themselves safe at work and to report any injuries immediately to their manager and complete an AIER. Continue to educate managers to contact EWHS when any employee informs them of an injury in order to begin the early intervention process.

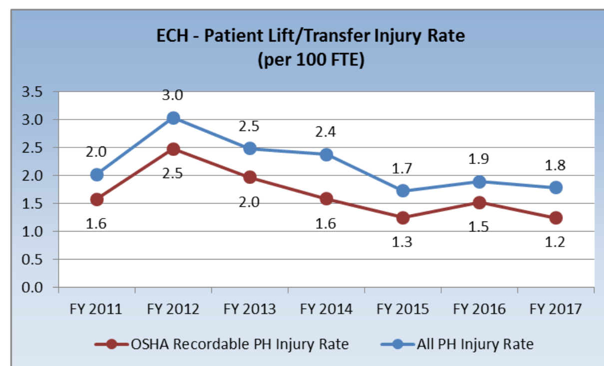
B. OSHA Recordable Injury/Illness Rates as Compared to U.S. & California Hospitals

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



The injury/illness rate for the hospital exceeded the state and national averages in 2015 (the most recent year available from the BLS). However, the hospital actively utilizes a Transitional Work Assignment Program, showing a commitment to getting people back to work as quickly as possible after an injury or illness.

C. Patient Lift/Transfer Injuries



Analysis

- **Injury Rates**: The rate of OSHA recordable patient lift/transfer injuries per 100 FTEs decreased to 1.2 in FY-17 compared with 1.5 in FY-16. The overall rate of patient handling injuries remained decreased from 1.9 in FY-16 to 1.8 in FY-17.
- **Injury Types:** The most common cause of patient handling injuries remain repositioning patients in bed, at 28% of the total. The rate has been consistent at 12 per each of the prior 3 years.

  Similar to prior years, lateral transfers and combined transfers follow, respectively.

  The incidence and rate reduction of vertical transfers (sitting to/from standing), from 25% of the total to 11% (5 total as compared to 12 in 2016 and 9 in 2015) is significant. This may be due to the introduction and robust training of Sara Stedy sit to stand equipment introduced to patient care units, both inpatient and outpatient. Also, older model Sara lifts were removed from inventory and new Sara Plus mechanical lifts were added.

  Injuries resulting from Cumulative Patient Handling rose to 11% of the total, as compared to 2 and 3% the prior 2 years.

  Patient fall prevention continues to be a source of injuries, at almost 10% of the total.

	2015	2016	2017
Repositioning Patients in Bed	32%	25%	28%
Lateral Transfers (assisted patient between bed and gurney)	16%	13%	19%
Combined Transfers (assist patients between lying and sitting	14%	17%	14%
Vertical Transfers (assist patient between sitting and standing)	24%	25%	11%

- **Injuries by Department**: Last fiscal year, Inpatient Rehab had the highest incidence of SPH injuries reported, at 8. This year, focused education and new equipment resulted in fewer than ever: 1 injury report. Rehab Services maintained their improvement with 1 reported.

The Mountain View departments Medical (2C) and Telemetry (3B) are trending up, each with 16% (n = 7 each); and ED and Patient Care Resources with 12% (n = 5 each.)

- **Injuries by Job Class:** Registered Nurses and Unit Support personnel (CNAs) once again incurred 90% of the total safe patient handling injuries, with RNs suffering double the rate: 60% as compared to 30% for CNA's.

Improvement strategies:

- **Education:** The Education Department has successfully rolled out quarterly training to include lift equipment by vendor and lift type and will continue this model. As compared to annual training, quarterly education promotes a consistent emphasis on safe patient handling and advocacy of equipment use.

  Educators report to the Clinical Education Department, rather than individual units, which has promoted consistency in training.

  Focus for prevention strategies in 2018 is patient repositioning and lateral transfers, with an emphasis on use of friction reducing devices such as Z Sliders; clinical techniques for reducing manual handling, such as application of trapeze bars; and increased education and promotion of use of repositioning slings with the overhead lifts in Mountain View. Los Gatos is not equipped with overhead lifts; therefore, they are not an option there.

  Focused education for CNAs is planned for Quarter 1, to include an emphasis on safe patient handling.

  Los Gatos prioritized safe patient handling at their Professional Development Days in quarter 4.

- **PMAT:** The Education Department partnered with the USF Clinical Nurse Leader program to develop, trial, and ultimately introduced the El Camino Hospital **P**atient **M**obility **A**ssessment **T**ool in quarter 3. It is designed to identify and promote appropriate equipment use and concomitantly reduce employee injury related to all transfers and cumulative patient handling and patient falls. It is not mandatory in Epic; consistency is lacking. An analysis has been initiated with plan of action to follow.

- **Equipment:** Hover mats have gained immense popularity and use. As a result of use, ECH qualified for 6 additional pumps at no charge, distributed to inpatient and outpatient areas in need. Unfortunately, a few injuries occurred this year as a result of faulty use or gurney mishap with a Hover mat. Additional HoverTech training is added to the schedule.

  Sling management, labeling and storage continues to be a work in progress.

  Additional sling offerings with the overhead lifts (limb holders) are under consideration for trial.

- **Bariatrics:** Gap analysis revealed need for a mechanical sit to stand device for the bariatric population in MV. Frequency and lack of storage space does not warrant purchase at this time in LG, since rental is an option. The MV campus has had a demonstration and Rehab staff trialed one option under consideration.

- **Department Specific:** Telemetry developed mandatory safe patient handling curriculum for classes held in quarter 4 to target increased injury incidence. ED will be targeted in the fall.

- **Accident Investigations**: Prompt accident investigation by managers improved, with 67% documented within 4 days. This is up from 38% and 43%, respectively, since adding HR Business Partners to the electronic distribution list.

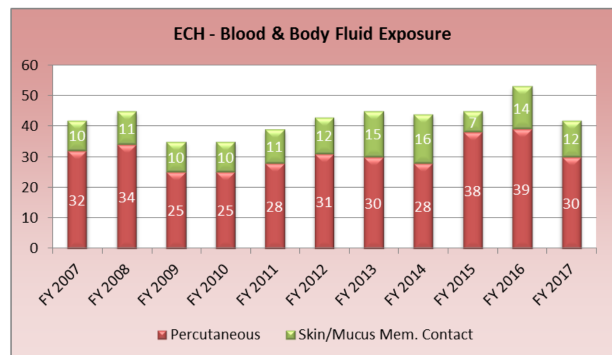
D. Bloodborne Pathogen Exposures

The rate of Blood borne pathogen exposures per 100 FTE decreased significantly to 1.7 in FY-17 compared to 2.2 in FY-16. The total number of exposures for both campuses decreased to 42 exposures in FY-176 compared to 54 in FY-16. Of these, 30 were percutaneous exposures and 12 were body fluid exposures due to splashes. This is the lowest reported rate in seven years.

There have been no significant trends noted involving particular devices.

Analysis:

- 52% of both sharps, contact, and mucous membrane exposures were the result of end user practice failures:
  - Failure to engage safety devices immediately after use (recapping)
  - Not wearing personal protective equipment (PPE) when indicated, particularly face and eye protection, when in areas/units where splashes should be expected.
  - Rushing when handling sharps



- 32% of exposures were caused by agitated or involuntary movement of patients (unsafe action by others).

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO
- Continue in-services for new products or when there is continued/repeated misuse or misunderstanding of a product
- 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
- Explore the possibility of establishing a Needle-stick Prevention Committee as it is estimated that 80% of all exposures from sharps and needle-sticks are preventable.

E. TB Conversions

There were no known occupational exposure conversions at either campus during FY-17

F. 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: 96.8% (Target: 95%)
- Life Safety - Clinical: 96.6% (Target: 95%)

G. 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 five most noted problems in FY-17 involved:

- Damaged or stained ceiling tiles
- 18" vertical clearance to fire sprinkler heads
- Damaged walls
- Improper storage of clean linen
- Inadequate clearance around fire extinguishers

H. 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	OR, PACU, L&D	
○ **Nitrous Oxide**		Below Cal OSHA PEL
○ **Sevoflurane**		Below NIOSH REL[1]
Formaldehyde	Cytology, Histology	Below Cal OSHA PEL
Lead/Cadmium	Radiation Oncology (MV)	Wipe Samples in all areas except the lid of the molding pot, the counter beneath molding pot dispenser and the surface of the molding board were below the recommended surface contamination levels [2]
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

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

[2] 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 2.0 - Security Management *(Interim Work Group Chair: **JoAnn Cartoni-Cry**)*

1. 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 Security Workgroup 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
- Fire Drills
- Missing Property
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism

2. Workplace Violence Prevention Plan

Workplace violence 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. The regulation took effect on April 1, 2017. Major elements of the new law are listed in the table below.

Elements of Regulation	Compliance Deadline	Status
Written Plan: Develop / implement a Workplace Violence Prevention Plan (WVPP). To include an annual review and update of plan	April 1, 2018	Written plan being developed. Requires annual review/update.
Training: Provide training to all staff as required	April 1, 2018	Training being developed
Response: Investigate violent incidents	April 1, 2017	Already in place
Reporting: Report incidents of physical violence against staff to Cal/OSHA	July 1, 2017	Implemented, July 1, 2017
Documentation: All incidents and training	April 1, 2017	Already in place

A task force has been created to oversee the implementation of Workplace Violence Prevention Plan for El Camino Hospital. The elements being addressed are listed below:

2. ***Written Plan*** – The El Camino Hospital WVPP is being drafted and revised.
3. ***Training*** – The law specifies training requirements for staff based on their roles in the hospital. A combination of online training and classroom instruction is being developed.

Group / Role	Included Staff
Anyone doing hospital business at the facility	○ Employees ○ Contractors ○ Physicians ○ Travelers ○ Volunteers
Employees having patient contact	○ Clinical Staff
Employees that respond to violent incidents (Code Gray Team) Employees whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior	○ Emergency Department ○ Behavioral Health ○ Hospital Supervisors ○ Security Officers ○ Facilities Engineers

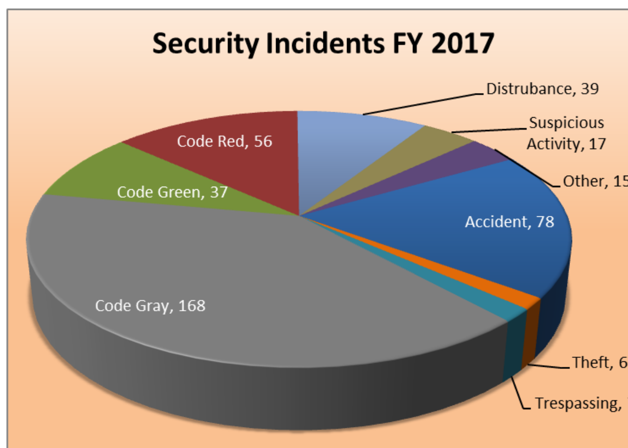
4. ***Reporting*** – Cal-OSHA requires that all incidents of physical violence against staff be reported within 72 hours. If the violence results in hospitalization (other than minor first aid) or a fatality, reporting must be completed with 24 hours. Verb al threats are not reportable to Cal-OSHA, however these are tracked internally.

   Procedures have been created to ensure all reportable incidents are sent to Cal-OSHA as required. A core team is in place to review all incidents to ensure reporting is completed within the time limits.

   Note: The reporting does not include any personal or protected information about patients or staff.

3. 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-17. The data includes activity from both campuses.



There were a total of 423 reported security incidents for FY-17 requiring immediate response. This is a decrease from FY-16 total of 453.

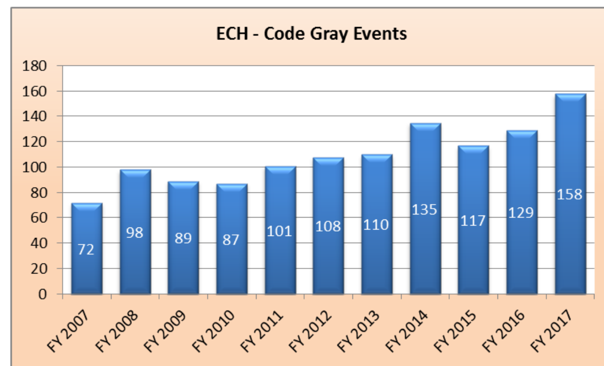
Review of the major FY-17 incidents showed that most incident categories including accidents, disturbances had no discernible trends or patterns.

- Code Gray, Code Red, Code Green, and Accidents accounted for 339 (80%) of the total.
- Code Silver (weapon or hostage situation) increased from 0 in FY-16 to 4 in FY-17. None of the incidents involved a firearm.
- FY-17 did see a decrease in reported thefts, trespassing and suspicious activity.

A. Code Gray Responses

Code Gray responses have remained steady. The total number of incidents in FY-17 was 168 compared to 116 in FY-16.

Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED, Behavioral Health and Medical Units. Responses are tracked 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 deal with angry or agitated persons. NCI training is required for all Behavioral Health staff, ED staff, security officers, facilities engineers and clinical managers. Staff in other departments are also encouraged to attend the training.

B. Bulletins, Alerts & Presentations

Security Services issued 10 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 3,910 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Stand-Bys & Restraints

Security Officers performed 1,649 patient watches, standbys and restraints. 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 111 fire drills and are 100% up-to-date. 20 fire watches were performed.

F. General Assistance

Security Officers performed 93,625 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 2,353 'Dual-sided' Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 1,848 temp badges were issued.

H. Investigations & Audits

Security Services performed 23 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. Inspections

Security Services performed a total of 15,302 (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.

J. 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.

K. Lost And Found

Security Officers performed 847 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

L. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 161 vehicle-related services including jump-starts, door unlocks and tows. 348 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 94 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.

N. Statistics – Mountain View Police Department Crime Data (Source: 2016 MVPD Annual Report)

City of Mountain View

Square Miles: 12
Population:........................77,846 (County of Santa Clara 1,919,402)
Personnel: ....Total 145 (90 Sworn vs. 55 Non-Sworn)
Beat No.1: ....6,982 number of dispatched calls, includes El Camino Hospital

Statistics *UCR data includes attempts and actual crimes*

Part I UCR: ....Total 1914 (1781 Property vs. 133 Violent)
Previous Year ....Total 1770 (1614 Property vs. 156 Violent)

Part II UCR: ....Total 2716
Previous Year ....Total 2599

Arrests-Misdemeanor: ......Total 1473 (1376 Adult vs. 97 Juvenile)
Previous Year ....Total 1598 (1397 Adult vs. 201 Juvenile)

Arrests-Felony: ....Total 306 (284 Adult vs. 22 Juvenile)
Previous Year ....Total 664 (610 Adult vs. 54 Juvenile)

Traffic Collisions: ....Total 498
Previous Year ....Total 235

Moving Violations: ....Total 2853
Previous Year ....Total 5990

Non-Moving Violations: Total 3232
Previous Year ....Total 3992

Indexes *Per 1,000 current year population*

Violent: 1.69
Previous Year 2.02
Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery

Property: 22.79
Previous Year 23.93
Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson
Note: Los Gatos Police Department data and crime statistics not available.

4. Effectiveness

Key indicators were identified to establish goals for FY-17 with opportunities to improve Security Management within the Environment of Care.

FY 17 Goals

1) > 90% non-medical emergency security response time less than 3 minutes
   This goal was accomplished.
2) Create at minimum 4 Security Awareness Pamphlets/Alert Bulletins
   This goal was accomplished.

FY18 Goals

1) 90% non-medical emergency security response time less than 3 minutes
2) Create at minimum 4 Security Awareness Pamphlets/Alert Bulletins

EC 3.0 - Hazardous Materials & Waste Management *(Work Group Chair: **Lorna Koep**)*

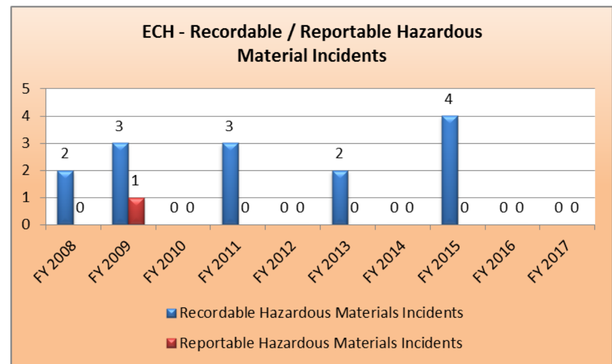
1. Scope

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.

2. Performance

A. Hazardous Material Incidents

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



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

B. Waste Water Discharge Violations – No waste water discharge violations in FY-17.

C. Monitoring and Inspecting

- Hazardous Waste Inspections
  - Mountain View: September 9, 2016
  - Los Gatos: January 18, 2017

  Both Inspections had several findings related to reporting and documentation. All items were corrected and approved by Department of Toxic Substances Control (DTSC).

  One finding in Mountain View noted that, due to increased volumes in the histology lab, the hospital is now considered a large quantity generator of hazardous waste. As such, we are required to submit a Source Reduction Report (SB14). A consultant was brought in to complete this report.

- Santa Clara County Annual Medical Waste Inspections
  - Los Gatos: has not yet been scheduled by the county.
  - Mountain View: November 29, 2016.
    - Three minor issues identified. All were corrected and accepted on the date of the inspection
      1) Found one peeling, faded sticker – replaced immediately.
      2) Overfilled secondary container in OR staging area – corrected immediately.
      3) Recommended placing absorbent pads in Pharmaceutical waste containers to prevent free liquids in the containers of high volume areas identified for wasting medications. Partnering with Stericycle and Talent Development to provide education on the process of wasting controlled substances.

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[3] 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.

- 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.

3. Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group.

Key indicators were targeted to establish goals for FY-17. The following goals presented opportunities to improve hazardous materials & waste management.

FY-17 Goals:

1) Expand composting program (Phase 2) to include cafeteria waste and restroom paper towels.

   This goal was partially accomplished. Composting containers continue to be used in the kitchen areas. The Mountain View campus expanded the composting program to include all public restrooms in the Old Main building. The measurement of success for this goal was an increase in the number of composting totes collected.
   - Los Gatos (96-gallon totes): increased 25%
   - Mountain View (64-gallon totes): increased 33%

   Efforts are continuing with training, optimization and exploring new opportunities to reduce overall waste. Plans are in place to expand composting to the public restrooms in Los Gatos and Oak Pavilion.

2) Develop a safe transportation process for Histology chemicals and wastes through the hospital. Evaluate the equipment used, process, pathways and secondary containment.

   This goal was partially accomplished. Facilities Engineering fabricated a stainless steel cart, but the weight and maneuverability of the cart did not meet the needs of the Histology staff. Continued investigation eventually located a suitable alternative that will be ordered during the first quarter of FY-18.

FY-18 Goals:

1) Reduction of hazardous chemical waste generated by Histology with the installation of new equipment. This will significantly reduce the volume of Xylene and Alcohol used. It is estimated the new equipment will come on line in Q3, FY-18.
   - Measurement of success: Comparison of the waste quantities generated in in the last half of FY-18 compared to the same period in FY-17.

2) Review and revise the hospital Hazardous Waste Guide with an emphasis on the RCRA List reflecting knowledge gained from Hazardous Waste inspections.
   - Measurement of Success:
     - Completion and distribution of new guides
     - Training for all required staff

EC 4.0 - Fire Safety Management *(Work Group Chair: **Pat DuBridge**)*

1. 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.

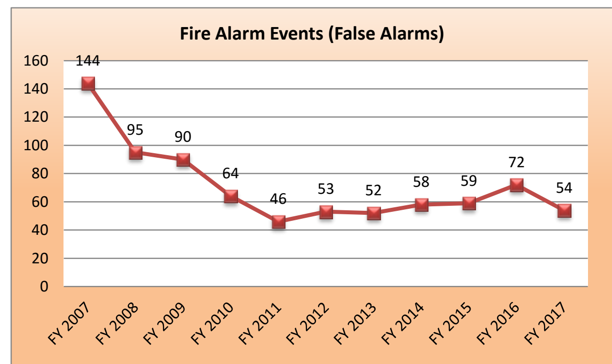
2. Performance

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-17.

- **Fire Incidents**
  There were no reported fire incidents in FY-17.

- **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 number of events in FY-17 (54) represents a decrease of 25% form FY-16 (72) and is the lowest since FY-13. This was accomplished despite heavy construction activity during FY-17.



- Fire Drills Completed / Scheduled

  103% of fire drills, a total of 110, were completed in FY-17. For all drills, there were 22 required actions by staff. 21/22 issues were fully corrected and the pending item is under review.

3. Effectiveness

Key indicators were targeted to establish goals for FY-17. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 17 Goals

1) In preparation for the construction projects on the Mt. View campus, Interim Life Safety Measure (ILSM) rounds will be conducted at least weekly. Issues identified during the rounds will be reported to the appropriate project manager to assure prompt correction. Unresolved issues will be reported to Central Safety Committee.

   This goal was accomplished. The process for ILSM rounds is working well. ILSM's are being performed and items are being tracked in the TMS database.

2) Maintain the FY-16 rate of fire alarm events (72) during FY-17. The number of major demolition and construction projects occurring in Mountain View makes this a challenge. However, combined with the regular ILSM rounds and follow up we are striving to maintain this current level of fire alarm events.

This goal was accomplished. Despite challenges presented by the volume of construction at both facilities, we had no actual fire events and significantly lowered our fire alarm events. We will continue work closely with the construction Teams in FY-18 to minimize fire risk as well as disruptions due to false alarms.

FY 18 Goals (Preliminary)

1) With continued construction projects at both campuses, Interim Life Safety Measure (ILSM) rounds will be conducted at least weekly. Issues identified during the rounds will be reported to the appropriate project manager to assure prompt correction. Unresolved issues will be reported to Central Safety Committee. This is a continuation of the FY-17 goal.
2) Continue efforts from FY-17 in reducing the number of fire alarm events during FY-18.

EC 5.0 - Medical Equipment Management *(Work Group Chair: **Lisa De La Rosa**)*

1. 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.

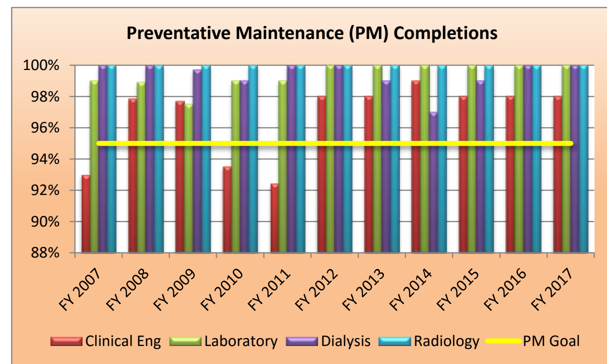
2. Performance

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-17.

- Reports to the FDA - There were nine reports through the Medwatch[4] system in FY-17. There were no patient deaths associated with any of the reports. The reports included:
  1) User error in using incorrect port on pacemaker device. Reported as potential device design failure. Harm to patient.
  2) Surgical stapler used in robotic lap surgery malfunctioned during surgery.
  3) Morcellator did not work, shocked user.
  4) Biopsy needle broke inside patient. Harm to patient as required operation to remove.
  5) Vacuum breast biopsy equipment failures.
  6) Contaminated Hanks solution

- Preventative Maintenance (PM) Completion Rate Percentage.

  The PM completion rate exceeded the target of 95% in all areas.
  - The completion rate for Clinical Engineering achieved 98% overall for FY-17.
  - All high risk, life safety equipment was maintained at 100% completion rates



- Product Recalls Percentage Closed / Received.

  For FY-17, there were 128 recorded product recalls; 112 have been closed. The 16 pending items require finalizing the paperwork.

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

3. Effectiveness

Key indicators were targeted to established goals for FY-17. The following goals presented a number of opportunities to improve Medical Equipment Management within the Environment of Care.

FY 17 Goals

1. Ensure Medical Equipment is being secured from vulnerability threats.

   This goal was accomplished. Clinical Engineering is meeting on a weekly basis with Information Security and using Nexpose to run vulnerability scans on all networked medical devise. For non-networked equipment, communication has been sent out to each manager to ensure proper handling of PHI on medical equipment.

2. Establish a process in procuring new equipment to ensure if networked connected it has proper processes in place.

   This goal was accomplished. Clinical Engineering worked in collaboration with Information Security in developing Procedures as part of the HITRUST. Each procedure details the steps necessary to be able to establish network connection to medical equipment.

FY 18 Goals

1. Ensure all medical equipment is segregated from other networked devices for system security.
2. Implement a process and timeline to upgrade all Windows XP systems to Windows 7 compatibility.

EC 6.0 - Utilities Management *(Work Group Chair: **John Folk**)*

1. 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.

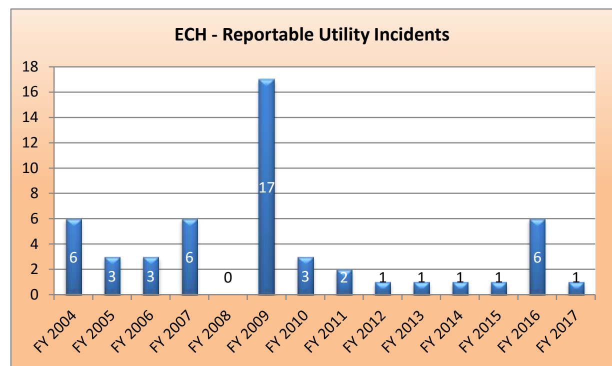
2. Performance

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-17.

- **Utility Reportable Incidents**

  There was 1 reportable incident in FY-17.

  - 4/6/17: Extended PG&E outage at Los Gatos due to severe weather. All systems functioned as designed.



- **PM Completion Rate % completed/ scheduled**

  The Utility Systems PM completion rate was 90%, which did not meet our goal of 95%. Critical systems were maintained as required for the facility operations.

- **Generator Test % completed/scheduled**

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

- **Egress Battery Light Testing % completed/scheduled**

  The percentage of the monthly and annual tests completed was 100%.

3. Effectiveness

Key indicators were targeted to establish goals for FY-17. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 17 Goals

1) Continue to refine an Enterprise wide tool for ensuring TJC compliance for significant Utilities Work Group related Elements of Performance (EP's).
2) Ensure Preventative Maintenance completion rates to achieve annual goal of 95%.
3) *Through pre-planning and collaboration with contractors minimize the risk of unplanned system outages related to construction activities.*

In summary, much work was done between the Development Team and the Engineering Team to formalize and control Utility shutdowns necessary for Construction activities. This has resulted in better planning that has minimized disruptions caused by this type of work. Tracking mechanisms for TJC items have become more robust and continue to be refined. Both of these areas will receive continued focus in FY-18 due to their criticality and the level of Construction activities.

Also, in FY-17, we completed on-going major overhauls to the Los Gatos electrical distribution systems and emergency power plants, which have had significant positive impact on our confidence in these older systems.

EM - Emergency Management *(Work Group Chair: **Steve Weirauch**)*

1. Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal emergencies and mass casualty external emergencies. The Emergency Management Work Group ensures an effective response to disaster or emergencies affecting the Environment of Care. 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 it continues to report to the Central Safety Committee.

2. Performance

Performance indicators for the Emergency Management program are reported monthly to the Central Safety Committee in the Safety Trends Report. The following Emergency Management indicators were reported in FY-17.

A. Events / Emergencies

There were four recorded events and/or emergencies during FY-17 requiring activation of the Hospital Incident Command System (HICS).

1. **Patient Surge – Mountain View (01/11 – 01/13/2017)** – A sustained surge in patients requiring care necessitated the activation of the Hospital Incident Command System (HICS) and the opening of the Hospital Command Center (HCC) in Mountain View. A coordinated effort by the staff and use of the surge plans developed for Super Bowl 50 enabled the hospital to continue operations and meet the needs of our patients. The HCC was operational during day-shift hours for 4 days.
2. **Patient Surge – Los Gatos (01/23/2017)** – A surge in patients and staff shortage due to sick calls necessitated the opening of the HCC in Los Gatos. Staff were able to draw on plans and adapt to continue operations and provide care to patients. The HCC was operational for approximately 6 hours.
3. **Power Outage – Los Gatos (04/06/2017)** – A power outage at the Los Gatos campus occurred on April 6th. Several issues were identified including the loss of all communications and failure of the electronic door access to the O.R. Corrective actions were already part of planned upgrades to the facility.
4. **WannaCry Ransom ware (05/13 – 05/15/2017)** – The threat of a ransom ware attack initiated a pre-emptive response from the IS department. The command center was activated on Saturday and continued through Monday, May 15th. The IS department patched and update all computers preventing a potentially crippling attack to the network.

B. 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-17, this requirement was met through the Statewide Medical & Health Exercise in November, 2016 (see below) and the actual HCC activations due to real patient surges in January, 2017. We conducted a second exercise at each campus; however we were able to focus each drill to the needs of the campus. These are also summarized below.

  a. **Statewide Medical & Health Exercise (November 17, 2016):** Both campuses participated in the statewide exercise. The scenario involved a mass casualty incident

involving a train derailment and school buses filled with children. The treatment of pediatric patients and a potential hazardous material contamination provided challenges to both campuses.

b. **Los Gatos (May 24, 2017):** A tabletop exercise was conducted in the Hospital Command Center involving the full evacuation of the hospital. The HICS team discussed procedures for evacuating patients from the building, setting up alternate care locations and treatment areas for patients until they can be transferred to other facilities and how to ensure staff are trained on these procedures.

c. **Mountain View (May 31, 2017):** The exercise involved evacuation of a medical floor (3C-West) utilizing existing procedures and equipment. A number of "patients" and "visitors" with varying medical issues were evacuated out of the building. The HCC was not opened. Instead, the focus was on the procedures for evacuating patients. In addition to existing equipment, participants also trialed a new evacuation device (Med Sled) that is being considered for replacing the existing equipment.

   Several issues were noted in the exercise, including locating and using the existing equipment and the intense manual lifting required when using the existing evacuation litters and chairs. Corrective actions were also recommended for communications and patient transfer after they leave the building.

- **Tabletop Exercises:** There is a continuous need for staff training on responding to emergency codes. Because of the wide variety of work environments and to reach the largest number of staff we continued with the series of tabletop exercises (TTX) based on each of our emergency codes. This series was begun in FY2015. They are designed to be conducted by the Safety Coordinator and/or manager of each department in a manner that best meets the unit's needs.

  An exercise "kit" is distributed to the Safety Coordinators with the request to complete the exercise during the quarter. The scenarios tested during the past year are Code Purple (missing or abducted child – age 1-17) and Code Red (fire) and Code Silver (Weapon or Hostage).

  Note that while good learning and practice opportunities, tabletop exercises do not meet the Joint Commission standards for exercises so these are above and beyond the requirements.

C. 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.
- Six decontamination training exercises were conducted for Mountain View. This included online training for new member and refresher training for all participants.

D. 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 co-chair of the education committee for SCC-EPCH and has participated in several conferences sharing the experiences and benefits of developing regional coalitions.

E. Hazard Vulnerability Assessment (HVA)

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 minor changes to the HVAs at both campuses in FY-17. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Epidemic	(2) Electrical Power Failure
(3) Weapon	(3) Chemical Exposure, External
(4) Evacuation	(4) Dam Failure
(5) Mass Casualty Incident - Medical/Infectious	(5) Mass Casualty Incident – Trauma

3. Effectiveness

Key indicators were targeted to establish goals for FY-17. The following goals presented opportunities to improve emergency management.

FY 17 Goals

1) Develop and implement a hospital Workplace Violence Protection Plan. This will be a joint goal with the Security Management Work Group. Measurable objectives:

   This goal was not accomplished. *Cal-OSHA delayed adoption of the healthcare workplace violence prevention regulations until April, 2017. As such, the requirements and guidance for the plan was not known until late in FY-17. This goal will be carried over to FY-18.*

2) Develop a program to allow non-clinical staff to participate in disaster training (decontamination) at both campuses. Measurable objective. This goal is carried over from FY-16.

   This goal was accomplished. The recruitment and training of additional staff to be part of the decon team has been adapted to allow non-clinical staff to participate without impacting their department's budget. The cost associated with non-clinical staff attendance will be covered by the Safety Cost Center.

FY 18 Goals

1) Develop and implement a hospital Workplace Violence Protection Plan. This will be a joint goal with the Security Management Work Group. Measurable objectives:
2) Replace Breathe-Easy PAPRs used for Decontamination training with Versaflo units.
3) Begin phase-in of new Med Sleds for evacuations

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.]

*** 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 12	FY 13	FY 14	FY 15	FY 16	FY 17
E.C. 1.0 - SAFETY MANAGEMENT							
Employee Safety							
1.	Total Injury/Illness Incident Reports	331	349	458	618	428	470
2.	OSHA Recordable Injury/Illness (Total)	137	173	171	306	193	164
	a. Lost Time	34	59	61	38	78	45
	b. No Lost Time	103	114	110	268	113	119
3.	Repetitive Motion Injury- Computer, keyboard, Mouse, Light Pen	10	12	14	5	19	17
4.	Repetitive Motion Injury (RMI) - Non-Computer	13	7	2	19	9	14
5.	Patient Lift/Transfer Injuries (OSHA Recordable)	44	33	36	27	37	28
6.	Patient Lift/Transfer Injuries	N/A	42	54	37	48	43
7.	Trip/Slip/Fall	48	43	50	41	58	67
8.	Staff Assaults by Patients	N/A	N/A	25	17	15	28
Infection Control							
1.	Blood & Body Fluid Exp.	41	45	44	45	53	42
	a. Percutaneous	27	30	28	38	39	30
	b. Skin/Mucus Membrane Contact	14	15	16	7	14	12
2.	TB Conversions (mo.)/qtr. %	0	0	0	0	0	0
Safety Rounds Scoring							
1.	Critical Area Score (# Compliant/total number)	N/A	N/A	N/A	N/A	96%	99%
E.C. 2.0 - SECURITY MANAGEMENT							
1.	Code Grey Incidents	108	110	135	117	129	167
2.	Other Security Incidents	153	127	158	178	324	270
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT							
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	0	2	0	4	0	0
3.	Waste Water Discharge Violations	0	0	0	0	0	0
4.	Eyewash Inspections	N/A	N/A	N/A	N/A	100%	100%
5.	Eyewash Corrective Actions comp/assigned	N/A	N/A	N/A	N/A	86%	85%
E.C. 4.0 FIRE PREVENTION MANAGEMENT							
1.	Fire Incidents -Actual	0	1	1	0	2	0
2.	Fire Alarm Events	53	52	58	59	72	54
3.	Fire Watches (New in FY-14)	N/A	N/A	4	2	8	21
4.	Fire Drills comp/scheduled	100%	100%	97%	100%	100%	103%
5.	Interim Life Safety Measures (ILSM) Tracking	N/A	N/A	94%	100%	100%	100%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT							
1.	Reports to FDA	2	11	2	6	3	6
2.	PM Completion Rate %						
	a. ECH (Clinical Engineering/Bio Med)	98%	98%	98%	98%	98%	98%
	b. Laboratory	100%	100%	100%	100%	100%	100%
	c. Dialysis	100%	99%	99%	99%	100%	100%
	d. Radiology	100%	100%	100%	100%	100%	100%
3.	Product Recalls % (Closed/rec'd)	N/A	95%	98%	88%	78%	95%
E.C. 6.0 - UTILITIES MANAGEMENT							
1.	Utility Reportable Incidents	1	0	1	1	6	1
2.	PM Completion Rate % completed/scheduled	97%	84%	92.7%	90.9%	97%	90%
3.	Generator test % completed/scheduled	100%	100%	100%	100%	100	100
4.	Egress Lighting monthly test % completed	100%	100%	100%	100%	N/A	100%
E.M. EMERGENCY MANAGEMENT							
1.	Drills, Internal & External	22	56	14	75	35	42
2.	Natural Disaster/Actual Event	2	2	0	2	4	4

Attachment 2b - Safety Trends Definitions

E.C. 1.0 SAFETY MANAGEMENT	
Employee Safety	
1. Total Injury/Illness Incident Reports	Total number of injuries/illnesses reported on Accident, Incident and Exposure Report (AIER) and followed up by Employee Wellness & Health Services. Includes first aid cases that do not meet the criteria as OSHA Recordable.
2. OSHA Recordable Injury / Illness (Total)	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. Repetitive Motion Injury - Computer Keyboard, Mouse	Number of OSHA recordable cases related to use of computer keyboards/mouse use if that use is at least 3 hours of the total workday. Does not include injury/illness as a result of acute injuries or non-keyboard/mouse activities.
4. Repetitive Motion Injury – Non-Computer	OSHA recordable RMI associated with work activities such as using syringes, washing scopes, pushing/pulling equipment, not as result of a specific incident.
5. Patient Handling Injuries (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.
6. All Patient Handling Injuries	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.
7. 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)
8. Staff Assaults by Patients	Number of staff assaulted by patients – includes hitting, kicking, biting, thrown objects.
Infection Control	
1. 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.
2. 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.
Safety Rounds Scoring	
1. Critical Area Score (# Compliant/total number)	Scoring of 25 critical areas, as defined during Joint Commission Inspection. Percentage of items in compliance for all areas inspected.
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 Incidents	Number of security incidents includes reported motor vehicle accidents, patient/visitor disturbance, patient elopement, suspicious person, theft, vandalism and participation in emergency codes (other than Code Gray which is reported separately).

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. Eyewash Inspections	Number of eyewash inspection completed/number scheduled.
5. Eyewash Corrective Actions Completed/Assigned	Number of corrective actions identified in eyewash inspection completed/total number of corrective actions assigned.
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 Watches	Number of fire watches initiated during the period. A fire watch is a temporary measure to ensure the continuous surveillance of a building or portion thereof for the purpose of identifying and controlling fire hazards, detecting early signs of fire, and raising an alarm of fire. Fire watches are implemented anytime the fire alarm system is disabled or out of service in an area.
4. Fire Drills Completed/Scheduled	Number of fire drills completed/number scheduled.
5. Fire Drill Corrective Actions (comp/assigned)	Percentage of action items assigned during fire drills that were completed during the month.
6. Interim Life Safety Measures (ILSM) Tracking (Q)	The percentage of ILSM's implemented that noted problems. (# of problems/total #ILSMs). ILSMs are health and safety measures put in place to protect the safety of patients, visitors, and staff during construction or maintenance activities that have an impact on the life safety systems in the hospital. Reported quarterly.
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 with 10% of the prescribed interval/items scheduled for maintenance. Reported quarterly.
a. Biomed	
b. Lab	
c. Radiology	
d. Dialysis	
3. Product Recalls % Closed	The percent of product recalls closed/completed compared to those received.
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. Generator Testing % Completed	Number of completed generator tests/number of scheduled generator tests. Reported quarterly.
4. Egress Lighting monthly test % completed/scheduled (Annual test in **BOLD** text)	Number of completed battery-powered egress lighting tests/number of scheduled tests. Testing required at Rose Garden & Evergreen Dialysis clinics. Reported monthly. Annual testing to be completed in November of each year.
E.M EMERGENCY MANAGEMENT	
1. Exercises, Internal and External	Planned internal/external emergency preparedness exercises completed. (Per The Joint Commission: 2 exercises implementing the hospital disaster plan; DHS Title 22: 1 drill per shift per quarter).
2. Natural Disaster/Actual Event	An internal or external emergency event that requires the activation of HICS.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality, Patient Care, and Patient Experience Committee Meeting Date: October 30, 2017
	Responsible party:	Cindy Murphy, Director of Governance Services
	Action requested:	For Information
	Background: IN FY16 we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. This written report is intended to supplement the Chair's verbal report.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : To inform the Committee about recent Board actions	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: None. This is an informational item	
	LIST OF ATTACHMENTS: Report on ECH and ECHD October 2017 Board Actions	

October 2017 ECH Board Actions*

October 11, 2017

a. Recognized the Cancer Center at El Camino Hospital for 10 years of providing high quality care.
b. Approved the FY18 Period 1 and Period 2 Financials.
c. Voted to recommend that the District Board adopt the Governance Committee's Proposals to Revise the ECH Board Member Election and Re-Election Process and the ECH Board Member Position Specification , retaining the same high priority competencies identified in FY17.
d. Approved the FY17 Compliance Summary Report and Semi-Annual Physician Expense Report,
e. Approved the FY17 Individual Executive Goal Scores and Incentive Plan Payments
f. Approved the HR Leave of Absence Policy
g. Approved the Annual Financial, 403(b), and Participant Cash Balance Plan Audits
h. Approved the Level II NICU Call Panel Agreement
i. Approved the Medical Staff Development Pan and Recruitment Budget not to exceed $5.9 million

October 2017 ECHD Board Actions*

October 17, 2017

a. Approved the FY17 Year End Consolidated and Stand-Alone Financials
b. Approved the FY 17 Financial Audit
c. Approved the Revised Budget for Major El Camino Hospital Capital Budgets: Behavioral Health Services Building (additional $4.6 Million) and Integrated Medical Office Building (additional $27.1 million).
d. Approved the Revised ECH Board Member Election and Re-Election Process and the ECH Board Member Position Specification , retaining the same high priority competencies identified in FY17.
e. Re-Elected El Camino Hospital Board Director Lanhee Chen to the El Camino Hospital Board of Directors for a second term of three years effective July 1, 2018.
f. Approved the FY17 Community Benefit Plan Report.

*This list 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.

Quality, Patient Care & Patient Experience:

El Camino Hospital Cardiac Electrophysiology Program

Shaun Cho, MD, FACC, FHRS

October 30, 2017

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The Disease: Abnormal Heart Rhythm

Tom Petty Died of Sudden Cardiac Arrest at Age 66 — What You Need to Know About the Heart Malfunction

People Magazine 3 days ago

Tom Petty died Monday at age 66 in Los Angeles after entering **cardiac arrest**. "He suffered **cardia**

Harbaugh has heart procedure

49ERS Harbaugh's irregular heartbeat prompts procedure at Stanford

By Eric Branch Updated 11:44 pm, Thursday, November 15, 2012

Giants manager Bruce Bochy to undergo another heart procedure

San Jose Mercury News

Giants manager Bruce Bochy said he would undergo an ablation procedure early next week to treat an **atrial fibrillation** – his second heart procedure this year and his third in the ...

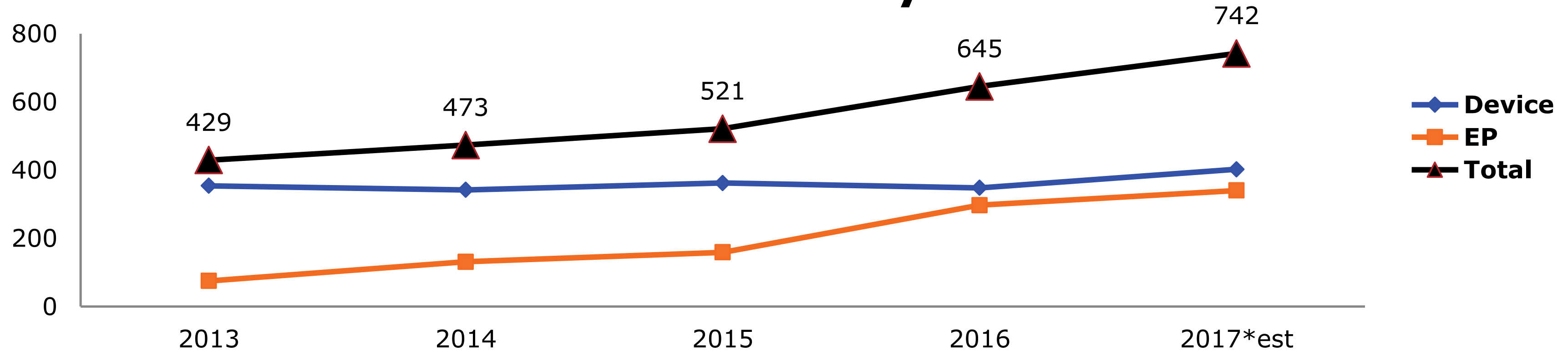
Cardiac Electrophysiology

- Diagnosis and treatment of heart rhythm disorders
  - Palpitations, irregular heart beats
  - Fainting (syncope) and near fainting
  - Heart racing, abnormal fast heart rhythms
  - Abnormally slow heart rate (ie, abnormalities of cardiac conduction)
  - Cardiac arrest (SCD)
  - Rhythm-related stroke
  - Genetic heart rhythm diseases

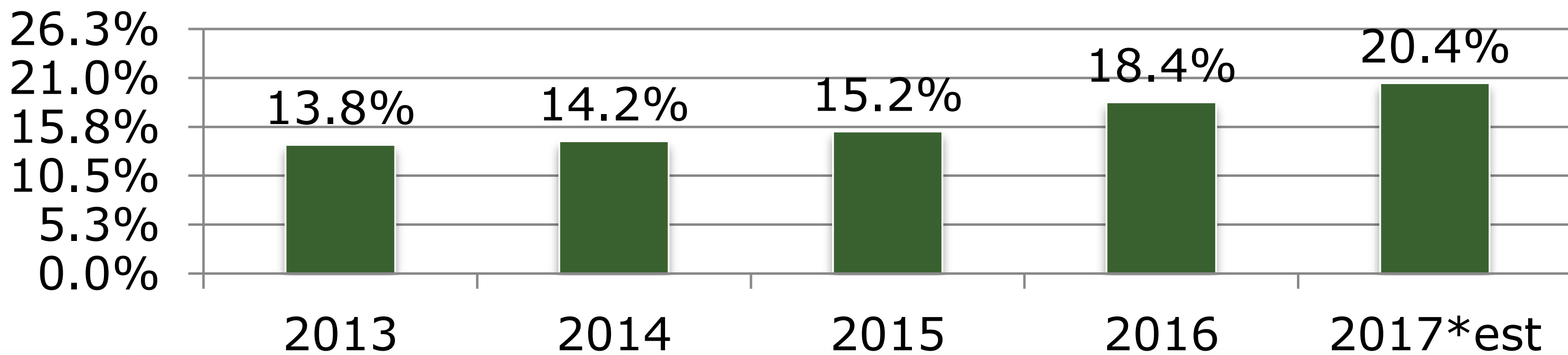
Cardiac Electrophysiology

- Management of Rhythm Disorders
  - Ablation
    - Supraventricular tachycardias
    - Atrial fibrillation
    - Ventricular tachycardia
  - Device Therapy
    - Pacemakers
    - Defibrillators
    - Cardiac resynchronization
    - Implantable loop recorders
  - Other
    - Left atrial appendage occlusion
    - Laser lead extraction

EP Volume



- 2017 173% volume increase from 2013
- 2017 EP reach 20% of total CathLab volume



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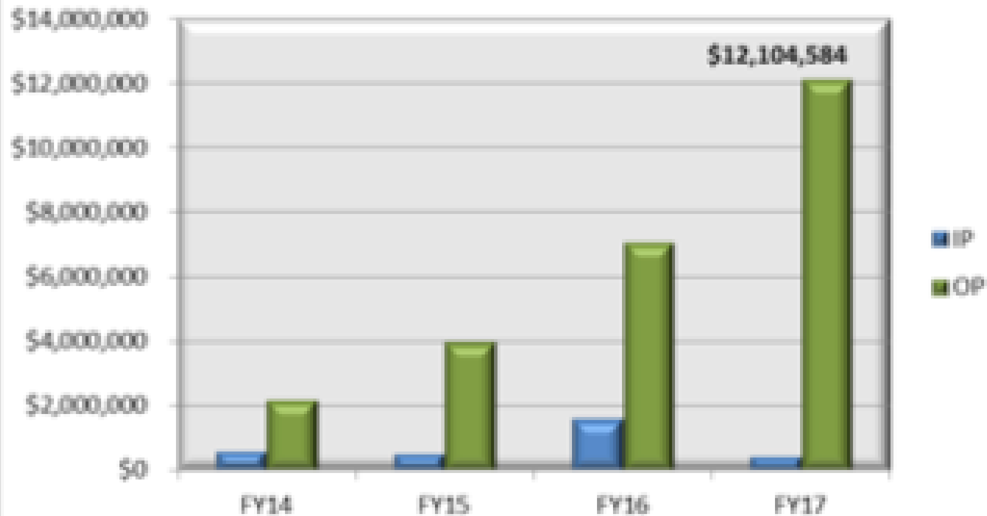

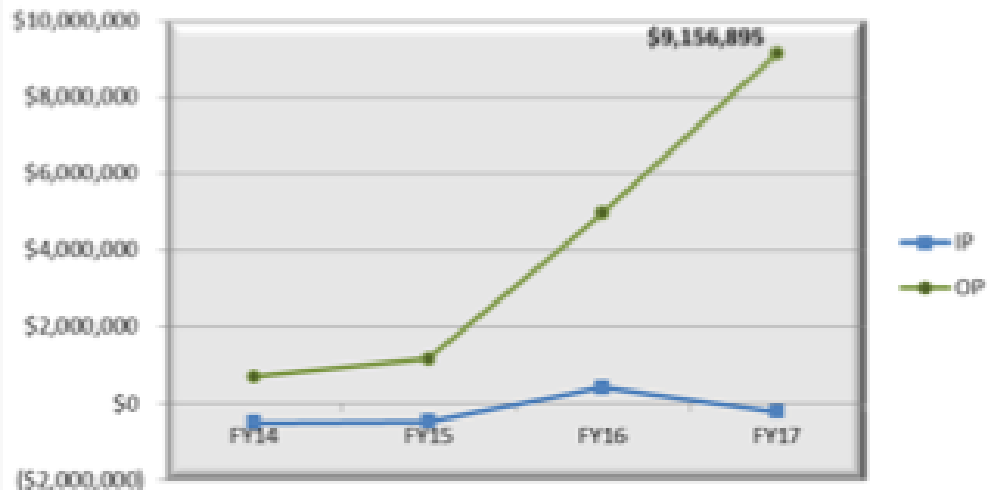

- **As outpatient procedures increase, Contribution Margin and Net Income continues to increase**
- **Excellent reimbursement for outpatient procedures**

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- ACC/NCDR Registries for the in-patient setting
  - ACTION Registry®-GWTG™
  - **AFib Ablation Registry™**
  - CathPCI Registry®
  - **ICD Registry™**
  - IMPACT Registry®
  - LAAO Registry™
  - PVI Registry™
  - STS/ACC TVT Registry™

NCDR ICD Registry Performance Measures 2017Q1 (Rolling 4 Quarters)

	Performance Measures	Distribution of Hospital Performance (10th percentile → 90th percentile; Better →)
4	**Proportion of ICD/CRT-D implant patients with left ventricular systolic dysfunction (LVSD), who were prescribed ACE-I or ARB therapy, as eligible, at discharge** My Hospital: 100.0% | U.S. Hospitals 50th Pctl: 88.4% | U.S. Hospitals 90th Pctl: 100.0% Percent of ICD/CRT-D implant patients with an ICD implant with an LVEF<40, who were prescribed ACE-I or ARB therapy, or ineligibility documented, at discharge. **[Detail Line:**1008]	100.0%; 64.7, 76.7, 88.4, 97.7, 100.0
5	**Proportion of ICD/CRT-D implant patients with a prior MI who were prescribed beta-blocker therapy, as eligible, at discharge** My Hospital: 100.0% | U.S. Hospitals 50th Pctl: 98.0% | U.S. Hospitals 90th Pctl: 100.0% Percent of ICD/CRT-D implant patients with a prior MI who were prescribed beta-blocker therapy, or ineligibility documented, at discharge. **[Detail Line:**1009]	100.0%; 84.8, 92.4, 98.0, 100.0
6	**Proportion of ICD/CRT-D implant patients with left ventricular systolic dysfunction (LVSD) who were prescribed beta-blocker therapy, as eligible, at discharge** My Hospital: 100.0% | U.S. Hospitals 50th Pctl: 97.7% | U.S. Hospitals 90th Pctl: 100.0% Percent of ICD/CRT-D implant patients with an LVEF<40, who were prescribed beta-blocker therapy, or ineligibility documented, at discharge. **[Detail Line:**1010]	100.0%; 86.3, 93.1, 97.7, 100.0
14	**Composite: Proportion of ICD/CRT-D implant patients prescribed all discharge medications (ACE-I/ARB and/or beta-blocker) for which they were eligible** My Hospital: 100.0% | U.S. Hospitals 50th Pctl: 87.1% | U.S. Hospitals 90th Pctl: 100.0% Percent of ICD/CRT-D implant patients who received prescriptions for all medications (ACE/ARB and beta blockers) for which they are eligible for at discharge. **[Detail Line:**1011]	100.0%; 61.9, 74.6, 87.1, 96.4, 100.0

NCDR ICD Registry Guideline Metrics 2017Q1 (Rolling 4 Quarters)

Guideline Metrics

Distribution of Hospital Performance
10th percentile — Better → — 90th percentile

25 **Proportion of ICD/CRT-D patients that fulfill class I, IIa, or IIb guideline indications**

My Hospital	U.S. Hospitals 50th Pctl	U.S. Hospitals 90th Pctl
91.5%	78.1%	98.8%

Percent of patients that received an ICD/CRT-D implant following class I, Iia, or Iib guideline indications.
Note: Based on 2008 Device Based Therapy Guideline and 2012 Device Based Therapy Focused Update **[Detail Line:**1012]

91.5%
33.8
60.1
78.1
91.3
98.8

26 **Proportion of ICD patients that fulfill class I, IIa, or IIb guideline indications**

My Hospital	U.S. Hospitals 50th Pctl	U.S. Hospitals 90th Pctl
89.7%	74.2%	100.0%

Percent of patients that received an ICD implant following class I, Iia, or Iib guideline indications.
Note: Based on 2008 Device Based Therapy Guideline and 2012 Device Based Therapy Focused Update **[Detail Line:**1016]

89.7%
33.5
56.5
74.2
89.0
100.0

27 **Proportion of CRT-D patients that fulfill class I, IIa, or IIb guideline indications**

My Hospital	U.S. Hospitals 50th Pctl	U.S. Hospitals 90th Pctl
83.3%	70.1%	100.0%

Percent of patients that received an CRT-D implant following class I, Iia, or Iib guideline indications.
Note: Based on 2008 Device Based Therapy Guideline and 2012 Device Based Therapy Focused Update **[Detail Line:**1020]

83.3%
21.2
50.2
70.1
89.4
100.0

ICD Registry Outcome

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EP Registry Suite™

Metrics	2013	2014	2015	2016	2017* (Jan-Jun)	All Hospital 50th Pctl
Failure to successfully place coronary sinus/left ventricular lead	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Incidence of death or major adverse event	3.1%	1.3%	1.3%	3.9%	3.0%	0.6%
Median post procedure LOS	1 day	1 day	1 day	1 day	1 day	1 day

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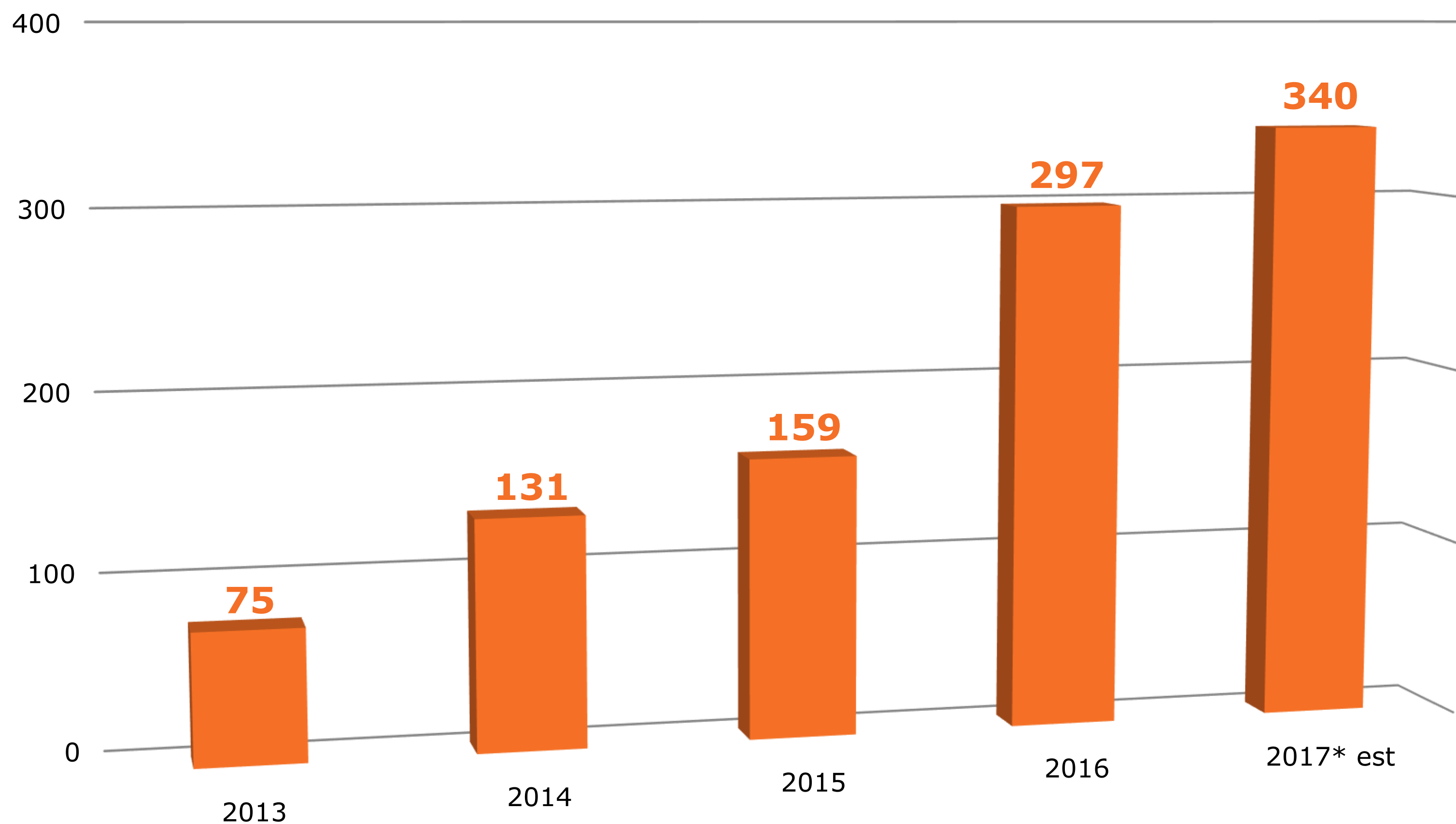
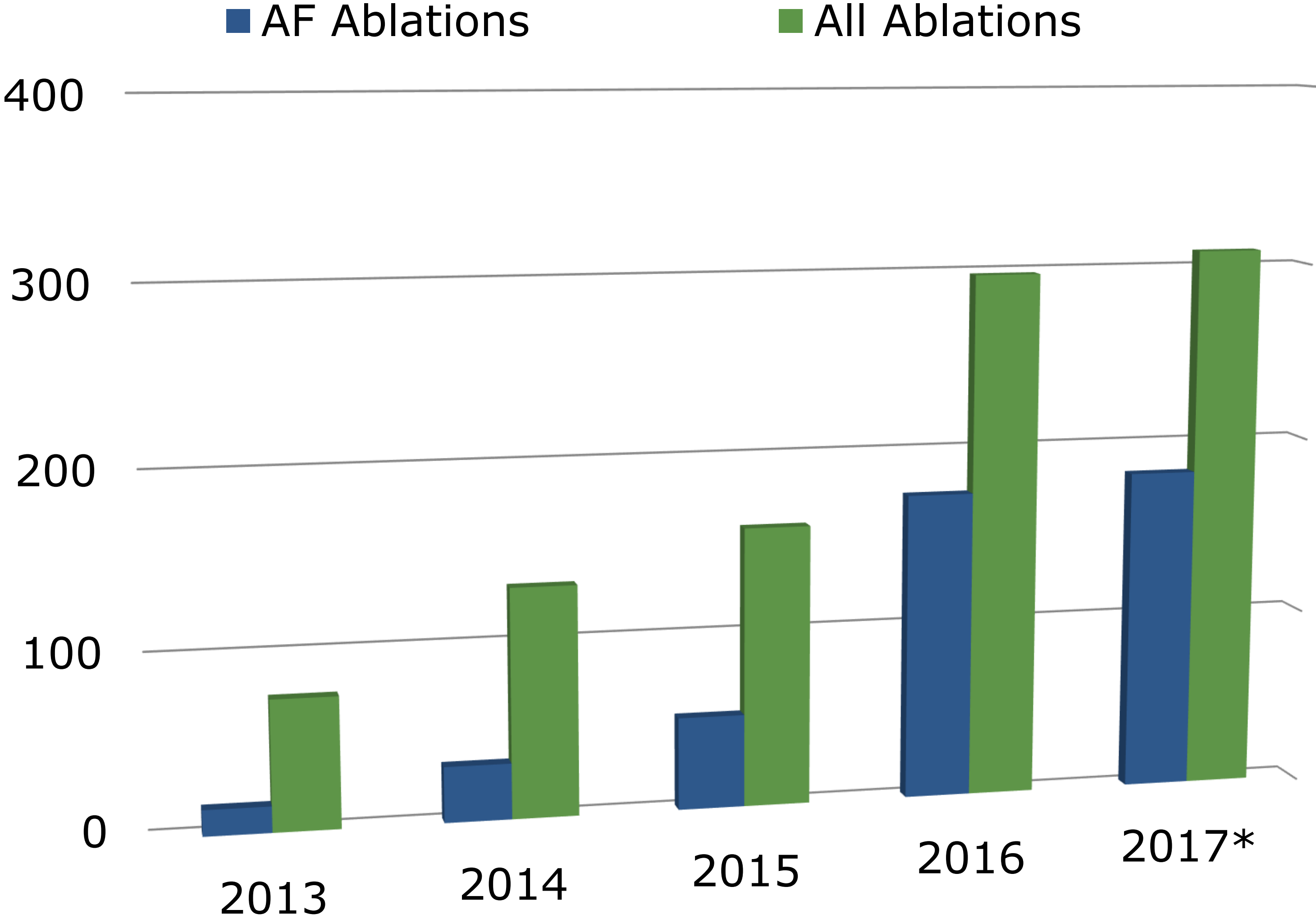
Volume



ECH AF Ablation Volume



Atrial Fibrillation: Scope of the Problem

- 1.5-2% prevalence worldwide (33.5 million)
- In US, aging Baby Boomers
- Prevalence expected to double in 50 years
- 1 in 4 lifetime risk of developing AF for those over age of 40

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The AFib Ablation Registry collects:

- Patient demographics for atrial fibrillation ablation procedures
- Procedure prevalence and acute management approaches
- Provider and facility characteristics
- History/risk factors
- Device utilization and adverse event rates
- Data will support the development of evidence-based guidelines for atrial fibrillation treatments

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- Quarterly risk-adjusted benchmark reports with performance measures and quality metrics to compare an institution's performance with that of peer groups and the national experience

- Executive summary dashboards for selected registries that offer big-picture reviews, at-a-glance assessments and patient level drill-downs

- A Physician Dashboard, currently available for physicians affiliated with CathPCI hospitals, to gauge performance on process and quality metrics; identify opportunities for improvement; and help earn Maintenance of Certification Part IV credit

EP Registry Suite™

- Rolled out March 2016
- 69 hospitals have joined
- No outcome report yet
- Data submission
  - Quarterly by discharged date

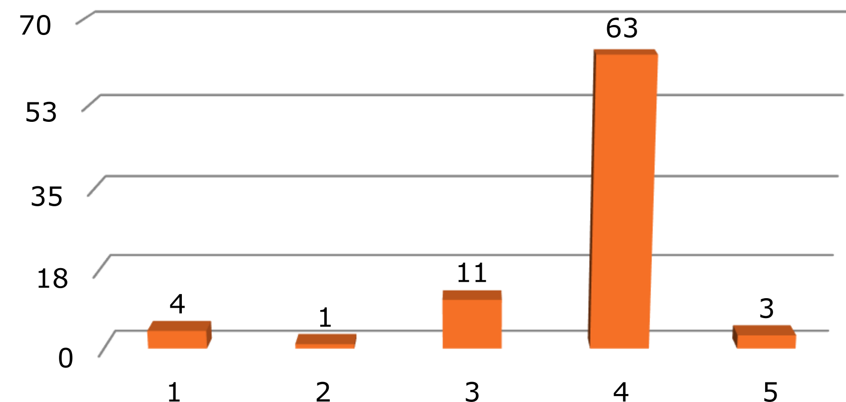
The first data submission will include 2016 Q1, Q2, and Q3

Call For Data	Patients Discharged	Data Submission Deadline 11:59PM ET
Q1 2016	Jan 1, 2016 - Mar 31, 2016	Dec 01, 2016
Q2 2016	Apr 1, 2016 - June 30, 2016	Dec 01, 2016
Q3 2016	July 1, 2016 - Sept 30, 2016	Dec 01, 2016
Q4 2016	Oct 1, 2016 - Dec 31, 2016	Mar 01, 2017
Q1 2017	Jan 1, 2017 - Mar 31, 2017	June 01, 2017

2016 Jun to Dec data

- 82 cases-All elective
- 23% female
- Average age=66.6yo
- AF classification
- Valvular AF=15%
- Atrial Flutter=37%
- Prior ablation=30%
- Average # vein isolated=3.6
- Cardioversion during procedure
  - 30%
- All general anesthesia

AF classification	Count
Long-standing Persistent	1
Paroxysmal	49
Persistent	32
Grand Total	**82**



Innovation

- Left Atrial Appendage Closure

- Leadless Pacemakers

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Quality and Safety Dashboard (Monthly)

Reports run: 10/18/17		Performance		Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS		Month	FYTD	FY2017	FY2018		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: Sep 2017*	1.60 (8/4,990)	1.33 (20/14,990)	1.49	0.74 (top decile CAL NOC		New goal from CALNOC @ 0.74, August result above the mean for July 2015-July 2017. USF Nursing Master students conducting validation on ECH nurses completion of fall risk assessment tool. Tiral of new toilet seat sensor to alarm if pt. raises up from toilet to address falls in bathroom.
2	^Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Sep 2017* *SIR Goal: <= 0.75*	1.43 (2/1,394)	2.87 (4/4,384)	Rate = 1.09 SIR = 1.06	SIR = 0.75		2 CAUT in Aug. - 2 in Sept. HAI A3 actions: Nurse -driven protocol for foley removal ready for MEC, competency for new foley insertion tray and procedure for ED, Critical Care,and OR, emphasis on daily bath, frequent peri care for pts. w/catheters.
3	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Sep 2017* *SIR Goal: <= 0.75*	0.00 (0/889)	0.00 (0/2,885)	Rate = 1.09 SIR = 1.06	SIR = <0.5		Zero CLABSI in 1st qtr FY2018. HAI A3 focus on CLIP form insertion observation and insertion bundle, daily assessment of continued need for CVL.
4	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Sep 2017* *SIR Goal: <= 0.75*	2.47 (2/8,112)	1.66 (4/24,317)	Rate = 1.89 SIR = 0.46	SIR = <0.75		2 C.Diff HAI in September, both related to long or mulitple antibiotic use. ABX Stewardship focused on appropriate ABX use with individual MD discussions.
Efficiency		Month	FYTD	FY17	FY 2018		
5	★Organizational Goal **Arthimetric Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: Sep 2017*	1.10	1.10	1.16	1.11		GMIOS has improved with CDI from FY17 of 4.08 to 4.19 in September. ALOS has also improved to 4.63, thus improving this ratio to below target goal.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2017 Definition	FY 2018 Definition	Source
Patient Falls	Sheetal Shah; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when		**QRR Reporting and Staff Validation**
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carso/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.		
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Catherine Carso/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficle Infection)	Catherine Carso/Catherine Nalesnik				
Arithmetic Observed LOS Average over Geometric LOS Expected.	Cheryl Reinking Catherine Carson (Jessica Hatala)		The Observed LOS over the Expected LOS Ratio is determined by calculatign the average length of stay of all Medicare financial class divided by the GMLOS (geomettric LOS associated with each patient's MD-DRG.		

Reports run: 9/20/17			Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** SEP-1 100% or O% *Date Period: Aug 2017*				**SEP-1: MONTHLY Compliance Rate** ECH vs All Core Measure Hospitals	Sep-1 Core measure compliance increased to 67% - represents 4 fallouts. All core measure hospitals at 50%.
7	**IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) *Date Period: Aug 2017*				**Percentage of Randomly Sampled ED Patients (LG & MV) with ≥ 30ml/kg Crystalloid IVF Ordered within 2 Hours of Time of Presentation (or NICOM) of Severe Sepsis or Septic Shock** *Patients Lacking Initial Hypotension or Lactate < 3 Excluded.*	Compliance at 80% orders for bolus received w/I 2 hrs of TOP.
Mortality	Performance Month	Performance FYTD	FY 2017	FY 2018		
8	**Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: July 2017*	1.00 (1.56%/1.56%)	1.00 (1.56%/1.56%)	1.02 (1.88%/ 1.83%)	0.62	CDI has increased Expected Mortality rate as more co-morbid conditions are documented, increasing the risk of death. 5 high volume DRGs O/E below 1.0 are Heart Failure/shock, Intracranial Hem/Cerebral infarc, Renal Failure w/cc, GI Hemorrhage w/cc, & Septicemia/servere sepsis
SERVICE	Performance Month	Performance FYTD	FY 2017	FY 2018		
9	«Organizational Goal **HCAHPS Rate Hosptal 0-10** **Top Box Rating 9 and 10** *Date Period: August 2017*	80.5 (186/231) (Aug preliminary not avail until 10/27)	79.4 (369/465) (Aug preliminary not avail until 10/27)	76.30			Data for August is premlinary, final data for August not availble unti l10/27, projected data at meeting 10/30 will be final. Nursing team addressing Nurse Communication results with focus on Handoff communication.

	Apr-16	May-16	Jun-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
Number of Sampled Cases	18	19	21	23	30	30	29	30	30	30	30	30	30	30	30
Cases with 30ml/kg ordered ordered within 2h TOP (or NICOM)	9	17	9	14	17	17	24	21	26	26	25	25	28	26	24
Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation	50%	89%	43%	61%	57%	57%	83%	70%	87%	87%	83%	83%	93%	87%	80%

Measure Name	Definition Owner	Work Group	FY 2017 Definition	Source
Sepsis Core Measure- SEP-1: MONTHLY Compliance Rate ECH vs All Core Measure Hospitals	Catherine Carson/Kelly Nguyen	Sepsis Steering Committee	New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate > 2 or evidence of organ dysfunction, Hospital must meet ALL 4 measures in order to be compliant with this core measure, Patients with septic shock require an assessment of volume status and tissue perfusion within 6 hours of presentation, Patients NOT included are those transferred from another facility or those placed on comfort cares.	**EPIC Chart Review**
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded)Shock	Catherine Carson		Percentage of Randomly Sampled ED Patients (LG & MV) who had IVF >=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate <3 Excluded)	**EPIC Chart Review**
Mortality Rate (Observed/Expected)	Catherine Carson			**Premier Quality Advisor**
HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10	Michelle Gabriel; Cheryl Reinking	Patient Experience Committee	"'9' or '10' (high)" for the Overall Hospital Rating item	**Press Ganey Tool**

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Medical Staff Ongoing Professional Practice Evaluation and Peer Review Update

Catherine Carson, Sr. Director of Quality Improvement and Patient Safety

October 30, 2017

Ongoing Professional Performance Evaluation

- TJC requires that all members of medical staff are reviewed for professional performance that impact quality of care and patient safety - MS 08.03.01
- Clinical Effectiveness staff have implemented Physician Focus software, built reports to pull data and will assist with evaluation of data and provide access for medical staff to clinical data
- Evaluation is required to be ongoing: ECH interval is every **8 months** (next date is scheduled for November)
- Medical Staff Department Chairs to review individual profiles and determine approval or further action

ECH OPPE Profile for All Providers

- Mortality Data (Source: Premier/EPIC)
- Review of outcome data: Clinical Complications/AHRQ Patient Safety Indicators (Premier/EPIC)
- 30 Day Readmissions (Premier/EPIC)
- Length of Stay Patterns (Premier/EPIC)
- Pattern of Medication Usage: Antibiotic Usage compared to Peer Group (Custom Metric/EPIC)
- Pattern of Blood Usage: (Custom Metric)
  - Physician's average number of units of blood transfused per case
  - Average transfusion trigger (Hg) per physician compare to the average transfusion trigger (Hg) per specialty
  - % of the cases physician used one unit of blood per transfusion

ECH OPPE Profile for All Providers-Additional Metrics

- Documentation Metric (EPIC/HIMS):
  - # of op notes/procedure notes/study notes available within 24 hours
  - Suspension days for delinquent H&P and Discharge Summary
- Behavioral Trends:
  - Any trends entered for the following indicators: Medical Staff Communication Concern, Variation from Bylaws, On Call Availability, Professional Conduct, Patient Family Complaint (Quality Database)
- # of Peer Review Cases (Quality Database)
- Custom Profiles for Specialties
  - Pathology
  - Anesthesiology
  - Radiology
  - Psychiatry

PhysicianFocus™ Example of Individual Profile

Peer Review Flow Chart

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Peer Review Process – Future State

- 2 Peer Review Coordinators (RNs) support all 13 Peer Review meetings
- New Peer Review Manager software module implemented to support new process
- Peer Review Coordinators support and attend all peer review committees
  - Identification of cases, case prep for the meeting, documentation of the review and follow up until the case is closed
  - PRC will do initial clinical review as well as support reviewing physician with necessary preparations for the case presentation
  - PRC will collaborate with departments in the ongoing design of the Peer Review process by identifying new quality indicators
- Utilize new Peer Review rating form, all data results into PRM software, enable direct software access to depts. Initial use by ED Peer Review Committees

Thank you!
Questions?

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Clinical Documentation Improvement Dashboard (Monthly)

Date Reports Run: 10/16/2017				Baseline	FY18 Goal	Trend	Comments
Coverage		Performance		FY2017	FY2018 goal		
1	**Medicare**	Sept 2017 394/454 87%	FYTD 85%	64%	85%	100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0% Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17	Change in Coverage Rate from Aug- Dec 2016 is due to a more efficient process (no additional staff hired) 1st new CDS hired on Dec 5. *1 month ramp up period for new hires 2nd new CDS: Feb 27 3rd new CDS: April 3 4th new CDS: May 22 Dec and Jan: Same number of Reviews (350), higher denominator due to flu volume. No CDS coverage for 2 weeks in April due to 2weeks of education.
2	**All Payor**	Sept 2017 703/969 73%	FYTD 68%	35%	85%	100%, 90%, 80%, 70%, 60%, 50%, 40%, 30%, 20%, 10%, 0% Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17	All payor review, including HMO and PPO payers, began in July 2017.
Physician Response		Performance		FY2017	FY 2018 goal		
4	**Query Response Rate**	Sept 2017 90%	FYTD 90%	90%	99%	100%, 96%, 92%, 88%, 84%, 80% Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17	Consistently above 88% since February. This is an improvement over baseline in FY 2016 and FY 2017. Measures Physician awareness of and participation in the CDI program.
5	**Query Agree Rate**	Sept 2017 61%	FYTD 61%	70%	>85%	90%, 85%, 80%, 75%, 70%, 65%, 60%, 55%, 50% Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17	Decreasing agree rate is equated with an increased volume of queries sent, lack of physician participation, and poor quality queries. We are sending 4x more queries than in the past (up from 80 queries sent in 8/16 to 300 in 9/17). Team is undergoing continuous compliance and medical education. Physician education continues. CDS are now developing relationships with the physicians by rounding on the pt care floors.

#	Impact	Performance		FY2017	FY 2018 goal	Comments
7	★Organizational Goal **Average GMLOS (days)** *(Medicare, adult, acute care, inpatient)*	**Sept 2017** 4.19	**FYTD** 4.20	4.08	Min 4.20 Target 4.25 Max 4.33	Higher GMLOS is better. This reflects the severity of the patients we treat at ECH. This is the denominator of the Observed/ Expected LOS Indicator. On schedule to meet Target goal by Q4 of FY2018. QE 9/2017 LOS O/E= 4.64/ 4.20, or 1.104
8	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Sept 2017** MCC 45% CC 25% NCC 26% Null 4%	N/A	**Nat 80th%** MCC 44% CC 27% No CC 29%	**Nat 80th%** N/A	Higher MCC Capture Rate is better. This effects Reimbursement, Expected GMLOS, Expected Mortality %, and CMI. National 80th Percentile is computed by CMS and published annually on 10/1.
9	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Sept 2017** MCC 25% CC 30% NCC 43% Null 2%	N/A	**Nat 80th%** MCC 31% CC 32% No CC 37%	**Nat 80th%** N/A	Surgical cases make up 30-40% of our Medicare patient volume. The biggest impact in reimbursement, CMI, GMLOS, and Expected mortality will come from increased Surgical CC/ MCC capture, coupled with sustained Medical CC/MCC capture. Outreach to HVI, General Surgery (Dr. Legha), and OrthoSurg has occured. General Outreach continues.
#	**Expected Mortality Rate** (Medicare, adult, acute care, inpatient) **FY2017 for Mortality O/E is aligned with CMS FY, Oct 1-9/30.	**QE Sept 2017** 3.84	**FYTD** 3.84	3.62% **	MedPAR 2018 O/E < 0.90	Higher Expected Mortality Rate is better. This reflects the severity of the patients we treat at ECH. This is the denominator of the Observed/ Expected Mortality Indicator. MedPAR 2016 O/E= 1.44 MedPAR 2017 O/E= 1.08

Average GMLOS chart (3.80–4.40): Aug-16, Sep-16, Oct-16, Nov-16, Dec-16, Jan-17, Feb-17, Mar-17, Apr-17, May-17, Jun-17, Jul-17, Aug-17, Sep-17

Medical CC/MCC Capture Rate chart:

	QE 9/2016	QE 12/2016	QE 3/2017	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
MCC	34%	45%	49%	43%	49%	42%	46%	46%	45%
CC	28%	25%	25%	27%	28%	29%	23%	27%	25%
No CC	38%	30%	26%	30%	23%	29%	31%	27%	26%

Surgical CC/MCC Capture Rate chart:

	QE 9/2016	QE 12/2016	QE 3/2017	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
MCC	19%	22%	21%	27%	25%	22%	28%	23%	25%
CC	24%	27%	28%	28%	29%	28%	21%	30%	30%
No CC	57%	51%	51%	45%	46%	50%	51%	47%	43%

Expected Mortality Rate chart:

YE 9/2016	QE 12/2016	QE 3/2017	QE 6/2017	QE 9/2017
2.97%	3.19%	3.93%	3.56%	3.84%

CMS Core Measure Results CY 2017

HOSPITAL QUALITY REPORTING -						Hospital Compare	
Strategy	Core Measures	Goal	Q1	Q2	YTD	National	State
Inpatient	**PC - SEP: Perfect Care - Severe Sepsis/Septic Shock** SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock	100%	52%	56%	54%	36%	N/A
	PC- STK: Perfect Care - STROKE STK-1 Venous Thromboembolism (VTE) Prophylaxis STK-2 Discharged on Antithrombotic Therapy STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter STK-4 Thrombolytic Therapy STK-5 Antithrombotic Therapy By End of Hospital Day 2 STK-6 Discharged on Statin Medication STK-8 Stroke Education STK-10 Assessed for Rehabilitation	100%	91%	89%	90%	N/A	N/A
	PC-IMM: Perfect Care - Immunization: Influenza Immunization- Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.	100%	98%	NA	98%	93%	94%
	PC-PCM: Perfect Care-PCM (Perinatal Care - Mothers) PC-01 Elective Delivery PC-02 Cesarean Section PC-03 Antenatal Steroids	100%	81%	79%	80%	N/A	N/A
	PC-PCB: Perfect Care-PCB (Perinatal Care - Babies) PC-04 Health Care-Associated Bloodstream Infections in Newborns PC-05 Exclusive Breast Milk Feeding	100%	76%	76%	76%	N/A	N/A
	PC-VTE: Perfect Care – Venous thromboembolism VTE-6 Incidence of Potentially-Preventable Venous Thromboembolism	100%	100%	100%	100%	98%	98%
	ED-1a: Median Time from ED Arrival to ED Departure for Admitted ED Patients- Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department	300min	381	316	338	297	345
	ED-2a: Admit Decision Time to ED Departure Time for Admitted Patients- Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients	120min	111	86	98	121	155

Color Indicator Legend: within goal min = Green, >goal min = Red, 95% - 100% = Green
90% - 94% = Yellow, <90% = Red, 0% = Green, ≥1% = Red

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CMS Core Measure Results CY 2017

Strategy	Core Measures	Goal	Q1	Q2	YTD	National	State
Outpatient	**PC-OP AMI: Perfect Care - Out Patient Acute Myocardial Infarction:** OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival § OP-4 Aspirin at Arrival	100%	100%	100%	100%	N/A	N/A
	PC-OP CP: Perfect Care - Out Patient Chest Pain OP-4 Aspirin at Arriva	100%	100%	100%	100%	95%	95%
	OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients	180min	196	172	181	163	173
	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional	15min	16	15	15	25	29
	OP-21: Hospital Outpatient Pain Management Population	30min	55	60	58	49	55
	PC-OP STK: Perfect Care - Out Patient Stroke OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	100%	60%	50%	56%	72%	70%
Hospital-Based Inpatient Psychiatric Services (HBIPS)	**PC-IMM: Perfect Care - Immunization**: IMM-2 Influenza Immunization(HBIPS)	100%	96%	NA*	96%	81%	77%
	PC-HBIPS: Perfect Care - Hospital Based Inpatient Psychiatric Services HBIPS-5a Multiple Antipsychotic Medications at Discharge with Appropriate Justification – Overall Rate	100%	85%	78%	81%	60%	62%
	PC-SUB: Perfect Care - Substance Abuse: 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	100%	87%	91%	89%	N/A	N/A
	PC-TOB: Perfect Care - Tobacco Use: 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	100%	84%	90%	87%	N/A	N/A

Color Indicator Legend: within goal min = Green, >goal min = Red, 95% - 100% = Green
90% - 94% = Yellow, <90% = Red, 0% = Green, ≥1% = Red

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Color Indicator Legend	95% - 100% = G 90% - 94% = Y <90% = R

HOSPITAL QUALITY REPORTING			2017											Hospital Compare		
Strategy	Core Measures	Goal	JAN	FEB	MAR	Q1	Truven Q1	APR	MAY	JUN	Q2	Truven Q2	YTD	National	State	Top 10th Percentile
Inpatient	PC - SEP: Perfect Care - Severe Sepsis/Septic Shock SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock	100%	71%	42%	33%	52%	46%	33%	46%	92%	56%	49%	54%	Not Available	Not Available	Not Available
Inpatient	**PC- STK: Pefect Care - STROKE** STK-1 Venous Thromboembolism (VTE) Prophylaxis STK-2 Discharged on Antithrombotic Therapy STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter STK-4 Thrombolytic Therapy STK-5 Antithrombotic Therapy By End of Hospital Day 2 STK-6 Discharged on Statin Medication STK-8 Stroke Education STK-10 Assessed for Rehabilitation	100%	96%	90%	89%	91%	Not Available	88%	85%	92%	89%	Not Available	90%	Not Available	Not Available	Not Available
Inpatient	**PC-IMM: Perfect Care - Immunization**: Influenza Immunization- Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.	100%	97%	97%	100%	98%	92%	NA	NA	NA	NA	NA	98%	93%	94%	100%
Inpatient	**PC-PCM: Perfect Care-PCM (Perinatal Care - Mothers)** PC-01 Elective Delivery PC-02 Cesarean Section PC-03 Antenatal Steroids	100%	68%	83%	92%	81%	80%	81%	73%	83%	79%	80%	80%	Not Available	Not Available	Not Available
Inpatient	**PC-PCB: Perfect Care-PCB (Perinatal Care - Babies**) PC-04 Health Care-Associated Bloodstream Infections in Newborns PC-05 Exclusive Breast Milk Feeding	100%	66%	76%	84%	76%	53%	80%	73%	75%	76%	54%	76%	Not Available	Not Available	Not Available
Inpatient	**PC-VTE: Perfect Care – Venous thromboembolism** VTE-6 Incidence of Potentially-Preventable Venous Thromboembolism	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	95%	100%	98%	98%	100%
Inpatient	**ED-1a: Median Time from ED Arrival to ED Departure for Admitted ED Patients-** Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department	300min	402	352	380	381	419	306	330	278	316	372	338	297	345	178
Inpatient	**ED-2a: Admit Decision Time to ED Departure Time for Admitted Patients-** Time (in minutes) from admit decision time to time of departure from the emergency department for admitted patients	120min	115	94	112	111	218	99	85	70	86	180	98	121	155	39
Outpatient	**PC-OP AMI: Perfect Care - Out Patient Acute Myocardial Infarction**: OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival □ OP-4 Aspirin at Arrival	100%	NA	100%	100%	100%	96%	NA	100%	NA	100%	96%	100%	Not Available	Not Available	Not Available
Outpatient	**PC-OP CP: Perfect Care - Out Patient Chest Pain** OP-4 Aspirin at Arriva	100%	NA	NA	NA	100%	96%	NA	100%	NA	100%	96%	100%	95%	95%	100%
Outpatient	**OP-18b**: Median Time from ED Arrival to ED Departure for Discharged ED Patients	180min	184	192	205	196	178	170	173	173	172	168	181	163	173	91
Outpatient	**OP-20**: Door to Diagnostic Evaluation by a Qualified Medical Professional	15min	15	18	13	16	49	15	16	14	15	43	15	25	29	9
Outpatient	**OP-21**: Hospital Outpatient Pain Management Population	30min	60	66	51	55	75	63	55	65	60	69	58	49	55	30
Outpatient	**PC-OP STK: Perfect Care - Out Patient Stroke** OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	100%	67%	NA	50%	60%	71%	100%	100%	0%	50%	73%	56%	72%	70%	100%
Hospital-Based Inpatient Psychiatric Services (HBIPS)	**PC-IMM: Perfect Care - Immunization**: IMM-2 Influenza Immunization(HBIPS)	100%	93%	95%	100%	96%	92%	NA	NA	NA	NA	NA	96%	81%	77%	Not Available
Hospital-Based Inpatient Psychiatric Services (HBIPS)	**PC-HBIPS: Perfect Care - Hospital Based Inpatient Psychiatric Services** HBIPS-5a Multiple Antipsychotic Medications at Discharge with Appropriate Justification – Overall Rate	100%	90%	67%	90%	85%	87%	67%	85%	77%	78%	87%	81%	60%	62%	Not Available
Hospital-Based Inpatient Psychiatric Services (HBIPS)	**PC-SUB: Perfect Care - Substance Abuse**: 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	100%	82%	85%	95%	87%	69%	94%	84%	95%	91%	72%	89%	Not Available	Not Available	Not Available
Hospital-Based Inpatient Psychiatric Services (HBIPS)	**PC-TOB: Perfect Care - Tobacco Use**: 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	100%	87%	79%	86%	84%	70%	90%	81%	100%	90%	69%	87%	Not Available	Not Available	Not Available

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To: ECH Quality Committee

From: Catherine Carson, Sr. Director
Tamara Stafford, Director, Talent Development

Re: Enterprise-wide Strategies in response to Employee Engagement/AHRQ Survey

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Review of the results of both the engagement survey results revealed a key driver for both employees and physicians to be:

The Organization makes every effort to provide safe, error-free care to patients.

This statement was selected as the enterprise-wide action item. Below is a list of action items under consideration and in process to address this statement:

- Analysis of specific department behavior regarding reporting events
  - Target interventions for some departments
- Patient Safety Newsletter – quarterly
  - Shares patient safety initiatives and actions taken as a result of reporting
  - Used to make connections between survey questions and organizational response
- Patient safety staff and Quality Medical Directors are providing direct feedback to submitters of QRRs
- Crucial Conversation training for senior leaders, directors and managers. This will also include key staff leaders in 2018
- Re-starting Executive Rounding
- Patient Safety Committee: consider splitting apart the enterprise Quality Improvement/Patient Safety Committee as it is focused on quality reporting and not safety reporting
- Nurse Communication (as measured in HCAHPS) is a nursing goal
  - Is focused on hand-off communication between shifts and between departments. Nursing is conducting an assessment of the current processes
- Addressing nursing concerns regarding staffing
  - Being proactive about staffing when there are open positions
  - Engaging additional traveler nurses for each shift in anticipation of flu season, especially in ED and CCU
  - Re-evaluation of the float pool and to standardize the number of float staff for each type of department
  - Addition of Behavioral Health Workers to ED staff to address 51-50 patients boarding in the ED
- Use of a nurse driven protocol regarding appropriateness of telemetry and facilitating discontinuation when the patient no longer clinically qualifies
- Addressing Nurse to Physician Communication
  - Assessing hospitalist services
  - Consideration of 24-hour in-person intensivist coverage (vs eICU)
  - Consider formalizing a “physician-liaison/advisor” for each department
  - Involve physicians in Workplace Violence Prevention Plan

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Patient and Family Centered Care Update

Cheryl Reinking, RN, MS, NEA-BC, Chief Nursing Officer

October 30th, 2017

Patient Centeredness Tactics

- Bedside Handoff Report
- Patient Centered Discharge Rounds
- Empathy Building Exercise
- Expansion of Getting to Know You Program
- Improved Discharge Instruction Methodology