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

Monday, November 5th, 2018 - 5:30 p.m.
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Jeffrey Davis, MD will be participating from 345 California Street, San Francisco, CA 94104.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (October 1, 2018) b. Safety Report for Environment of Care ***Information*** c. Patient Story d. FY19 Pacing Plan e. Progress Against FY19 Committee Goals	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required** **5:33 – 5:35**
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**Discussion** **5:35 – 5:40**
5.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 5**	Mark Adams, MD, CMO		**Discussion** **5:40 – 5:50**
6.	**CDI DASHBOARD** **ATTACHMENT 6**	Mark Adams, MD, CMO		**Discussion** **5:50 – 6:05**
7.	**CORE MEASURES** **ATTACHMENT 7**	Mark Adams, MD, CMO		**Discussion** **6:05 – 6:20**
8.	**PERFORMANCE IMPROVEMENT – PHYSICIAN MANAGEMENT** **ATTACHMENT 8**	Mark Adams, MD, CMO		**Discussion** **6:20 – 6:35**
9.	**HOW DOES EL CAMINO HOSPITAL DEFINE QUALITY** **ATTACHMENT 9**	Mark Adams, MD, CMO		**Discussion** **6:35 – 7:05**
10.	**HOSPITAL UPDATE** **ATTACHMENT 10**	Mark Adams, MD, CMO		**Discussion** **7:05 – 7:10**
11.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**Information** **7:10 – 7:13**

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
12.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required 7:13 – 7:14**
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**7:14 – 7:15**
14.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (October 1, 2018)	Julie Kliger, Quality Committee Chair		**Motion Required 7:15 – 7:17**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - CMO Report	Mark Adams, MD, CMO		**Discussion 7:17 – 7:22**
16.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Quarterly Quality and Safety Review	Mark Adams, MD, CMO		**Discussion 7:22 – 7:27**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required 7:27 – 7:28**
18.	**RECONVENE OPEN SESSION/REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**7:28 – 7:29**
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 7:29 – 7:30pm**

Upcoming FY19 Meetings: December 3, 2018 | February 4, 2019 | March 4, 2019 | April 1, 2019 | May 6, 2019 | June 3, 2019
Board/Committee Educational Gathering: April 24, 2019

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, October 1, 2018
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Katie Anderson	**Peter C. Fung, MD**
Ina Bauman	
Jeffrey Davis, MD	
Julie Kliger	
David Reeder, Chair	
Wendy Ron	
Melora Simon	

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:33pm by Chair Reeder. Ms. Anderson participated via teleconference. A verbal roll call was taken. Dr. Fung was absent and Ms. Ron arrived at 5:40pm during Agenda Item 6: FY19 Quality Dashboard. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	Chair Reeder asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. INTRODUCTIONS	Committee Members and staff present introduced themselves. Chair Reeder commented that, due to his upcoming departure from the Board, Ms. Kliger will be taking over as Chair of the Committee beginning in November. He also thanked the staff for all of their efforts supporting the Committee.	
4. CONSENT CALENDAR	Chair Reeder asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (August 6, 2018); Minutes of the Open Session of the Quality Committee Meeting (September 5, 2018); and for information: Patient Story; FY19 Pacing Plan; and Progress Against FY19 Committee Goals. **Movant:** Simon **Second:** Bauman **Ayes:** Anderson, Bauman, Davis, Kliger, Reeder, Simon **Noes:** None **Abstentions:** None **Absent:** Fung, Ron **Recused:** None	***Consent Calendar approved***
5. REPORT ON BOARD ACTIONS	Chair Reeder reviewed the Report on Board Actions as detailed in the packet.	
6. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the Quality Committee FY19 Dashboard, reporting CAUTIs are up 5%, no new CLABSIs, and 2 new cases of C. Diff. He also reported there has been a steady drop in the observed/expected mortality index since May. Dr. Adams noted the readmissions observed/expected index FYTD column should read n/a since the graph ends in June 2018 and later data is not yet available. He also explained that LOS has been trending well since March and was at target in	

	June and July, but there is a lot more work to do on ED Throughput because the organization is not near target yet. Both sepsis mortality rate and index are down since May. Dr. Davis commented that dealing with sepsis is so important and asked if this data gets to the front line staff and how it is discussed. Ms. Kliger commented that it is important to personalize the data and show staff how the work to decrease sepsis mortality applies to their work. In response, Catherine Carson, RN, Sr. Director, Quality Improvement and Patient Safety, commented that there are nurses on the Sepsis Committee (which meets monthly) and take this information back to the units. Cheryl Reinking, RN, CNO, reported that perhaps less than 100% of units are talking about sepsis. Ms. Bauman commented that the nursing staff is extremely busy and needs to be able to prioritize. Dr. Davis suggested taking advantage of educational forums already in place to avoid additional burden. Shreyas Mallur, MD, Associate CMO, commented that improvement in this area also requires physician education,	
7. MEDICAL STAFF CREDENTIALING PROCESS	Chair Reeder explained that the Committee's Charter provides for oversight of the Medical Staff Credentialing Process. Dr. Adams reviewed the entire process with the Committee as presented in the packet including the essential criteria for admission to the Medical Staff, verifications, references, background checks, and malpractice claims history. He explained that once a practitioner has satisfied requirements for admission to the Medical Staff, privileges or "what the practitioner can do" must also be approved. Board Certification in a specialty allows for core privileges to be granted, but if specialized privileges are requested further information and sometimes proctoring, is required. The Hospital provides ongoing professional practice evaluations (OPPEs) to each active member every 8 months that includes core competencies. The Committee discussed whether there is or should be a structural way to evaluate fitness and competency of aging physicians. Dr. Davis and Ms. Kliger suggested it would be good for the Committee to get anonymized data showing how medical quality is measured and more information about the core competencies.	
8. EMERGENCY DEPARTMENT SATISFACTION	Cheryl Reinking, RN, CNO, reported monthly data for ED Patient Satisfaction ranged from the 22nd percentile nationally in July 2017 to as high as the 81st percentile in May 2018. July and August 2018 were at the 43rd and 24th percentiles respectively. Ms. Reinking reported on improvement milestones and the emotional stressors ED patients face as well as staff interventions that can improve the patient experience.	
9. HOSPITAL UPDATE	Mark Adams, MD, CMO, answered questions from the Committee members about the hospital update.	
10. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:06pm. **Movant:** Ron **Second:** Simon **Ayes:** Anderson, Bauman, Davis, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Fung **Recused:** None	***Adjourned to closed session at 7:06pm.***
11. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:14pm. Agenda Items 11-16 were covered in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (August 6, 2018), the	

	Minutes of the Closed Session of the Quality Committee Meeting (September 5, 2018) and the Annual Safety Report by a unanimous vote of all members present, (Anderson, Bauman, Davis, Kliger, Reeder, Ron, Simon) Dr. Fung was absent.	
12. AGENDA ITEM 18: ADJOURNMENT	Chair Reeder adjourned the meeting at 7:15pm.	***Meeting adjourned at 7:15pm.***

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

_____

Julie Kliger
Chair, Quality Committee

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

FY-2018 Evaluation of the Environment of Care and Emergency Management Programs

with

Goals for FY-19

Prepared by:

Steve Weirauch
Manager, Environmental, Health & Safety

Matt Scannell
Director, Safety and Security

Created: 09/05/2018

Table of Contents

Executive Summary

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

Safety Management

- The safety program indicators showed an increase in the rate of all work-related injuries compared to FY-17. A significant number of reported injuries were due to a potential exposure and prophylactic treatment for staff.
- Patient handling injuries continued to decrease to the lowest recorded level. This was attributed to training and the use of safe patient handling equipment.
- Bloodborne pathogen exposures also increased with a significant rise in skin and mucous membrane exposures (splashes). This was attributed to staff not wearing personal protective equipment as required. Training and enforcement of procedures are being reviewed and the Sharps Safety Committee is being restarted.

Security Management

- The healthcare workplace violence prevention regulation adopted by Cal-OSHA in FY-17 had most elements taking effect FY-18. The hospital has all elements of the plan in place and continues to work to provide a safe environment for all staff. Training, risk assessments and the reporting of physical assaults to staff are ongoing.
- Code Gray events (aggressive or threatening person) also increased during the year. Contributing factors were determined to b:
  - Staff awareness to call for assistance early if patient appears threatening; a positive outcome to ensure staff safety.
  - Multiple incidents involving the same patient. A task force is developing procedures to address and minimize these events.

Hazardous Material Management

- No citations from the Santa Clara County Environmental Resources Agency
- No waste water violations
- One recordable hazardous materials incident – small chemo spill by patient

Fire Safety Management

- Two reported fire incidents.
  - Small fire in Los Gatos kitchen – minimal damage
  - Soffit lighting fire in Mountain View CT Scanner room. Minimal damage, room back in service the same day.

Utility Management

- Two reportable utility incidents – brief power outages

Emergency Management

- Nine events requiring the activation of the Hospital Incident Command System (HICS)
  - Power/Telecommunications outage in Mountain View
  - Power Outage in Mountain View (PG&E event)
  - Two patient surge events at the Mountain View campus
  - Mock Joint Commission Survey
  - CDPH General Acute Care and Medical Expense Reimbursement Plan (MERP) Licensing Survey
  - Fire in Imaging Services

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 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 2018. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

EC 1.0 - Safety Management *(Work Group Chair: **Mari Numanlia-Wone***

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 Prevention
- Security Management
- Environmental Services
- Facilities Services
- Patient Care Services
- Human Resources
- Radiation Safety

2. Performance

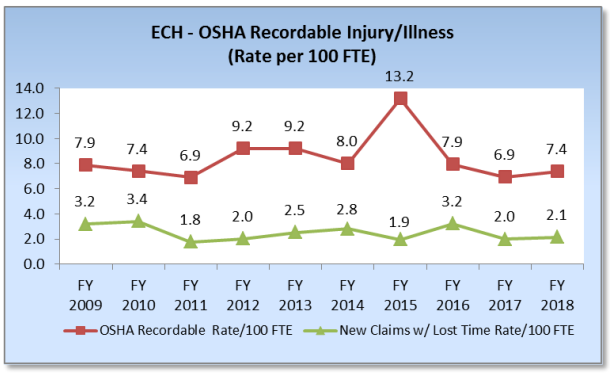
Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-18. 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 increased in FY-18 to 7.4 as compared to 6.9 in FY-17. The total *number* of recordable incidents decreased to 176 compared to 167 in FY-17.

The rate of injuries for lost work days for all open claims (per 100 FTEs) increased slightly to 2.1 in FY18 from 2.0 in FY-17.



Analysis

- It is important to note that 11 of the 176 OSHA recordable incidents were related to two unusual outliers. Possible exposure incidents required prophylactic treatment. These 11 cases had to be classified as OSHA recordable.
- 15 days of loss time were attributed to the unusual Brucella exposure mentioned above. These were lost days caused by adverse reactions to the prophylactic treatment; not the exposure itself.
- Injury Rates**:** The three largest injury type contributing to the Cal/OSHA recordable injury and illness rate were strains/sprains (40%), contusions (19%) followed by exposures needle sticks (14%).

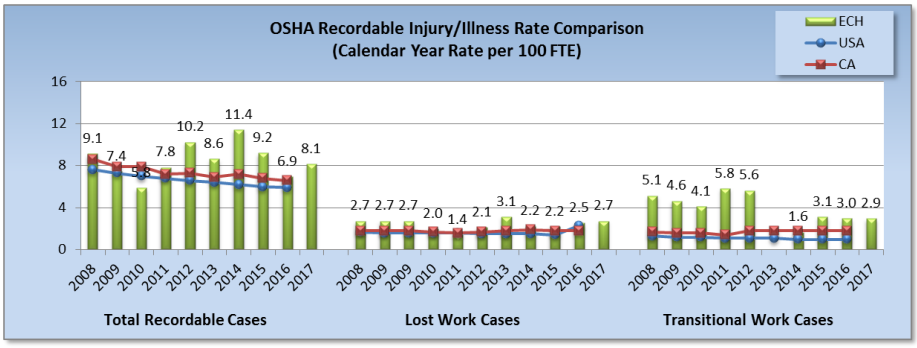
Improvement Strategies:

Improvement strategy for F/Y 19 is to expand the incident investigation and corrective action process. We have sought assistance from an outside consultant to review our "as is" process and help us develop a "future state" with the tools and resources we already have. The deliverable from this process will be a policy outline for incident investigation and action tracking.

- The consultant will conduct an interview with the El Camino Hospital Employee Wellness and Health department to get a better understanding of the current process for reporting injuries and tracking actions items to closure.
- The consultant will facilitate a working session with Employee Wellness and Health, Human Resources, Safety, Facilities/Engineering, Environmental Services, and Nursing Leadership to review current practices and develop a future state model for investigations and corrective action tracking that utilizes current systems and staffing available at El Camino.
- A discussion of best practices for incident investigation and action tracking, as well as a comparison of where El Camino Hospital programs stand against those practices
- Facilitated discussion and development of a process flow map that details how incident investigation and corrective action programs can be managed moving forward.
- Development of a policy outline that can be used to both document the process changes moving forward and serve as a backbone for future supervisor/manager training on incident investigation.

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[1].

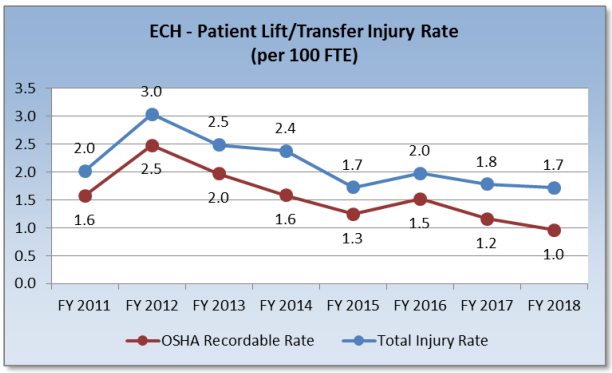


The injury/illness rate for the hospital exceeded the state and national averages in 2016 (the most recent year available from the BLS). However, El Camino Hospital actively utilizes a Transitional Work Assignment Program, showing a commitment to getting people back to work as quickly as possible after an injury or illness, exceeding both the national and California rates.

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

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis



- **Injury Rates**: The rate of OSHA recordable patient lift/transfer injuries per 100 FTEs **decreased to 1.0 in FY-18 compared with 1.2 in FY-17!** The overall rate of patient handling injuries also decreased from 1.8 in FY-17 to 1.7 in FY-18.

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

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

- **Lost Days due to Patient Handling Injuries:** There were a record low number of lost days incurred during FY-18; 40% fewer than in FY-17.

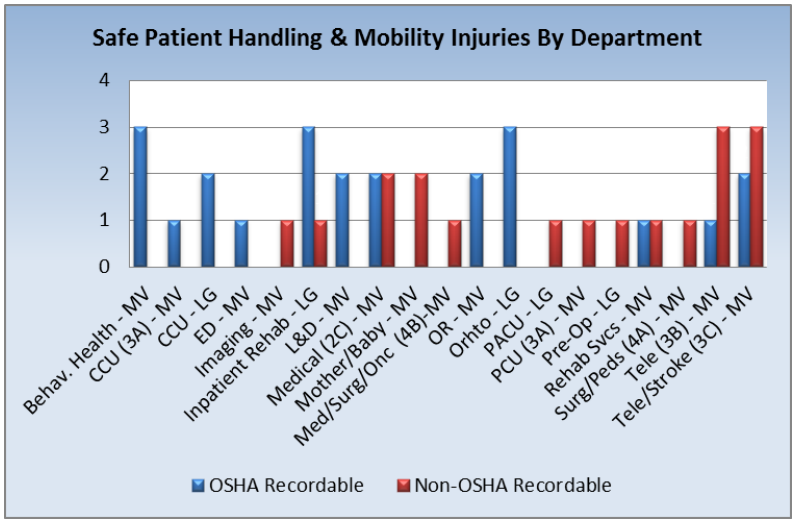
- **Injury Types:**

Activity	2015	2016	2017	2018
Repositioning Patients in Bed	12	12	12	16
Lateral Transfer *(assisting patient between bed and gurney)*	8	6	8	1
Combined Transfer *(assist patients between lying and sitting)*	6	8	6	5
Vertical Transfer *(assist patient between sitting and standing)*	5	12	5	3
Miscellaneous Patient Handling *(patient fall, car extraction)*	5	6	5	9
Cumulative Patient Handling	5	1	5	4
Patient Holding *(prevention of patient fall or lifting post-fall)*	2	3	2	3
Grand Total	43	48	43	41

  - There were a record low number of injuries resulting from lateral transfers (1 as compared to 8, 6 and 8 the last 3 years, respectively.) This is likely due to the adoption, availability and acceptance of HoverMats and pumps.
  - The rate of vertical transfers (7% of the total) continues to decline, with 3 in FY-18 as compared to 5, 12 and 5 during the prior 3 years. Use of the SARA Stedy Sit to Stand Lift continues to grow in popularity among staff, protecting both employees from injuries and patients from falls.
  - The Education department has been pivotal in organizing quarterly SPHM hands-on training opportunities with vendors visiting nursing departments, in addition to a fiscal year-end skills lab that includes PMAT training and a variety of equipment.

- Miscellaneous patient handling injuries are higher than previous years (9 in FY-18 as compared to 5, 6 and 5, respectively for the past three years) accounting for the second most common cause of injury. All have been the result of preventing/assisting a patient from falling or lifting post fall.
- Patient repositioning continues to be the most common injury cause, up to 39% of the total from 28, 25 and 32%, respectively.
- More than 50% of the injuries reported were with patients weighing over 90 kg (200 lbs.) and 17% (n=7) were over 136 kg (300 lbs.)
- The LG campus had proportionally more SPHM injuries reported this FY than last.

- **Injuries by Department**



Improvement strategies:

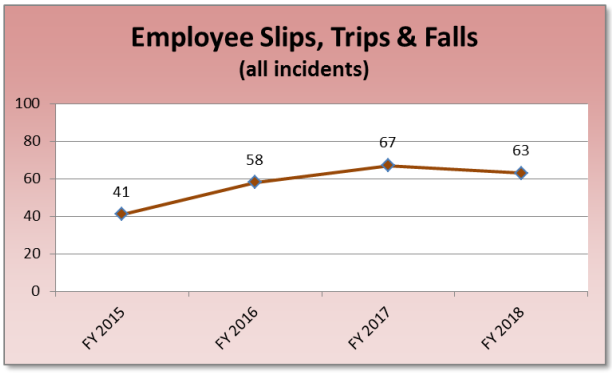
- A bariatric readiness task force has been established. A gap analysis, vetting and standardizing products, simplifying ordering/rentals, and increased education are under way.
- Encourage nursing staff to perform, communicate and document PMATs (Patient Mobility Assessment Tool) to assess patient safe mobilization and identify equipment needs for fall prevention. Documentation of the PMAT is not mandatory in iCare which leads to confusion as to compliance. EWHS is partnering with Nursing Education and iCare for a solution. Currently, the PMAT banner is pulled over from the prior admission in iCare, which may not be applicable for the current admission. A request has been submitted for resolution.
- A specially trained Physical Therapist has begun to meet with employees who suffered a SPHM injury to review practice and prevention strategies and encourage and promote use of lifting equipment.
- A trial partnership is planned with the highest incidence unit: Tele/CVA to discover opportunities for improvement.
- Incentives will be offered to employees who participate in SPHM educational offerings.
- Efforts to increase unit involvement in the SPHM committee and establish Unit Champion and Shift Peer Leader participation are under way.

- Additional Sara Stedys are recommended for the LG campus for accessibility so that units aren't sharing.
- The SPHM Committee plans to announce Quick Hit Safety Tips on a quarterly basis to share information and promote awareness.
- Renewed strategies to promote use of Repositioning Sheets in lieu of draw sheets for patient repositioning are planned.
- Further analysis is needed regarding the proportionately higher number of injuries reported in Los Gatos. The representation and involvement of Unit Champions is robust and growing; however, the Los Gatos facility is not equipped with overhead lifts and locations for storage of equipment are very limited. Therefore, it is necessary for units to share equipment and/or staff to have to travel farther to obtain equipment.
- Partnership established among the Patient Falls, SPHM and Slip, Trip, Falls Prevention committees to coordinate prevention resources.
- An air-assist, portable sit-to-stand aid will be evaluated by the SPHM committee for consideration for patient use post-fall.

D. Slips, Trips, Falls Injuries

Analysis

- **Injury Rates**: The number of slips, trips and falls in the hospital has risen dramatically hint he last four years. A renewed effort in understanding and preventing these injuries is underway.



- **Injury Types:**

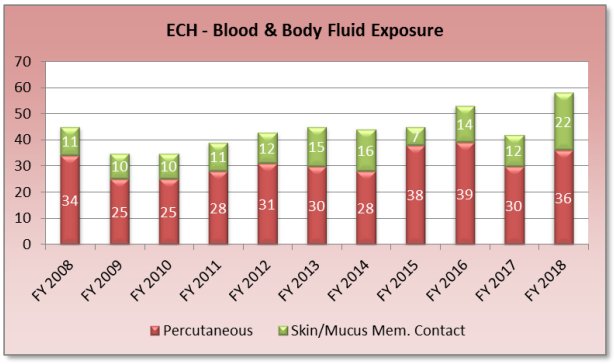
Activity	2018
Injury occurred outside of buildings	18
Injury occurred due to contaminant and/or slippery floor	19
Injury occurred due to cords or tubing, bodily reactions, surface irregularities, or items in path	6
Falling from a chair or stool	5
Involving steps or handrails	4
Other *(e.g., tripping on carpeting, lighting, etc.)*	11

Improvement Strategies:

- **Task force** meeting monthly, to investigate all accidents. Manager of each department reporting an injury is encouraged to attend to review the cause and strategize prevention efforts.
- Initiatives and awareness campaigns
- Partnering with consultant to improve investigation process
- Exterior grounds inspections in partnership with Facilities to improve lighting, landscape and stair safety
- Implementing the use of cord clamps in patient rooms to keep cords and tubing from being a trip hazard.

E. Bloodborne Pathogen Exposures

The rate of Blood borne pathogen exposures per 100 FTE increased significantly to 2.4 in FY-18 compared to 1.7 in FY-17. The total number of exposures for both campuses increased to 58 exposures in FY-18 compared to 42 in FY-17. Of these, 36 were percutaneous exposures and 22 were body fluid exposures due to splashes. The amount of exposure due to splashes nearly doubled in FY-18 compared to FY-17.



We have seen a trend with subcutaneous injections and failing to activate the safety device.

Analysis:

- 45% 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
- 21% of exposures were caused by agitated or involuntary movement of patients (unsafe action by others).
- Bloodborne Pathogen Needle Stick/Sharp by Job Type

Job Title	# exposure
Certified Nursing Assistant (CNA)	1
Environmental Services (EVS)	2
Phlebotomist	3
Registered Nurse (RN)	19
Respiratory Therapist (RT)	1
Technician	10
Total	**36**

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 re-establishing a multidisciplinary Sharps Safety Committee or Task Force as it is estimated that 80% of all exposures from sharps and needle-sticks are preventable.

F. TB Conversions

There were no known occupational exposure conversions at either campus during FY-18.

G. Safety Training Indicators

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

- New employee orientation: 100% (Target: 100%)
- Life Safety - Non-Clinical: 92.8% (Target: 95%)
- Life Safety - Clinical: 95.0% (Target: 95%)

H. Safety Inspections

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

The most noted problems in FY-18 involved:

- Damaged or stained ceiling tiles
- Damaged walls
- Isolation and Crash carts stocked and clean (tops of crash carts were dusty)
- Improper use of outlet strips (one power strip plugged into another)
- 18" vertical clearance to fire sprinkler heads
- Improper storage of clean linen (not in closed cart or cabinet)
- Electrical panels not locked

I. Environmental Monitoring

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

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

3. Effectiveness

Key indicators were identified to establish goals for FY-18 with opportunities to improve Safety Management within the Environment of Care.

FY 18 Goals

1) Implement a tracking mechanism for all staff safety hazards and risk found as a result of the Injury Investigation Process

   Measurement of success: 100% of staff work-related hazards and risks identified will be ranked by priority.

   This goal was not accomplished. We looked at how we can effectively rank 100% of staff work related hazards and risks identified by priority. There were two barriers identified:
   - ✓ The current home grown system we use to report work related injuries and managers' investigation (AIER) does not provide a way to efficiently rank risks identified by priority.
   - ✓ Managers/Supervisors injury investigation completion rate and quality is not optimal

2) Documentation and tracking of actual and proposed control for hazards and risks identified as a result of the Injury Investigation Process

   Measurement of success: 100% of hazards and risks identified proposed or actual controls will be documented.

   This goal was not accomplished. We documented around 5% of proposed and actual controls identified for the F/Y 18. The two barriers mentioned above apply to this goal. The systems and processes currently in place do not provide a pathway to document proposed corrective actions of risks identified. We started using the AIER system Employee Health notes section to document some of the corrective actions. This is not ideal as EWHS are the only ones who have access to this section.

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

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

EC 2.0 - Security Management *(Work Group Chair: **Matt Scannell**)*

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

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

Plan Element: Written Plan	**Status: COMPLETED**
• The written plan has been completed and approved. • The plan requires annual review / update by the Security Management Work Group	

Plan Element: Response: Investigate violent incidents	**Status: ONGOING**
• This is being completed through the Security Management Work Group.	

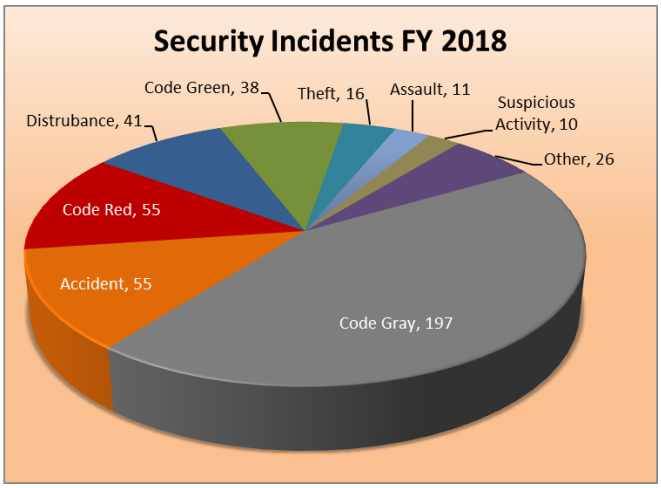
Plan Element:	**Training (annual)**	**Status: ONGOING**
• Hospital has developed two levels of training. 1. AVADE – Computer based training module assigned to most staff. 2. Nonviolent Crisis Intervention (NCI) training – module and classroom assigned to employees working in departments considered "High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

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

- An ongoing WPV Reporting team is ensures reporting is completed as required.
- In FY-18, 61 incidents were reported to OSHA.
  - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
- 78% (48 incidents resulted in no injury. The remaining events were minor injuries (bruised, soreness, scratches). No major injuries were reported.

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-18. The data includes activity from both campuses.



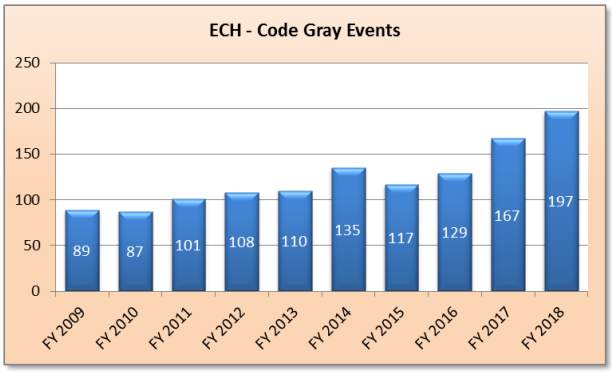
There were a total of 449 reported security incidents for FY-18 requiring immediate response. This is an increase from FY-17 total of 423.

Review of the major FY-18 incidents showed:

- Code Gray (Angry or Violent Person) remained the most frequent incident at 44% of the total. This was an 18% increase over FY-17.
- Code Red and Accidents each accounted for 12% of the total (55 events each). Neither of these had any discernible trends or patterns.

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY-18 was 196 compared to 168 in FY-17.



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

- MV Telemetry/Stroke (3C) – 17%
- MV Critical Care Unit (CCU) – 15%
- MV Emergency Department (ED) – 15%

Responses are tracked and monitored to help identify possible improvements to the process.

Contributing factors to this increase have been attributed to

- Increased staff awareness to call for assistance earlier if they feel threatened.
- An increase in the number of incidents involving the same patient often cause by a lack of pass down between shifts or transfers of past behaviors by the patient. A task force is developing new procedures to address these issues.

The Hospital utilizes the **Non-violent Crisis Intervention® (NCI)** training program for all staff who deal with angry or agitated persons. This training is part of the Workplace Violence Prevention program and is required for staff in designated High-Risk areas - Behavioral Health, ED, Security, Facilities Engineering and Hospital Supervisors. Staff in other departments are also encouraged to take this training as an optional course.

B. Bulletins, Alerts & Presentations

Security Services issued 5 personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

C. Patient Belongings

Security Officers performed 4,369 chain-of-custody transactions involving patient's belongings.

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

Security Officers performed 965 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. 5 fire watches were performed.

F. General Assistance

Security Officers performed 93,783 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 2,128 'Dual-sided' Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 1,768temp badges were issued.

H. Investigations & Audits

Security Services performed 37 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 12,666 (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 221 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 529 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 165 vehicle-related services including jump-starts, door unlocks and tows. 914 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 75 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[4] (Source: 2017 MVPD Annual Report)

City of Mountain View

Square Miles: 12
Population:.....80,447 (County of Santa Clara 1,938,153)
Personnel: .....Total 145 (90 Sworn vs. 55 Non-Sworn)
Beat No.1: .....6,963 number of dispatched calls, includes El Camino Hospital

Statistics *UCR data includes attempts and actual crimes*

Part I UCR: .....Total 2164 (1976 Property vs. 188 Violent)
Previous Year .....Total 1914 (1781 Property vs. 133 Violent)

Part II UCR: .....Total 2800
Previous Year .....Total 2716

Arrests-Misdemeanor: .....Total 1553 (1465 Adult vs. 88 Juvenile)
Previous Year .....Total 1473 (1376 Adult vs. 97 Juvenile)

Arrests-Felony: .....Total 375 (353 Adult vs. 22 Juvenile)
Previous Year .....Total 306 (284 Adult vs. 22 Juvenile)

Traffic Collisions: .....Total 610
Previous Year .....Total 498

Moving Violations: .....Total 1827
Previous Year .....Total 2853

Non-Moving Violations: Total 2199
Previous Year .....Total 3232

Indexes *Per 1,000 current year population*

Violent:.....2.01
Previous Year 1.69
Violent Crime Index includes Criminal Homicide, Forcible Rape, Aggravated Assault, and Robbery

Property: 23.35
Previous Year 22.79
Property Crime Index includes Burglary, Larceny, Motor Vehicle Theft, and Arson

4. Effectiveness

Key indicators were identified to establish goals for FY-18 with opportunities to improve Security Management within the Environment of Care.

FY 18 Goals

1) >90% non-medical emergency security response time less than 3 minutes

[4] Los Gatos Police Department data and crime statistics not available

This goal was accomplished.

2) Create at minimum 4 Security Awareness Pamphlets/Alert Bulletins
This goal was accomplished.

FY19 Goals

1) 90% non-medical emergency security response time less than 3 minutes
2) 20% reduction in number of reportable workplace violence incidents

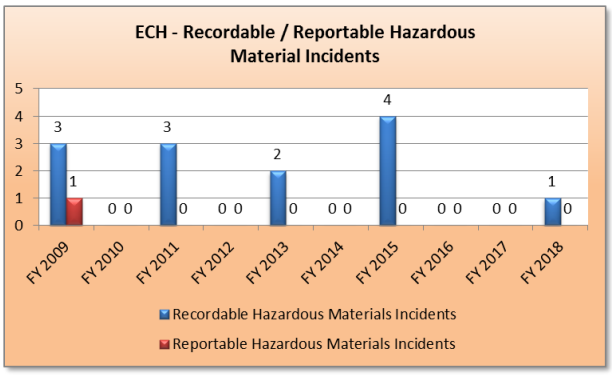
EC 3.0 - Hazardous Materials & Waste Management *(Work Group Chair: **Lorna Koep**)*

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.



- **Recordable Hazardous Material Incidents**[5] – 1 recordable spill. A chemo patient pulled out IV while attempting to use restroom. Cleanup handled safely.
- **Reportable Hazardous Material Incidents**[3] – No recordable spills.

B. Waste Water Discharge Violations – No waste water discharge violations in FY-18.

C. Monitoring and Inspecting

- **Hazardous Waste Inspections**-No Inspections for FY 18
- **Santa Clara County Annual Medical Waste Inspections**
  - **Los Gatos**: December 21, 2018
    - Three minor issues identified. All were corrected and accepted on the date of the inspection
      1) Laboratory and Phlebotomy: An inappropriate container was supplied with a phlebotomist service cart for containing sharps waste. According to the laboratory manager, the unit was not in use and will be dismantled because the carrying unit for the sharps container was unable to support the current sharps container type.
      2) L&D OR: A cleaned, disinfected and readied operating room in the labor and delivery department was observed containing paper and plastic waste in the lined medical waste hamper unit used during a procedure. No waste should be in this lined medical waste receiving container except during a procedure. Utilized a proper secondary red bag waste container with a tight-fitting lid for medical waste. Condition was corrected during the inspection and was discussed with the Department Manager and Infection Control personnel

[5] 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.

3) Bio-Cage: An empty Stericycle reusable pharmaceutical waste container interior was found wet including the absorbent pad lined at the bottom. The hospital was instructed to reline the container with a new absorbent pad. According to facility staff, it was a new container from Stericycle and may not have been thoroughly dry after the cleaning process or was accidentally gotten wet during transport to the facility.

- **Mountain View**: March 7, 2018
  - Two minor issues identified. All were corrected and accepted on the date of the inspection
    1) Laboratory and Pathology: Tabletop red bag containers must be leak resistant, have tight fitting covers, be kept clean and in good repair. Containers may be of any color and shall be labeled with the words "biohazardous waste" or with the international biohazard symbol and be visible on all lateral sides. A few containers were found without lids or a red bag liner. Overfilled secondary container in OR staging area – corrected immediately.
    2) Bio-Cage: Observed one full recyclable pharmaceutical container found on its side with leaked fluid material evident. Condition was corrected and properly cleaned up immediately. Make certain containers are secure and properly lidded during storage in the biohazardous accumulation area prior to locking the site.

- 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. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[6] training course.

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

[6] HAZWOPER: Hazardous Waste Operations and Emergency Response

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.
   - ***This goal was accomplished.*** It was estimated that there was a 26% reduction in Xylene usage during the last half of FY-18 when compared to the same period in FY-17.

     From January through June in FY-17, 134 cases of xylene were ordered. During the same period in FY-18, the quantity was reduced to 92 cases. This period in FY-18 saw a slight increase (1.4%) in the number of samples processed, so taking that into account, the calculations show a 26% reduction in Xylene use.

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
   - ***This goal was partially accomplished.*** The revised guides were created and approved. Training for staff will be conducted in early FY-19.

FY-19 Performance Improvement Indicators:

1) Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15) minutes
   - **Measurement of success**: >90% of staff know procedure. Data will be collected through Safety Rounds

2) Staff know how to access and print safety data sheets.
   - **Measurement of success**: >90% of staff know procedure. Data will be collected through Safety Rounds

EC 4.0 - Fire Safety Management *(Work Group Chair: **John Folk**)*

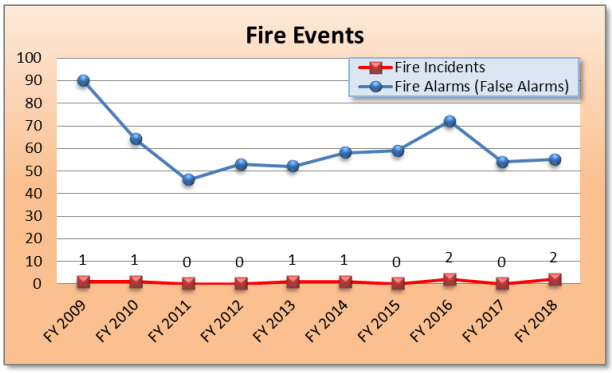
1. Scope

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-18.

- **Fire Incidents**
  There were 2 reported fire incidents in FY-18.
  - January – a small fire was reported in the kitchen area in Los Gatos.
  - May – a fire occurred in the Imaging CT Scanner room in Mountain View. A soffit light overheated and burned the plastic lens. Fire was quickly extinguished and room was back in operation later the same day.



- **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-18 (56) remained relatively flat compared to FY-17 (54). This was accomplished despite heavy construction activity during FY-18.

- Fire Drills Completed / Scheduled

  All required fire drills (total of 111) were completed in FY-18. 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-18. The following goals presented a number of opportunities to improve fire prevention management within the Environment of Care.

FY 18 Goals

1) Complete a life safety assessment to compliance with NFPA 101-2012 in Mountain View and Los Gatos.

   This goal was accomplished. The results of the assessment are being prioritized by the facilities team and the completion of any deficiencies is being monitored by the Central Safety Committee.

2) Certify identified Engineers to obtain their fire pump certification

   This goal was accomplished. *One Engineer was certified in FY 2018 which meets the compliance requirements and there are plans to increase this number in early FY 2019.*

3) Certify fire doors in Hospital and associated outpatient clinics as applicable.

   This goal was accomplished. The assessments have been completed for both Los Gatos and Mountain View Hospital buildings. Ongoing monitoring of this process is being done by the Central Safety Committee.

FY 19 Goals

1) Educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new IMOB and BHS buildings.
2) Identified supervisory staff will attend NFPA code classes to further their knowledge and applications of fire safety codes.
3) Develop an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.
4) Increase oversight an improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities.

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-18.

- Reports to the FDA - There were nine reports through the Medwatch[7] system in FY-17. There were no patient deaths associated with any of the reports. The reports included:
  1) St. Jude Advisor catheter became twisted and stuck upon itself lengthening procedure while physician worked to untwist the catheter. Reported as potential device design failure. No harm to patient.
  2) MRI screening revealed Paraguard IUD –patient reported pelvic discomfort when placed into 1.5 Espree MRI unit. Unsure if device is MRI safe as literature reports.
  3) GlideScope not booting up during code; intubation accomplished without device.
  4) Siemens Radiology equipment during Neuro interventional case—tech support assisted to finish case without harm to the patient.
  5) IABP battery failures—reported to vendor; batteries assessed and more education and training provided to staff.
  6) Prismaflex system—defective scale calibration—no harm to the patient
  7) Da Vinci Robot—small piece of the tip of the XI robotic instrument long bipolar grasper broke off; retrieved without patient harm, near miss.
  8) Smiths Medical Level I rapid infuser with door malfunction / sensing—door assembly loose and not all blood transfused during massive transfusion protocol
  9) BT Controller RF (Boston Scientific) malfunction during bronchiothermaplasty. Alair catheter gave red flashing light despite checking all connections and grounding process. Controller unit had to be removed from service. Delay in patient care.
  10) Battery failure on Airvo transport respiratory device on three separate occasions
  11) Respironic Lumix TX respirator providing NPPV to patient abruptly shut off—no harm to patient

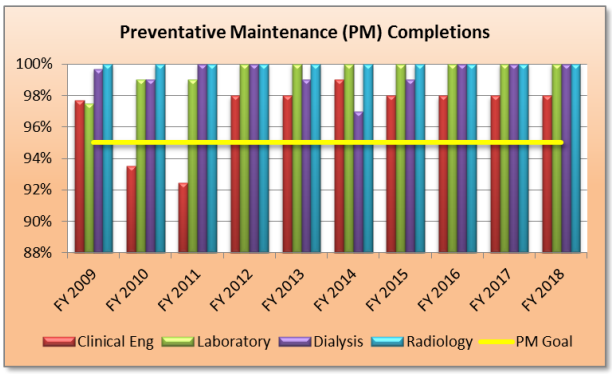
[7] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

12) Ethicon Synthetic Absorbable Suture found to have needle severed or bent during various surgical cases--needle retrieved from irrigation pouch with tip snapped off

13) Argon Plasma Coagulator—ERBE APC—screen powered down twice in the middle of the procedure—taken out of service; no harm to the patient.

- 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% for FY-18.
  - All high risk, life safety equipment was maintained at 100% completion rates



- Product Recalls Percentage Closed / Received.

  For FY-18, there were 86 recorded product recalls; all have been closed.

3. Effectiveness

Key indicators were targeted to established goals for FY-18. The following goals presented a number of opportunities to improve Medical Equipment Management within the Environment of Care.

FY 18 Goals

1) Ensure all medical equipment is segregated from other networked devices for system security.

   This goal was accomplished. Clinical Engineering met with Information Security on a weekly basis to work towards the segmentation of all medical equipment. Wireless segmentation was accomplished in working with Information Security and Network. A procedure was developed using HITRUST to ensure proper authorization approval was followed in ensuring the segmentation of the wireless Medical Equipment remains.

2) Implement a process and timeline to upgrade Windows XP systems to Windows 7 compatibility.

   This goal was accomplished. Clinical Engineering worked in collaboration with Information Security's application Nexpose to run vulnerability scans on all networked medical equipment. Clinical Engineering worked closely with Clinical Management to ensure medical equipment that had an Operating System upgrade available was properly budgeted and downtime scheduled during upgrades.

FY 19 Goals

1) Medical Equipment wired segmentation.
2) Develop risk assessment for onboarding medical equipment.

2019 Performance Indicator Addition (Monitoring and Inspection)

Performance Improvement Indicator	Target
Staff knowledge: Staff know how to contact Clinical Engineering should a piece of equipment malfunction	>/=90%
Staff can describe the proper way to replace or to request accessories: as an example BP Cuffs, Lead sets, etc…	>90%

EC 6.0 - Utilities Management *(Work Group Chair: **Nick Stoliar**)*

1. Scope

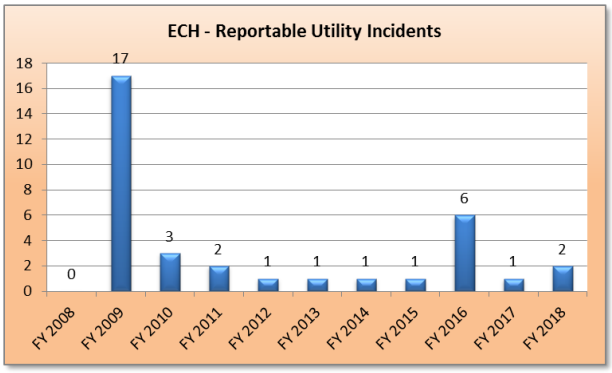
The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities 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-18.

- **Utility Reportable Incidents**

  There were 2 reportable incidents in FY-18. Both were power outages in September.



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

  The Utility Systems PM completion rate was 89%, 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.

3. Effectiveness

Key indicators were targeted to establish goals for FY-18. The following goals presented opportunities to improve Utility Management within the Environment of Care.

FY 18 Goals

1) Installation of new chiller in Mountain View

   This goal was accomplished. This was completed in first quarter of FY 2019

2) Complete the Operating Room electrical distribution upgrades in Los Gatos

   This goal was accomplished. This goal was completed in the 2nd quarter of FY 2018

3) Update battery replacement cycles for UPS systems to three years cycles

   This goal was accomplished. This goal was completed in FY 2018

4) Upgrade Mountain View boiler exhaust to accommodate source testing process

   This goal was accomplished. This goal was completed in 3rd quarter of FY 2018

5) Upgrade pneumatic tube system controls in Mountain View

   This goal was accomplished. This goal was completed in the 4th quarter FY 2018.

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-19 due to their criticality and the level of Construction activities.

Also, in FY-18, 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.

FY 19 Goals

1) Educate all Engineering staff on new utility systems, connections and equipment as it relates to the new IMOB and BHS.
2) Continue to monitor and ensure contractor access controls to sensitive Engineering areas.
3) Develop a periodic equipment replacement or renovation plan for both Mountain View and Los Gatos.

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; and in FY-19, the work group will become a separate committee from Central Safety.

2. Performance

Performance indicators for the Emergency Management program were reported monthly to the Central Safety Committee in the Safety Trends Report. Going forward in FY-19, the Emergency Management Committee will report significant events to Central Safety on a quarterly basis. The following Emergency Management indicators were reported in FY-18.

A. Events / Emergencies

There were nine recorded events and/or emergencies during FY-18 requiring activation of the Hospital Incident Command System (HICS).

1. **Power / Telecommunications Outage – Mountain View (07/20/2017)** – Construction work cut data fiber, data copper, and UPS electrical lines feeding Women's Hospital and Oak Pavilion. A command center was opened to handle issues. Lines were restored by 2:30 AM on 07/21.
2. **Power outage – Mountain View (09/18/2017)** – The outage occurred at approximately 12:30 PM on the PG&E grid. Hospital generators operated as designed. A limited command center was opened to handle disruptions to buildings not on the generators. Cedar Pavilion, 125 South Drive were closed for the day. Power was restored by 2:30 PM.
3. **Patient Surge – Mountain View (01/10/2018)** – 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 at 07:00. A coordinated effort by the staff and use of the surge plans enabled the hospital to continue operations and meet the needs of our patients. The HCC was operational during day-shift hours until 11:30 AM on 01/11/2018.
4. **Patient Surge – Mountain View (02/06/2018)** – A surge in patients needing care necessitated the opening of the HCC Mountain View. Staff were able to provide care to patients and this HCC was closed at 02:15 PM.
5. **Mock Joint Commission Survey – Enterprise (02/06-2018)** – A command center was opened to coordinate a mock joint commission survey initiated to help us prepare for the actual survey later in the year.
6. **CDPH General Acute Care and Medical Expense Reimbursement Plan (MERP) Licensing Survey – Enterprise (04/11/2018)** - arrival of the CDPH for a re-licensing survey prompted the opening of the HCC to coordinate the survey. The HCC was activated for three days.
7. **Fire in Imaging Services – Mountain View (05/11/2018) –** A fire in soffit lighting occurred at approximately 4:10 PM in one of the CT scanner rooms. The fire was quickly extinguished and the responding team was able to handle the situation and cleanup. The room was re-opened for operations at 11:00 PM that evening.

8. **Code Silver – Mountain View (05/27/2018)** – A patient was observed with a gun in the MV ED. The patient was not threatening. The MVPD was called and responded.
9. **Social Media Posting – Los Gatos (06/12/2018)** – A social media posting by the family of a patient went viral creating a backlash to the hospital. A command team was initiated to respond to the situation.

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-18, this requirement was met through the Statewide Medical & Health Exercise in November, 2017 (see below), actual HCC activations due to Mountain View patient surges in January, 2018 and a spring exercise in June. These are also summarized below.
    a. **Statewide Medical & Health Exercise (November 16, 2017):** Both campuses participated in the statewide exercise. The scenario involved three major terrorist incidents at different points throughout Santa Clara County resulting in facility lockdowns and mass casualties/fatalities. Caring for victims and the security of the facility provided challenges to both campuses.
    b. **Santa Clara Valley Emergency Preparedness Healthcare Coalition (SCVEPHC) Wildfire Tabletop Exercise (June 11, 2018):** A tabletop exercise was conducted in the Mountain View 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. **Santa Clara Valley Emergency Preparedness Healthcare Coalition (SCVEPHC) Wildfire Functional Exercise (June 11, 2018):** A functional exercise and tabletop discussion was conducted in the Los Gatos Hospital Command Center involving the full evacuation of the hospital. The HICS team developed plans and provided all documentation required to safely evacuate the hospital.
- **Code Pink Drills (Los Gatos: 6/28/2018; Mountain View: 6/29/2018)** – Exercises were conducted at both campuses to test staff's ability to respond to an infant security band alert.
- **Decontamination Team Training (April & May, 2018) -** Training and functional exercises were held several times to train and test the ED staff and decontamination teams on proper response to the arrival of contaminated patients to the hospital.

C. Emergency Management Training

- New hire orientation (100% for all employees)
- Safety coordinator meetings (48% 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.
- Seven decontamination training exercises were conducted (5 in Mountain View and 2 in Los Gatos). 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 chair of the SCC-EPHC 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 no changes to the HVAs at both campuses in FY-18. 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-18. The following goals presented opportunities to improve emergency management.

FY-18 Goals

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

   This goal was accomplished. A Workplace Violence Prevention Task Force was convened to assist with the creation and implementation of the plan for El Camino Hospital. The task force completed its mission and was dissolved in June. The Security Management Work Group is responsible for plan maintenance and revisions. There were four elements of the plan addressed.

   1) A written Workplace Violence Prevention Plan was drafted and approved.

   2) Training programs were created and assigned to staff. This includes a computer-based module for the majority of staff and a continuation of the Nonviolent Crisis Intervention training for staff in positions determined to be high-risk (greater likelihood of interacting with potentially violent or aggressive persons).

3) The hospital has been reporting all incidents of physical assault on staff to OSHA are required in the regulations. The hospital has taken a conservative approach to reporting and is reporting all incidents regardless of whether an injury occurred or not. In FY-18, we reported 61 incidents (43 of these did not result in injury to the staff, and none of the injuries were reported as serious).

4) Workplace Violence Assessments – assessments were conducted by most departments noting unique concerns and challenges for providing a safe environment. Improvements based on these assessments are still being evaluated and implemented.

2. Replace Breathe-Easy PAPRs used for Decontamination training with Versaflo units.

   This goal was accomplished. The Powered, Air-Purifying Respirators (PAPRs) in Mountain View were replaced with the 3M Versaflo units. Training was completed for all Decon Team members during the annual training/drills.

3. Begin phase-in of new Med Sleds for evacuations

   This goal was accomplished. The first supply of Med Sleds was purchased using HPP Grant Funding. The units have been deployed in Mountain View, replacing the old litters and chairs. Awareness training is being completed for staff in departmental skills day that will continue in FY-19. Additional units for Los Gatos and Mountain View will be purchased in FY-19 utilizing additional HPP Grant funds.

FY-19 Goals

1. Continue the replacement of Evacuation litters and chairs with Med Sleds at in Los Gatos and other buildings, as needed.
2. Expand the use of mass notification system (Everbridge)
   a. Investigate adding users to system to notify more staff of events
   b. Train key staff to be able to use/send alerts

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 13	FY 14	FY 15	FY 16	FY 17	FY 18
E.C. 1.0 - SAFETY MANAGEMENT							
Employee Safety							
1.	Total Injury/Illness Incident Reports	349	458	618	428	470	411
2.	OSHA Recordable Injury/Illness (Total)	173	171	306	193	164	176
	a. Lost Time	59	61	38	78	45	51
	b. No Lost Time	114	110	268	113	119	125
3.	Repetitive Motion Injury- Computer, keyboard, Mouse, Light Pen	12	14	5	19	17	10
4.	Repetitive Motion Injury (RMI) - Non-Computer	7	2	19	9	14	9
5.	Patient Lift/Transfer Injuries (OSHA Recordable)	33	36	27	37	28	23
6.	Patient Lift/Transfer Injuries	42	54	37	48	43	41
7.	Trip/Slip/Fall	43	50	41	58	67	63
8.	Staff Assaults by Patients	N/A	25	17	15	28	39
Infection Control							
1.	Blood & Body Fluid Exp.	45	44	45	53	42	58
	a. Percutaneous	30	28	38	39	30	36
	b. Skin/Mucus Membrane Contact	15	16	7	14	12	22
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	96%	99%	98%
E.C. 2.0 - SECURITY MANAGEMENT							
1.	Code Grey Incidents	110	135	117	129	167	197
2.	Other Security Incidents	127	158	178	324	270	252
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT							
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	2	0	4	0	0	1
3.	Waste Water Discharge Violations	0	0	0	0	0	0
4.	Eyewash Inspections	N/A	N/A	N/A	100%	100%	100%
5.	Eyewash Corrective Actions comp/assigned	N/A	N/A	N/A	86%	85%	80%
E.C. 4.0 FIRE PREVENTION MANAGEMENT							
1.	Fire Incidents -Actual	1	1	0	2	0	2
2.	Fire Alarm Events	52	58	59	72	54	55
3.	Fire Watches (New in FY-14)	N/A	4	2	8	21	5
4.	Fire Drills comp/scheduled	100%	97%	100%	100%	103%	103%
5.	Interim Life Safety Measures (ILSM) Tracking	N/A	94%	100%	100%	100%	100%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT							
1.	Reports to FDA	11	2	6	3	6	15
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	99%	99%	99%	100%	100%	100%
	d. Radiology	100%	100%	100%	100%	100%	100%
3.	Product Recalls % (Closed/rec'd)	95%	98%	88%	78%	95%	82%
E.C. 6.0 - UTILITIES MANAGEMENT							
1.	Utility Reportable Incidents	0	1	1	6	1	2
2.	PM Completion Rate % completed/scheduled	84%	92.7%	90.9%	97%	90%	89%
3.	Generator test % completed/scheduled	100%	100%	100%	100	100	100%
E.M. EMERGENCY MANAGEMENT							
1.	Drills, Internal & External	56	14	75	35	42	7
2.	Natural Disaster/Actual Event (Hospital Command Center Opened)	2	0	2	4	4	8

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. 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.
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 event that requires the activation of HICS and opening a Hospital Command Center (HCC).

To whom it may concern,

I'm writing this email because I feel a member of your staff deserves recognition for her work here at ECLG. I was admitted on [redacted] for a C-section with my 2nd son. The evening of [redacted] my son ended up in the NICU because of some breathing problems he was having. You can imagine the stress and anxiety I was feeling not knowing what was going on with my child. The only thing that kept me sane during this time was knowing that my child was in the best care possible because his nurse was Dawn Straughn.

Dawn is an angel sent from above, and I will never be able to truly express my gratitude to her. She took care of my son as if he was her own. You can see that Dawn isn't just a nurse to earn a paycheck, but she genuinely cares about each child and their families. She is compassionate, kind, patient, and has a heart made of gold. She made my husband and I comfortable, and explained everything in a way we would understand. When I would go back to my room, I was able to rest knowing my son was safe and in the best care possible.

Dawn is a huge asset to ECLG and my family will be eternally grateful for her. There is truly nothing I will ever be able to do to truly pay her back for everything she has done for us. Dawn thank you a million times for everything. Thank you for giving my son the best care and loving him as your own. You will always hold a special place in our hearts and in our family.

Sincerely,
[redacted], mother of [redacted]

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY19 Pacing Plan

FY2019 Q1		
JULY 2018	**AUGUST 6, 2018**	**SEPTEMBER 5, 2018**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Patient Story ▪ Progress Against FY 2019 Committee Goals (Nov 5, March 4, June 3) ▪ FY19 Pacing Plan ▪ Med Staff Quality Council Minutes	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY18 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 1. FY18 Quality Dashboard Results 2. Approve Committee Charter 3. Culture of Safety Discussion 4. LEAN Progress Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 7. Update on Patient and Family Centered Care 8. Mortality and Readmissions Metrics (FY19 Quality Goals) 9. Annual Patient Safety Report 10. FY18 Quality Dashboard Final Results 11. Pt. Experience (HCAHPS) 12. ED Pt. Satisfaction (Press Ganey)
FY2018 Q2		
OCTOBER 1, 2018	**NOVEMBER 5, 2018**	**DECEMBER 3, 2018**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: ~~1. Pt. Experience (HCAHPS)~~ 2. ED Pt. Satisfaction 3. Medical Staff Credentialing Process Update	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Safety Report for the Environment of Care 4. Quarterly Quality and Safety Review 5. Performance Improvement with Physician Management	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Culture of Safety Survey Report (Include OR)

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY19 Pacing Plan

FY2019 Q3		
JANUARY 2019	**FEBRUARY 4, 2019**	**MARCH 4, 2019**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Quarterly Quality and Safety Review 2. Physician Survey Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Proposed FY20 Committee Goals 4. Proposed FY20 Organizational Goals
FY2019 Q4		
APRIL 1, 2019	**MAY 6, 2019**	**JUNE 3, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Leapfrog Survey 2. Value Base Purchasing Report 3. Pt. Experience (HCAHPS) 4. ED Pt. Satisfaction (Press Ganey) 5. Approve FY20 Committee Goals 6. Proposed FY20 Committee Meeting Dates 7. Proposed FY20 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Approve FY20 Committee Goals (if needed) 4. Proposed FY20 Organizational Goals 5. Proposed FY20 Pacing Plan 6. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Approve FY20 Pacing Plan

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY18 Achievement and Metrics for FY19 (Q1 FY19) - FY20 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board – reviewed FY18 results on 9/5/18; FY20 goals review paced for 3/4/19
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) N/A - Review Medical Staff credentialing process (FY19) – COMPLETE - reviewed at 10/1/2018 meeting
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY19 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline – on track
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – paced quarterly
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals – on the FY19 dashboard

SUBMITTED BY:

Chair: David Reeder
Executive Sponsor: Mark Adams, MD, CMO
Approved by the El Camino Hospital Board on June 13, 2018

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality, Patient Care and Patient Experience Committee November 5, 2018
	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 a verbal report by the Chair of the Committee and/or Board members who also serve on the Committee.	
	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: 1. Report on October 2018 ECH and ECHD Board Actions	

ECH Board Actions*

1. October 10, 2018
    a. Approved FY19 Period 2 Financials
    b. Approved FY18 Financial Audit
    c. Approved FY18 Annual 430(b) Retirement Plan and Cash Balance Retirement Plan Audits
    d. Approved Appointment of Robin Driscoll to the El Camino Hospital Foundation Board of Directors
    e. Approved Revised Executive Benefit Plan Policy (Life Insurance and Eligibility Date Provisions)
    f. Approved Purchase of Los Gatos Imaging Equipment (O-Arm)
    g. Approved NICU Medical Director and Neuro-Interventional Call Panel Contracts
    h. Appointed Director Julie Kliger as Quality, Patient Care and Patient Experience Committee Chair
    i. Approved FY18 CEO Incentive Plan Payment

ECHD Board Actions*

2. October 16, 2018
    a. Approved Resolution 2018-11 recognizing Community Benefit Partner Bay Area Women's Sports Initiative
    b. Approved Resolution 2018-12Adopting Calendar year 2019 Meeting Dates
    c. Approved Resolution 2018-13 Amending the ECHD Conflict of Interest Code
    d. Approved FY18 ECH and ECHD Consolidated Year-End Financials
    e. Approved the FY18 Community Benefit Report
    f. Approved the FY18 Year-End Stand Alone Financials
    g. Approved the FY19 Financials YTD
    h. Approved the FY19 Financial Audit
    i. Approved a Revision to the El Camino Hospital Bylaws providing that a vacancy in the Board of Directors shall be deemed to exist when a Director, who was appointed or elected as a Director while serving as a Director of the sole Member is no longer a director of the sole Member.

*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.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	FY19 Quality Dashboard Quality, Patient Care and Patient Experience Committee November 5, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ, Sr. Director, Quality and Patient Safety/Chief Quality Officer
	Action requested:	For Discussion
	Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2019 Quality, Efficiency and Service Goals.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
	Summary and session objectives : To provide the Committee with a snapshot of the FY19 metrics monthly with trends over time and compared to the actual results from FY18 and the FY19 goals. Annotation is provided to explain actions taken affecting each metric.	
	Suggested discussion topics: 1. Hospital-acquired Infections: Zero for September for CAUTI, CLABSI, and C. Diff. 2. Readmissions Index is lower for July 2018.	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: 1. FY19 Quality Dashboard	

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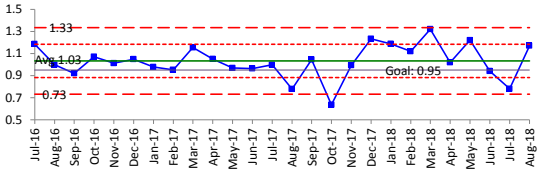
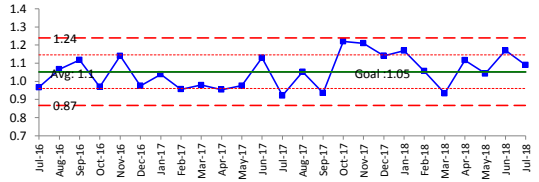
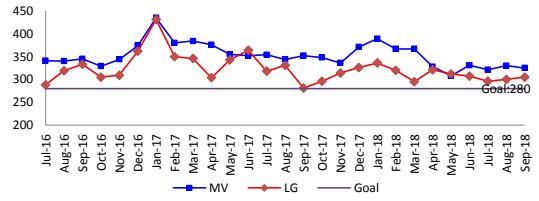
FY19 Organizational Goal Update

September 2018 (Unless otherwise specified)

Month to Board Quality Committee:
November, 2018

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Quality		**Month**	**FYTD**				
1	*Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: August 2018*	1.17 (1.56%/1.34%)	0.97 (1.38%/1.43%)	1.05	0.95		Developing new notes in iCare for MD co-signature to document Pressure Injuries, Malnutrition, so these can be part of documentation that increases risk of mortality. NP Palliative care notes can also be included. New Mortality review tool for quality and HVI. CDI Manager will meet with Medical Directors to discuss physician documentation.
2	*Organizational Goal **Readmission Index (All Patient, All Cause Redmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: July 2018*	1.09 (7.72%/7.11%)	1.09	1.08	1.05		Team Health Hospitalist joined Weekly Readmit review team, which now makes referrals for quality of care issues to Peer Review. Readmits within 24hr of discharge are now combined into one admission and DRG payment.
3	★Organizational Goal **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: September 2018*	MV: 325 mins LG: 305 mins	MV: 325 mins LG: 300 mins	MV: 350 mins; LG: 314 mins	280 mins		Continue to track performance from order to floor and are conducting the second improvement workshop to create standards that will support consistency in the processes. Team will work with managers to track adherence to the process and to understand and help to remove barriers. A new Provider Workgroup has started to look a the opportunities with Physician consult for admission & getting the admission order entered.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	Catherine Carson				**Premier Quality Advisor**
Readmission Index (All Patient, All Cause Redmit) Observed/Expected	Catherine Carson				**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**EPIC**

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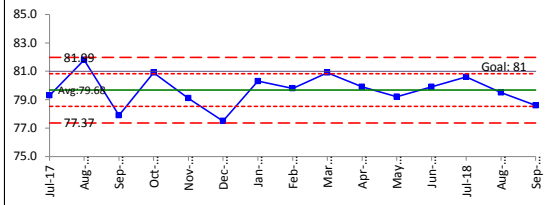
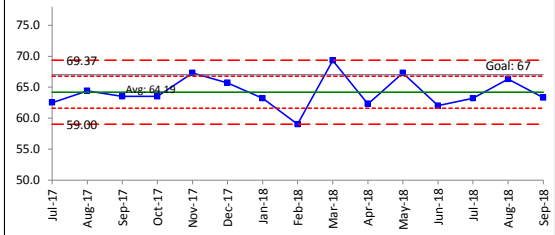
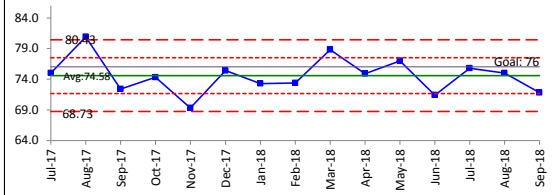
September 2018 (Unless otherwise specified)

Month to Board Quality Committee:
November, 2018

	Service	FY19 Performance Month	FY19 Performance FYTD	HCAHPS Baseline Q4 2017-Q3 2018	FY19 Target	Trend	Comments
4	«Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: September 2018*	78.6 (197/250)	79.6 (617/775)	80.0	81.0		Focus in on "Purposeful Rounding" implementation and the Listening Carefully Toolkit.
5	«Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: September 2018*	63.3 (149/235)	64.3 (472/734)	65.1	67.0		Teams promoting a "No pass Zone," all staff are to not pass a room with a call light on and enter the room to acknowledge the light and then access the appropriate staff. Also setting an objective of addressing each call light w/i 5 minutes and before the call light cycles again.
6	«Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: September 2018*	71.8 (178/248)	74.3 (571/769)	74.5	76.0		Team includes EVS, Facilities, and Nursing to identify room clutter and debris, and find solutions to limit it. New Admit Pack reducing materials brought into patient's room. EVS completely emptying all cupboards in patient rooms at discharge.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10		**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10		**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10		**Press Ganey Tool**

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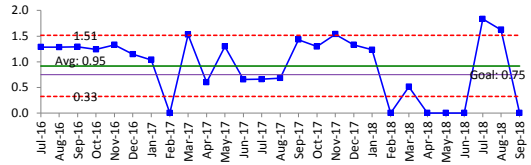
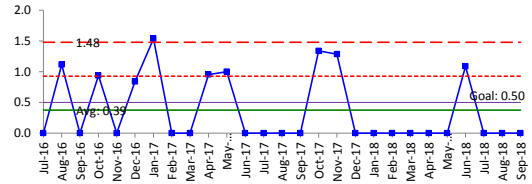
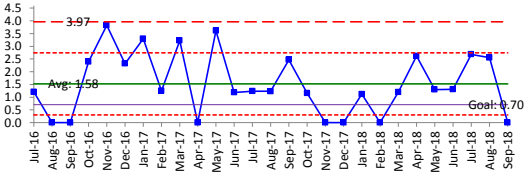
September 2018 (Unless otherwise specified)

Month to Board Quality Committee:
November, 2018

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
Quality		**Month**	**FYTD**				
7	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: September 2018* *SIR Goal: <= 0.75*	0.0 (0/1066)	1.18 (4/3390)	0.77	SIR Goal: <= 0.75		No new CAUTI infections in September!
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: September 2018* *SIR Goal: <= 0.50*	0.0 (0/979)	0.0 (0/2641)	0.28	SIR Goal: <= 0.50		3 consecutive months with no new CLABSI infections!
9	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: September 2018* *SIR Goal: <= 0.70*	0 (0/7663)	1.74 (4/22958)	1.13	SIR Goal: <= 0.70		No new C.Diff infections in September.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than 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 Carson/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Catherine Carson/Catherine Nalesnik				

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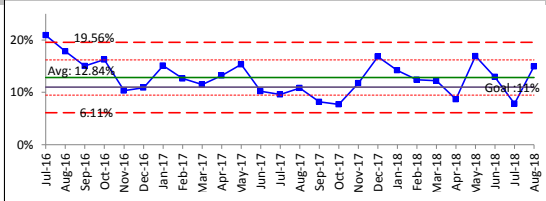
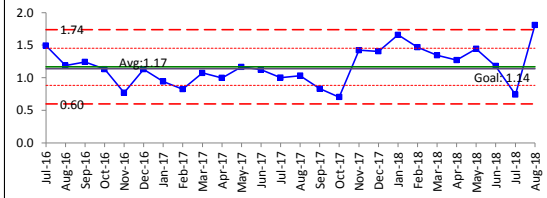
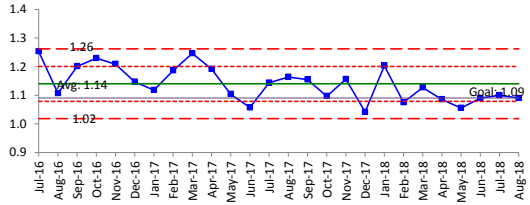
FY19 Organizational Goal Update

September 2018 (Unless otherwise specified)

Month to Board Quality Committee:
November, 2018

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Comments
		Month	FYTD				
10	**Sepsis Mortality Rate Enterprise, based on ICD 10 codes** *Date Period: August 2018*	14.94%	11.59%	11.72%	11%		California's mortality rate for 2017 = 14.9 % while the northern CA (Hospital Council) rate for 2017 is 13.7%. ECH rate continues close to this benchmark.
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: August 2018*	1.81	1.25	1.22	1.14		Sepsis Manager working with CDI Manager to assess severity of illness provider documentation in Sepsis charts, to increase the risk of mortality.
Efficiency							
12	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: August 2018*	1.09	1.10	1.12	1.09		LOS Index at target for second month, becoming stable near target.

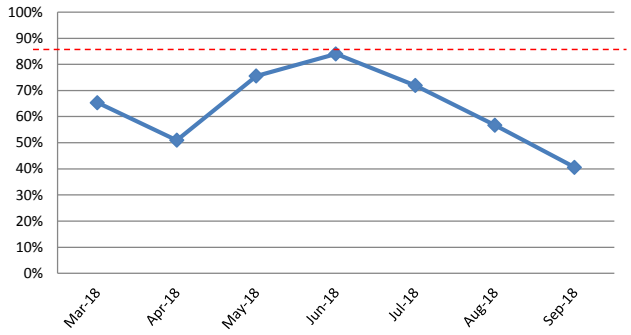
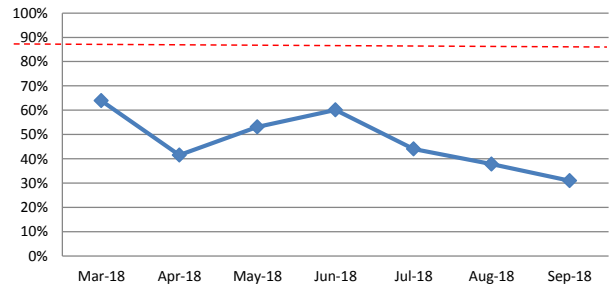
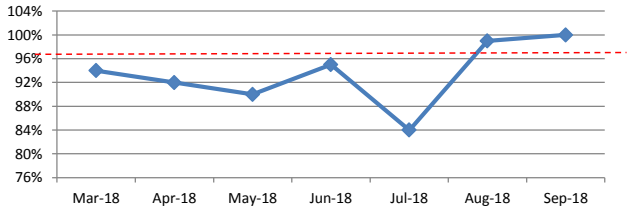
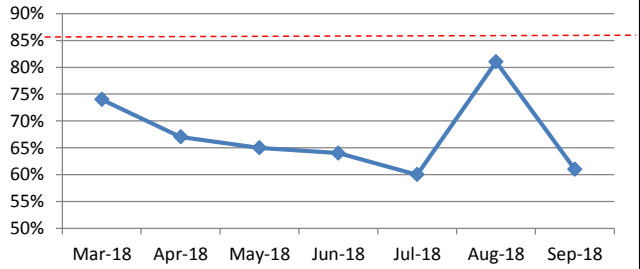
Definitions and Additional Information

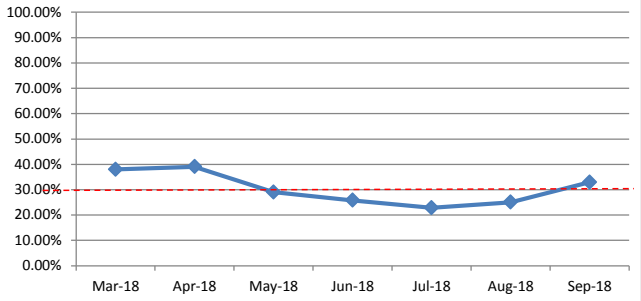
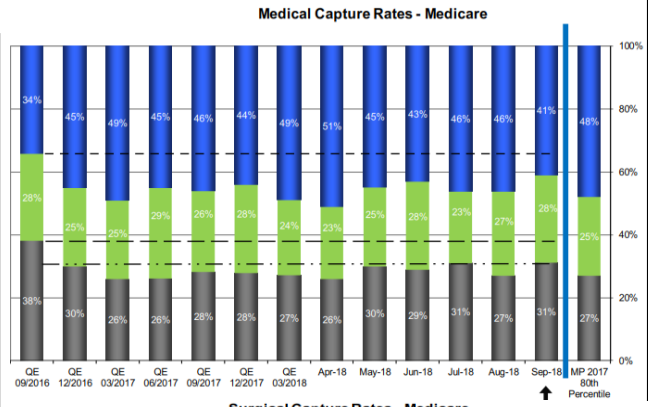
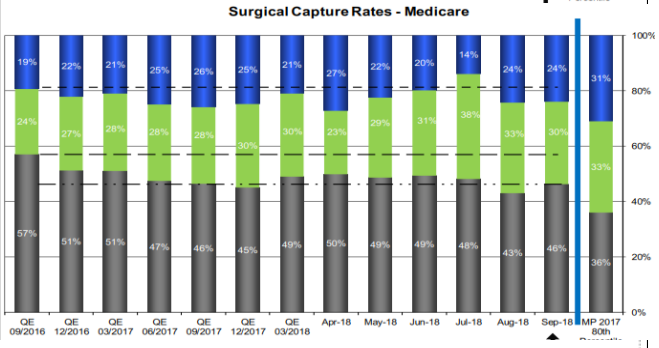
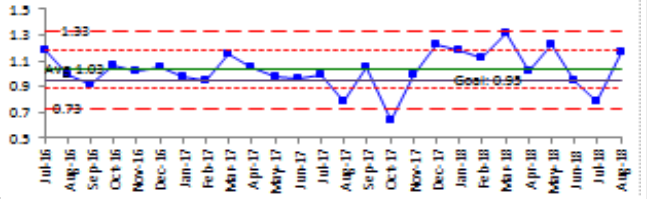
Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Rate Enterprise, based on ICD 10 codes	Catherine Carson				**Premier Quality Advisor**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	Catherine Carson				**Premier Quality Advisor**
Arithmetic Observed LOS Average over Geometric LOS Expected (Medicare definition, MS-CC, Inpatient)	Cheryl Reinking Catherine Carson (Cornel Delogramatic)		The Observed LOS over the Expected LOS Ratio is determined by calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient's MD-DRG.		**Premier Quality Advisor**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	CDI Dashboard Quality, Patient Care and Patient Experience Committee November 5, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ, Sr. Director, Quality and Patient Safety/Chief Quality Officer
	Action requested:	For Discussion
	Background: This dashboard provides metrics for assessing ECH's Clinical Documentation Improvement Program.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives: To provide the Committee with ECH current CDI metrics	
	Suggested discussion topics: 1. 4 new full time staff added to CDI team over the summer, 3 with good experience, one foreign physician with some CDI experience. 2. Physician response rate to queries at 100%. CDI Manager working to standardize queries and talking with providers about intent of queries.	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: **1.** CDI Dashboard (to September 2018 data)	

Clinical Documentation Improvement Dashboard (Monthly) October 2018

			Baseline	FY19 Goal	Trend	Comments
	Coverage	Performance	FY2018	FY2019 goal		
1	Medicare	Sep 2018 64%	64%	90%		Result affected by high turnover in staff. In August-September hired 3 new staff members. Expecting productivity to increase by October 2018.
2	All Payor	Sep 2018 31%	35%	85%		Priority in reviews was allocated to Medicare FFS and Senior advantage plans
	Physician Response	Performance	FY2018	FY 2019 goal		
4	Query Response Rate	Sep 2018 100%	78%	>95%		Query response rate reached 100%
5	Query Agree Rate	Sep 2018 61%	61%	>85%		CDI Manager is meeting and working with groups of physicians to understand and standardized CDI queries.

#	Impact	Performance		FY2018	FY 2018 goal		
7	**Query rate (number of clarification forms)** *(Medicare, adult, acute care, inpatient)*	**Sep 2018** **32%**		**24%**	Min 20 Target 25 Max 30		Despite low coverage rate the number of clarification queries are kept at target level
8	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Sept 2018** **MCC 41%** **CC 28%** **NCC 31%**	**N/A**	**Nat 80th%** MCC 44% CC 27% No CC 29%	**Nat 80th%** MCC 45% CC 27% No CC 28%		Medical CC/MCC rate dropped with only 1 trained CDI in place. 3 new CDIs added and working in October.
9	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Sept 2018** **MCC 24%** **CC 30%** **NCC 46%**	**N/A**	**Nat 80th%** MCC 31% CC 32% No CC 37%	**Nat 80th%** MCC 31% CC 32% No CC 37%		Surgical CC/MCC improved and represents CDI efforts and focus on educating surgeons around documentation.
	***Organizational Goal** **Expected Mortality Rate (a**dult, acute care, inpatient)	**Aug 2018** **1.17** (1.56%/1.34%)	**N/A**	**1.05**	Premier target 0.95		Ongoing effort from CDI team to clarify severity of the case and the risk of mortality for all cases.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	CY 2018 Core Measure Summary Report Quality, Patient Care and Patient Experience Committee November 5, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ, Sr. Director, Quality and Patient Safety/Chief Quality Officer
	Action requested:	For Discussion
	Background: This report provides the data for the current calendar year 2018 of required CMS and TJC Core Measure metrics.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : To provide the Committee with ECH current performance of core measures. Annotation includes what programs to which the different metrics are applied.	
	Suggested discussion topics: 1. Good performance for the Perinatal Care metrics (PC) 2. Good performance for the 1st month of the 2018-2019 flu season on Immunization of patients. This measure is retired as of Jan. 1, 2018 and ECH will continue the measure through the end of this flu season. 3. HBIPS = Hospital-based Inpatient Psychiatric unit measures.	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: 1. CY18 Year-to-Date Core Measure Summary Report (to August 2018)	

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CY 2018 Core Measure Summary Report

VBP Included in CMS Value-Based Purchasing Program:

Included in CMS Star Ratings: PRIME Included in PRIME:

Included in Leapfrog 95%-100%= G 90% - 94% = Y <90% = R

Inpatient Measure Name		ECH Goal	CY18 Q1	CY18 Q2	CY18 Q3*	2018 YTD	*External Benchmark
PC-01	Elective Delivery Prior to 39 weeks gestation (lower=better) VBP	0%	5.3%	1.4%	2.7%	2.4%	3%
PC-02	Cesarean Section Rate (lower=better) PRIME	<23.9%	25%	26%	26%	26%	26%
PC-03	Antenatal Steroids	100%	No cases	100%	100%	100%	98%
PC-04	Health Care Associated Bloodstream Infection in Newborns (lower=better)	0%	0%	0%	0%	0%	2%
PC-05	Exclusive Breast Milk Feeding During Hospital Stay PRIME	70%	63%	71%	66%	67%	51%
VTE-6	Hospital Acquired Potentially Preventable Venous Thromboembolism (lower=better)	0%	0%	0%	0%	0%	0%
IMM-2	Influenza Immunization	100%	96%	Not flu season	Not flu season	96%	100%
ED-1b	Median Time from ED Arrival to ED Departure for Admitted Patients	<280 minutes	361	330	294	330	169
ED-2b	Median time – admit Decision Time to ED Departure Time for Admitted Patients	<120 minutes	88	92	82	88	35
Outpatient Measure Name		**ECH Goal**	**CY18 Q1**	**CY18 Q2**	**CY18 Q3***	**2018 YTD**	***External Benchmark**
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower=better)	<180 minutes	178	179	179	179	90
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%	No cases	50%	57%	99%
PC-OP CP	Perfect Care - Out Patient Chest Pain	100%	No Cases	No cases	No cases	No cases	No data is available for this measure
PC-OP AMI	Perfect Care - Out Patient Acute Myocardial Infarction	100%	100%	No cases	No cases	100%	100%

Q3 includes July and August 2018 only

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CY 2018 Core Measure Summary Report

VBP Included in CMS Value-Based Purchasing Program:

Included in CMS Star Ratings: PRIME Included in PRIME:

Included in Leapfrog 95%-100%= G 90% - 94% = Y <90% = R

Hospital Based Inpatient Psychiatric Services (HBIPS) Measure Name		ECH Goal	CY18 Q1	CY18 Q2	CY18 Q3*	2018 YTD	*External Benchmark
IMM-2	Influenza Immunization	100%	94%	Not flu season	Not flu season	94%	92%
HBIPS-2	Hours of Physical Restraint Use (per 1000 patient hours) (lower=better)	TBD	0.0001	0.0005	Not available	0.0003	0.0006
HBIPS-3	Hours of Seclusion Use (per 1000 patient hours) (lower=better)	TBD	0.0009	0.0001	Not available	0.0005	0.0002
HBIPS-5	Patients Discharged on multiple antipsychotic medications with appropriate justification	100%	84%	88%	63%	78%	67%
PC-TOB	Perfect Care - Tobacco Use	100%	85%	84%	87%	85%	71%
PC-SUB	Perfect Care - Substance Abuse	100%	99%	97%	92%	97%	76%
TR-1	Transition Record with Specified Elements Received by Discharged Patients	100%	76%	75%	78%	76%	52%
TR-2	Timely Transmission of Transition Record	100%	62%	67%	75%	67%	47%
MET	Screening For Metabolic Disorders	100%	98%	98%	99%	98%	79%
Q3 includes July and August 2018 only							

*Benchmark source- IBM Care Discovery Quality Measures January 2018-August 2018	
Core Measures	**Benchmark**
Non-HBIPS and Non- PC	CMS Standard of Excellence-Top 10% of Hospitals
HBIPS	IBM All Core Measure Note: Event measures (HBIPS-2 and HBIPS-3) are calculated by event occurrence date; YTD and external benchmarks are only from January-June 2018
Perinatal	TJC

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item: Physician Performance Improvement Activities	Physician Performance Improvement Quality, Patient Care and Patient Experience Committee November 5, 2018
	Responsible party:	Mark Adams, MD, CMO; Dan Shin, MD, Medical Director, Quality & Physician Services
	Action requested:	For Discussion
	Background: The Committee requested that examples of physician performance improvement activities be presented. One of the core competencies for physicians is practice-based learning and systems knowledge. These examples illustrate how physicians can demonstrate their competence in those areas.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : Provide four illustrative examples of physician directed performance improvement activities: **1.** Antibiotic stewardship **2.** Hospital-acquired C. diff reduction **3.** Blood utilization reduction **4.** Drug alerts and adverse drug reactions	
	Suggested discussion questions: 1. How are physicians engaged in these activities? 2. What were the lessons learned in these examples?	
	Proposed Committee motion, if any: None. This is a discussion item.	
	LIST OF ATTACHMENTS: None	

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item: What is Quality?	How Does El Camino Hospital Define Quality Quality, Patient Care and Patient Experience Committee November 5, 2018
	Responsible party:	Mark Adams, MD, CMO
	Action requested:	For Discussion
	Background: The Board Quality Committee requested that we allocate time to discuss the question of "What is Quality?" While we have seen a substantial industry devoted to evaluating and measuring healthcare quality develop nationally, there remains considerable variation around what that really means. In many respects, quality is both a qualitative and quantitative subject that is defined differently depending on the observer. For example, patients view quality quite differently than the government, an employer, or a health insurer.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : To assist the Committee in its role in oversight for quality and safety by better understanding how quality is defined and assessed in different settings and through different lenses.	
	Suggested discussion questions: 1. We have included some samples of how other organizations define quality—do these resonate with the committee members? 2. How should we account for quality beyond what have become industry standard metrics?	
	Proposed Committee motion, if any: None, this is a discussion item.	
	LIST OF ATTACHMENTS: 1. Samples of quality definitions from other healthcare organizations	

What is Quality?

Definition and Source:

1. Institute of Medicine: Six Domains of Health Care Quality

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

    Institute of Medicine (IOM) definition:

    "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

    IOM framework on consumer perspectives of healthcare needs includes four categories of how consumers think about their care:

    - **Staying Healthy:** Getting help to avoid illness and remain well
    - **Getting Better:** Getting help to recover from an illness or injury.
    - **Living with Illness or Disability:** Getting help with managing an ongoing, chronic condition or dealing with a disability that affects function.
    - **Coping with the End of Life**: Getting help to deal with a terminal illness.

2. CMS Quality Strategy 2016 with 6 goals in the delivery of quality healthcare:

    a. Make care safer by reducing harm caused in the delivery of care.
    b. Strengthen person and family engagement as partners in their care.
    c. Promote effective communication and coordination of care.
    d. Promote effective prevention and treatment of chronic disease.
    e. Work with communities to promote best practices of healthy living.
    f. Make care affordable

    CMS continued: Quality in healthcare means providing the care the patient needs when the patient needs it, in an affordable, safe, effective manner. Quality healthcare also means engaging and involving the patient, so the patient takes ownership in preventive care and in the treatment of diagnosed conditions.

    Quality in the healthcare context is a collaborative effort that involves the patient, the independent physician, the patient's family, and the community as a whole.

3. Stanford Healthcare:

What is quality?

Patients and families know quality care when they experience it. A nurse's response time, a doctor's bedside manner, the hospital's atmosphere—all of these things affect how people feel about the quality of their healthcare. When hospitals talk about quality, it is generally in reference to very specific clinical data collected and analyzed over a period of time. Quality measurement isn't always easy. Different agencies and groups have different ways of reporting clinical outcomes that can affect the way they rate a hospital on a certain quality measure. Reporting systems can also be cumbersome or costly, making ratings even more difficult to produce. Today, there are limits to the numbers of conditions, treatments, and procedures that are reported and monitored, but as data systems and methods improve, more and more information will be available.

Quality data show how well a department or institution achieves desired health outcomes for a particular procedure, often by tracking how closely clinical staff meet standards of care. At Stanford Health Care, we strive to ensure that the care we provide is:

Safe: Avoiding injuries to patients from the care that is intended to help them.
Effective: Providing services based on scientific knowledge and best practice.
Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patients' values guide all clinical decisions.
Timely: Reducing waits and sometimes harmful delays for both those who receive and provide care.
Efficient: Avoiding waste, including waste of equipment, supplies, ideas and energy.
Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.
Measuring quality data allows us to see where we are providing the best care and helps us identify areas for improvement.

4. Virginia Mason Medical Center:

Quality and Patient Safety: Safe care is great care. And the best medical outcomes come from the safest environments. At Virginia Mason, ensuring the safest possible patient care is our most important goal. This means providing patient care that lives up to our vision of being the Quality Leader; it means patient safety is at the top of our list. Virginia Mason is committed to making information about health care outcomes available to patients to help them make informed decisions about their care.

Be Informed:

As a patient, you have the right to expect the services you receive to be delivered safely and correctly every time. You also have the responsibility to actively participate in your own care. By researching health care quality and safety information, you can make informed choices about where to receive treatment and also better understand the risks involved with some procedures.

5. UCSF Medical Center

UCSF Medical Center and UCSF Benioff Children's Hospital San Francisco are committed to providing the safest highest quality care to patients. We measure our performance against our own rigorous standards as well as compare the outcomes of our care with top medical centers nationwide in our effort to continually improve the care we provide. We believe that sharing our results with the public is an obligation and a critical factor in our mission of continuous improvement. At UCSF, we define optimal quality care as:

- Superior care and outcomes
- Outstanding patient safety
- Care delivered in a timely manner
- Fair, unbiased access to health care

6. John Hopkins Health System

Each day in a hospital, staff members undertake complicated tasks caring for patients. Johns Hopkins Medicine's patient safety efforts aim to ensure that all of these steps work together to deliver high-quality, compassionate care to all patients across our health system.

The Armstrong Institute's goal is to eliminate preventable harm to patients and to achieve the best patient outcomes at the lowest cost possible, and then to share knowledge of how to achieve this goal with the world. The institute also provides an infrastructure that, for the first time, oversees, coordinates and supports patient safety and quality efforts across Johns Hopkins' integrated health care system.

Leadership Update
November 5, 2018
Mark Adams, MD, CMO

Operations

We activated Centralized Telemetry (ECG) Monitoring for the two units in MV and the one unit at LG that were using unit based monitoring the week of September 24th. This new approach allows for all telemetry patients to be monitored in a central location in MV on the third floor. Visual monitoring for patients at risk of falling through the use of portable cameras will also occur in this location. The tech is able to speak to the patient through the camera, which is useful in helping the patient immediately while simultaneously alerting the patient's nurse to assist. The new system allows us to monitor up to 68 telemetry patients and visually monitor up to 15 patients at risk for falling across the enterprise. It is commonly used across the nation due to its improved efficiency and effective system of monitoring.

Workforce

As of October 1, 2018, 87% of our employees had responded to the Employee Engagement Survey launched on September 17th. Last year's participation rate was 79% so we are extremely proud of surpassing this year's 82% participation goal.

Financial Services

Cash collections were $8 million ahead of target for the first two months of FY19. As of September 18th, we implemented$1,001,266 in cost savings of our total initiative for FY19 of $2,200,000.

Marketing and Communications

We completed consumer research surveys for the Cancer Center and our ethnic audiences and will use the findings to inform patient care, marketing/communications efforts, and provide recommendations for operational consideration. The team launched our website rebuild to new Drupal content management system platform. This work aligns with information security and consumer digital expectations. The team also lead or supported multiple community events including "A Healthy Mind" events at Lynbrook High School (125 parents/families at evening event; entire school during daytime events & staff education) and the MOMS 10-year anniversary symposium. We also produced "Art at the Bedside" art exhibition placed in Los Gatos City Council Chambers for the next few months.

Information Services

Between the months of March and September 2018 patient enrollment in MyChart Enrollment averaged 1740 (16.3%) patients per month.

Corporate and Community Health

Department of Managed Healthcare auditors were complimentary of our comprehensive Quality Management program during their three-day triennial clinical audit of CONCERN.

El Camino Hospital/El Camino Healthcare District provided support to the following organizations through the Community Benefit sponsorship program during the month:

- Downtown Streets Team
- AACI- Asian Americans for Community Involvement

- Gardner Health Services
- Community Health Partnership
- Rebuilding Together
- Community Services Agency – Mountain View Los Altos
- NAMI
- Community Seva
- West Valley Community Services
- Bonnie J. Addario Lung Cancer Foundation
- Child Advocates Silicon Valley

Graduates of The South Asian Heart Center's STOP-D (diabetes) program achieved an average 5.4% improvement in HBA1C and average weight loss of 6.1 lbs. (3.24%). Our Facebook Marketing Campaign to promote the program has yielded 100 signups in 4 months.

The Chinese Health Initiative collaborated with churches in the South Bay to provide diabetes prevention workshops conducted by registered dietitians in Chinese. A total of 120 community members attended the workshops. We held our 8th annual physician dinner with 28 physicians in attendance. Mark Adams, MD, CMO, presented ECH's strategic update and Ashish Mathur, the executive director of the South Asian Heart Center, presented a diabetes prevention lifestyle change program and facilitated a discussion with physicians on how to adapt the model to the Chinese population. We also collaborated with the ECH Cancer Center and New Hope Chinese Cancer Care Foundation to offer a skin cancer prevention workshop attended by 40 community members.

Silicon Valley Medical Development, LLC

SVMD signed an Asset Purchase Agreement with Deborah Freehling, MD, Otolaryngology, and ECMA entered into Employment Agreements with both Dr. Freehling and Katrina Chaung, MD, effective November 1, 2018.

Government and Community Relations

Five hospital employees received scholarships to attend city leadership programs this year in Mountain View, Los Gatos, Sunnyvale (2), and San Jose. We also expect to place employees in the Los Atos and Santa Clara leadership programs. ECH continues to host many of these programs, providing executive speakers on health and hospital services and current topics.

Auxiliary

The Auxiliary contributed 7,874 volunteer hours in August 2018.