El Camino Health

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

Monday, November 01, 2021 – 5:30pm
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

PURSUANT TO GOVERNMENT CODE SECTION 54953(e)(1), El CAMINO HEALTH **WILL NOT BE PROVIDING A PHYSICAL LOCATION TO THE PUBLIC FOR THIS MEETING**. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 962 2889 9103#. No participant code. Just press #.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:43**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (10/04/2021) ***Information*** b. Report on Board Actions c. FY 22 Pacing Plan d. FY 22 Enterprise Quality Dashboard e. Safety Report for the Environment of Care f. Quality Committee Follow-Up Tracking g. CDI Dashboard h. Core Measures			
4.	**CHAIR'S REPORT**	Julie Kliger, Quality Committee Chair		**information 5:43 – 5:48**
5.	**PATIENT STORY**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer		**discussion 5:48 – 5:53**
6.	**FY 2022 QUARTERLY BOARD DASHBOARD REVIEW**	Mark Adams, MD, Chief Medical Officer		**discussion 5:53 – 6:13**
7.	**EL CAMINO HEALTH MEDICAL NETWORK QUARTERLY REPORT**	Vince Manoogian, Interim President of ECHMN Ute Burness, RN ECHMN VP of Quality & Payer Relations		**discussion 6:13-6:33**
8.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**discussion 6:33-6:36**

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) 988-8483 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
9.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 6:36 – 6:37**
10.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**information 6:37-6:38**
11.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (10/04.2021) b. Quality Council Minutes (10/06/2021)	Julie Kliger, Quality Committee Chair		**motion required 6:38– 6:39**
12.	*Health and Safety Code Section 32155* **MEDICAL STAFF OFFICE AUDIT REORT**	Diane Wigglesworth, Senior Director Corporate Compliance		**Information 6:39-6:49**
13.	*Health and Safety Code Section 32155* **MEDICAL STAFF CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, CMO		**motion required 6:49-6:59**
14.	*Health and Safety Code Section 32155* **Q1 FY 22 QUARTERLY QUALITY & SAFETY REVIEW**	Mark Adams, MD, CMO		**Information 6:59-7:14**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: **SERIOUS SAFETY EVENT/RED ALERT REPORT** (verbal report out)	Mark Adams, MD, CMO		**discussion 7:14-7:19**
16.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**motion required 7:19-7:20**
17.	**RECONVENE OPEN SESSION/ REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		**information 7:21– 7:22**
18.	**CLOSING WRAP UP**	Julie Kliger, Quality Committee Chair		**discussion 7:22 – 7:27**
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**motion required 7:27 – 7:28pm**

Next Meeting: February 7, 2022, March 7, 2022, April 4, 2022, May 2, 2022, June 6, 2022

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Hospital Board of Directors
Monday, October 4, 2021
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent	Others Present
Julie Kliger, MD, Chair	Apurva Marfatia, MD	Mark Adams MD, CMO
Krutica Sharma, MD	Terrigal Burn, MD	Jim Griffith, COO
Carol Somersille, MD	Michael Kan, MD	Cheryl Reinking, CNO
George O. Ting	Jack Po, MD	
Alyson Falwell	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 5:32pm by Chair, Julie Kliger. A verbal roll call was taken. Dr. Marfatia, Dr. Burn, Dr. Kan, Dr. Po and Ms. Simon were not present during roll call. All other members were present at roll call and participated in-person or telephonically. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020 and N-29-20 dated March 18, 2020.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any members 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. (a) Minutes of the Open Session of the Quality Patient Care and Patient Experience Committee Meeting (10/04/2021); For information: (b) Report on Board Actions; (c) Article of Interest **Movant**: **George Ting** **Second**: **Alyson Falwell** **Ayes**: Kliger, Sharma, Somersille, Ting, Falwell **Noes**: None **Abstain**: None **Absent**: Burn, Kan, Marfatia, Po, Simon **Recused**: None	***Consent Calendar approved***
4. CHAIR'S REPORT	Chair Kliger reported that during the last board meeting and subsequent conversations with other Quality Committee members, there has been a general view that because COVID-19 seems to be a matter of fact and something that will chronically be with us, we should be viewing our quality metric workflows operation and that is beyond necessarily the scope of the Committee. We should look to find ways to normalize rearrange/reengineer processes so that we are not treating Covid-19 in the Quality metric and not impacted by it as a one-off as if this Public Health event is with us to stay in some form or fashion so our processes and workflows, especially those that impact our quality metric need to	

	be altered. And in the future as we move forward, we do not want to hear why quality metrics may be performing differently than otherwise planned due to Covid but rather that they are performing as planned because we realize Covid along with other normal operational ups and downs occur. It is important to recognize that the board as well as several committee members and the management teams themselves recognize that things need to change and we need to absorb these new conditions and work within the conditions that we have. The board has requested understanding of how the management team is going to normalize the Covid-19 aspect of operations. In the next one or two board meets, we want a summary or overview of what processes have changed/reengineered especially as it relates to the quality metrics that we measure in the consent dash board as well as in the board level dashboard.	
5. PATIENT STORY	Cheryl Reinking presented a Press Ganey survey regarding a patient who came into the hospital with Sepsis. The patient stated he was treated well in the ICU as it relates to his Sepsis; however, the discharge teachings that his wife received were a bit challenging. This patient had a complicated case, he was admitted with Sepsis and was discharged from the hospital with an IV, a wound and a colostomy bag. Although we provide discharged patients with a lot of information for educating family members about caring for such things as IVs, wounds, and colostomy bags, however, once the patient and his wife left the hospital they felt unprepared and this was concerning to us. We decided to have two care nurses who actually work with patients who have these conditions to teach patients and their family members how to manage the colostomy and how to change the bags that we give them along with other types of accouchements that goes with their care once they leave the hospital. We further decided that care nurses should call the patient about 24hrs after discharge and ask how things are going at home and what other assistance they might need. If the patient is feeling frustrated, if they have questions, we will connect them with care coordination to make sure they get the kind of follow-up care through either a home healthcare agency or help them make an appointment with their primary care physician. I thought we could apply these learnings across the enterprise especially with patients who have complicated discharge plans.	
6. FY2021 & FY2022 QUALITY DASHBOARD METRICS	The FY2021 Enterprise Dashboard that was discussed last month is being brought back for reference and to compare with the FY2022 Enterprise Dashboard because there were two items that were shown last month that did not quite have the final June numbers. Those were the 2 maternity measures that were added and didn't really change much from the final results. This is merely an FYI. We made some minor changes to the FY2022 Enterprise Dash Board and we set new targets based on the baseline which really became available recently. We have July and some August results but it's too early in the fiscal year to make too many conclusions about anything but I do think it's important. There were two typo errors in the FY 2022 dashboard: 1) number 5, the in-patient likelihood to recommend, the baseline for FY2021 should read 80.1 not 80.3 and 2) the serious safety event rate, the fiscal year to date is 2.61 not 1.25. Also, we added medication precursor safety events to the dashboard which is new and something	

	we will talk more regarding the high reliability and the culture safety portion. As a reminder, when you are looking at these they have been on the Consent Agenda for quite a while and perhaps we have gotten out of the habit of really looking at them but these are control charts. There is inherent variability in each of these measures that you will find in any institution. There is no way to actually have no variability at all when you are dealing with these sort of measures in complex environments with patients and this is why we apply control lines hence the name control charts. The way to read these is 1) to make sure that whatever variation there is it is well contained within the control limits and if that's the case this is a measure that's under control with some variability we expect to see sometimes. One case can cause a blip up and down hence why there is some variability. 2) some of these measures for example, readmission, the latest month is kind of high 1.05 but as far as the target, when we originally started working on readmissions 2 years ago, the very top performing organizations in the country based on Premier Data Analytics, the company we use for our national benchmarking and data analyst as well as risk adjust all the data to make it meaningful was .90. We recently asked to have it reviewed again by Premier and actually the top performers in the country today have a readmission index of .95 so it has gone up from .90 significantly. We set our target at .92 very aggressively which means we want to be well below the very top performers in the country. This will be very difficult for us to accomplish but, we want to be put to task to try to meet that difficult target. 3) The mortality index has also seen a major change across the country. The FY22 target has been adjusted to .90 and we did come in slightly below that. The reason we have adjusted that again is that the mortality index of the very top performers across the country is now .90 and we felt given that trend .90 keeping us in the very top tier of the country in terms of that index was the correct target for the organization. This one is strategical and not an organizational goal but it is something we want to continue to track. In August it had gone up 1.02 we had 31 deaths and 32% of those were Sepsis deaths. Sepsis continues to drive the Sepsis mortality index and there were only 2 Covid patients. In terms of Covid, we have for the most part moved on. Although we will continue to have Covid patients for the near future, we are running 8-10 patients a day and those patients have been assimilated into the same as all our other patients and we are not treating them any differently from all our other patients. We have now accepted them as part of our in-patient population.	
7. CULTURE OF SAFETY SURVEY RESULTS	We had some good engagement scores from employees and physicians and alignment was fairly good. In the past, we have noticed it seemed a little lower than the rest of the scores in the whole survey. We have been focusing a lot of attention on this. Press Ganey is the agency that does the analysis and survey. The employee culture of safety is 3.96 which is a little lower than the past survey which was 4.04 and that survey was done just before the pandemic in early 2019. Press Ganey basically took the prior two years, not this year and folded those results together nationally. Basically, they combined the national averages for 2019 and 2020 for different organizations. Compared to our last survey	

	there was some deterioration from the employees, however the physicians were up compared to the employees for Culture of Safety. Clearly, Covid has taken a toll on everyone, particularly in healthcare and people are stressed a lot. For the Culture of Safety, some of the key areas are: What happens when people make mistakes? 1) Can I report it without fear of punishment? 2) How are safety issues addressed and can people speak up freely? 3) How do people work together, doctors and nurses, and different departments in the hospital? These are all areas where there is clearly room for improvements. This information has been shared across the nursing units and they are working on addressing. Physicians' scores have gone up since the last survey and some of the results are even above the national averages. This year we really want to emphasize the Culture of Safety part of the improvement. For the broader organization which includes all clinicians, doctors, and nurses, everyone is moving towards higher reliability. In a high reliability organization, people not only feel good but, they feel positive about reporting errors, issues, problems, and safety issues, this is where we want to move. In order to do that there are a couple of things we need to do. We need to be responsive as we get reports and we need to be action oriented in addressing how we treat errors. We know that people make mistakes and how we address those are really important because this is really the very foundational part of the culture. Currently there are several key elements to that; 1) we need senior leadership to be involved and behind it and, 2) we need to make sure we have the right resources. We have engaged Press Ganey which now owns HPI, Healthcare Performance Improvement which has a long track record of helping organizations on becoming highly reliable. We have started our assessment period, this will be a two year journey and we have a 2 year contract with Press Ganey. The initial part is an assessment that started today and once we have that assessment we will be looking at how we basically design the high reliability work for El Camino and then we will start the big task of educating and training all the members of the organization. I think we are at a point that we have to move to high reliability to have that consistent high performance that we all want. Coming off the pandemic, I believe this is really the time to strike now and hopefully we will see the results over time. There will be lot more to share over time.	
8. PUBLIC COMMUNICATIONS	There was no public communication.	
9. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at 6:57pm. **Movant**: **Carol Somersille** **Second**: **George Ting** **Ayes**: Kliger, Kan, Po, Sharma, Somersille, Ting, Falwell, Simon **Noes**: None **Abstain**: None **Absent**: Marfatia, Burn **Recused**: None	***Adjourned to closed session at 6:57pm***

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Julie Kliger, MPA, BSN
Chair, Quality Committee

Prepared by: Audrey Sehon-Davis, Executive Assistant II

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee
From: Stephanie Iljin, Supervisor of Executive Administration
Date: November 01, 2021
Subject: Report on Board Actions

Purpose: To keep the Committee informed regarding actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

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

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

3. Background: Since the last time we provided this report to the Quality Committee, the Hospital Board has met twice and District Board has met once. In addition, since the Board has delegated specific authority to the Executive Compensation Committee, the Compliance and Audit Committee, and the Finance Committee, those approvals are also noted in this report.

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECH Board	October 13, 2021	- AB 361 Resolution Adopting Findigs to Continue Virtual Public Meetings During State of Emergency - Minutes of the Open & Closed Session of the Hospital Board Meeting (09/22/2021) - Credentialing and Privileges Report - FY 21 Individual Performance Incentive Scores and Payouts - Real Estate Strategy Update - Policy Revisions - NICU Professional Agreement - FY 21 Annual Organizational Goal Results - Radiation Oncology Recruitment Loan Agreement - Medical Staff Report - FY 21 Audited Financial Report - FY 21 CEO Incentive Compensation Payment
	October 27, 2021 Study Session	- N/A

Report on Board Actions
November 01, 2021

Board/Committee	**Meeting Date**	**Actions** (Approvals unless otherwise noted)
ECHD Board	October 19, 2021	- AB 361 Resolution Adopting Findings to Continue Virtual Public Meetings During State of Emergency - Minutes of the Open Special Study Session of the District Board Meeting (06/17/21) - Minutes of the Open & Closed Session of the District Board Meeting (06/29/21) - Minutes of the Open Special Study Session of the District Board Meeting (09/14/21) - FY21 Year-End Consolidated Financials - FY21 Year-End Community Benefit Report - Annual Adoption of Community Benefit Grants Policy - FY 21 Year-End ECHD Standalone Financials - ECHD FY 22 YTD Financials (Period 2) - FY 22 Community Benefit Board Policy Guidance
Executive Compensation Committee		- N/A
Compliance Committee		- N/A
Finance Committee		- N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 10/19/2021 **FY22 Pacing Plan**

FY2022 Q1		
JULY 2021	**AUGUST 2, 2021**	**SEPTEMBER 7, 2021**
No Committee Meeting **Routine (Always) Consent Calendar Items:** ▪ **Approval of Minutes** ▪ **FY 22 Quality Dashboard** ▪ **Progress Against FY 2021 Committee Goals (Quarterly)** ▪ **FY22 Pacing Plan (Quarterly)** ▪ **Med Staff Quality Council Minutes (Closed Session)** ▪ **Hospital Update** **Additional Agenda Items:** 1. Health Care Equity 2. Culture of Safety 3. Patient Perspective 4. Likely to Recommend	Standing Agenda Items: 1. Report on Board Actions 2. Consent Calendar (PSI Report) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items 1. Q4 FY21 Quarterly Quality and Safety Review 2. Quarterly Board Dashboard Review 3. EL Camino Health Medical Network Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (ED Patient Satisfaction) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report QC Follow-Up Items Special Agenda items: 7. Annual Patient Safety Report 8. Pt. Experience (HCAHPS)
FY2022 Q2		
OCTOBER 4, 2021	**NOVEMBER 1, 2021**	**DECEMBER 6, 2021**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. FY 21 & FY 22 Quality Dashboard Results 8. Culture of Safety Survey Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: ~~7. Report on Medical Staff Peer Review Process~~ ~~8.~~7. Safety Report for the Environment of Care ~~9.~~8. Q1 FY22 Quarterly Quality and Safety Review ~~10.~~9. FY 22 Quarterly Board Dashboard Review ~~11.~~10. EL Camino Health Medical Network Report ~~12.~~11. Medical Staff Office Audit Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda items: 7. Readmission Dashboard 8. PSI Report 9. Report on Medical Staff Peer Review Process

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QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 10/19/2021 **FY22 Pacing Plan**

FY2022 Q3		
JANUARY 2022	**FEBRUARY 7, 2022**	**MARCH 7, 2022**
No Committee Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Q2 FY22 Quality and Safety Review 8. EL Camino Health Medical Network Report 9. Quarterly Board Quality Dashboard Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Proposed FY23 Committee Goals
FY2022 Q4		
APRIL 4, 2022	**MAY 2, 2022**	**JUNE 6, 2022**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up items Special Agenda Items: 7. Value Based Purchasing Report 8. Pt. Experience (HCAHPS) 9. Approve FY23 Committee Goals 10. Proposed FY23 Committee Meeting Dates 11. Proposed FY23 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar(CDI Dashboard, Core Measures) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow Up Items Special Agenda Items: 7. Proposed FY23 Pacing Plan 8. Q3 FY22 Quality and Safety Review 9. Proposed FY23 Organizational Goals 10. EL Camino Health Medical Network Report 11. Quarterly Board Quality Dashboard Report	Standing Agenda Items: 1. Board Actions 2. Consent Calendar (Leapfrog) 3. Patient Story 4. Serious Safety/Red Alert Event as needed 5. Credentials and Privileges Report 6. QC Follow-Up Items Special Agenda Items: 7. Readmission Dashboard 8. PSI Report 9. Approve FY23 Pacing Plan 10. Medical Staff Credentialing Process 11. Progress on Quality and Safety Plan 12. Finalize FY23 Organizational Goals 13. Approve Quality Assessment and Performance Improvement Plan (QAPI)

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

Revised 10/19/2021 **FY22 Pacing Plan**

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, CPHQ, Sr. Director Quality
Date: November 1, 2021
Subject: FY22 Enterprise Quality, Safety, and Experience Dashboard

Summary:

1. Situation: The Enterprise Quality, Safety, and Experience dashboard is used throughout the organization to illustrate, track, and communicate a key set of metrics to align the quality, safety, and experience improvement work. These key metrics are selected based on a careful review of the organizational incentive goals, strategic goals, and areas of concern based on standardized benchmarks. These are not the only metrics that are tracked but represent the highest priority for the organization.

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

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

3. Background: At the beginning of each fiscal year, an assessment is completed to identify specific areas for quality/performance improvement. A subset of these areas are then prioritized and designated as leading indicators to be tracked universally throughout the organization so that all clinicians—physicians included—and support staff are aligned in the improvement activities. Measures that demonstrate sustained improvement are removed (but still tracked) and others added. These twelve (12) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2021 Quality, Efficiency and Service Goals.

4. Assessment:

- **A.** Readmission Index @ 1.00 with 112 readmissions
- **B.** 6 SSEs for August 2021: 1 SSI, 2 Reportable PI, 1 Med. Error, 1- Incorrect Tx, 1-Fall/injury
- **C.** New metric: Precursor Medication Safety Events, 15
- **D.** Mortality Index decreased to 0.98 with 32 deaths
- **E.** HCAHPS Likelihood to Recommend for inpatient units decreased to 79.4
- **F.** ED LTR improved to 73.5
- **G.** ECH MD Likelihood to Recommend continued to decline
- **H.** Two Surgical Site Infections in MV
- **I.** Sepsis mortality Index improved to 0.91
- **J.** PC-01 w/1 that was high risk for hemorrhage with labor
- **K.** PC-02, Cesarean Sections increased with high volume
- **L.** Patient Throughput minutes increased, see annotation.

See additional detailed comments in the annotation of the report

5. Other Reviews: None

6. Outcomes:

Suggested Committee Discussion Questions: None

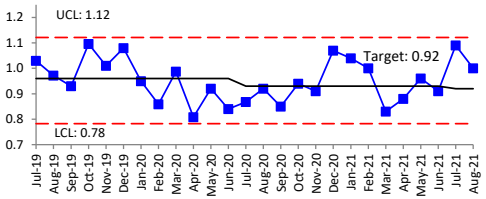
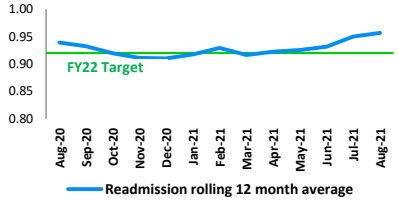
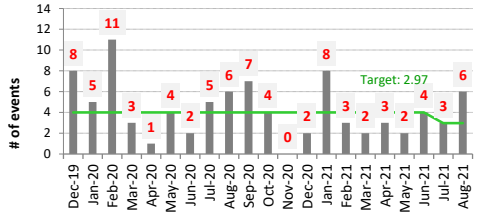
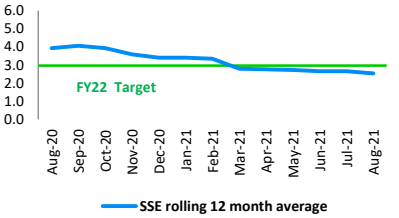
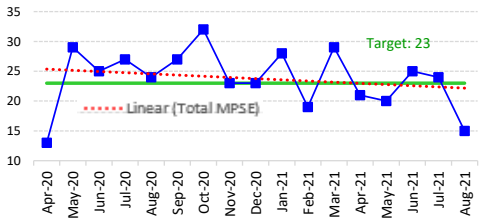
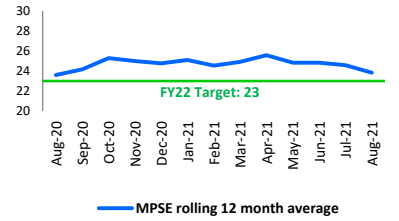
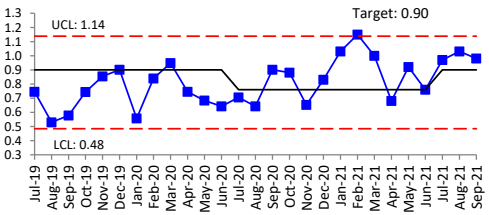
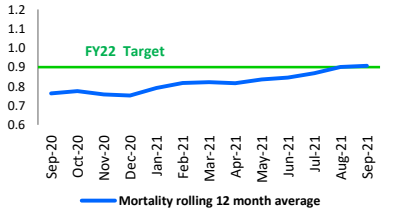
List of Attachments: FY 2022 Enterprise Quality, Safety, and Experience Dashboard, July & August data

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2021 (unless otherwise specified)

Month to Board Quality Committee:
November, 2021

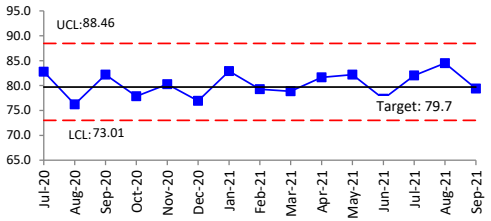
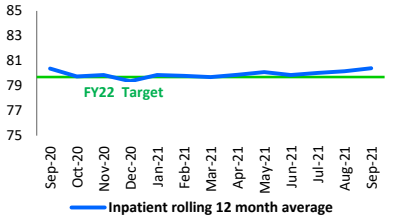
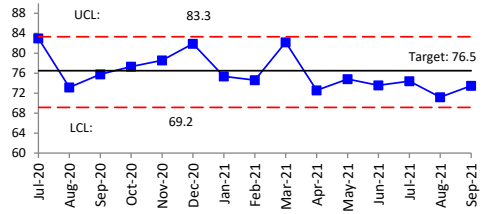
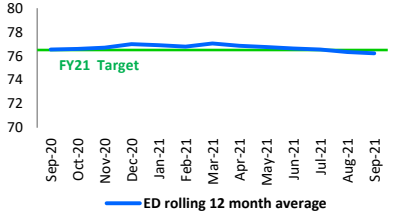
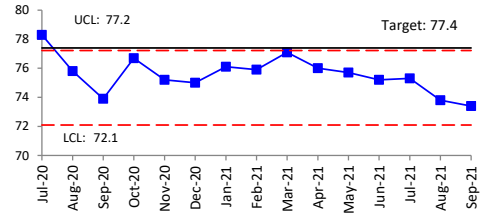
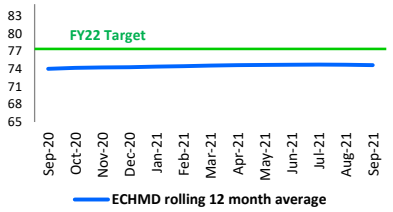
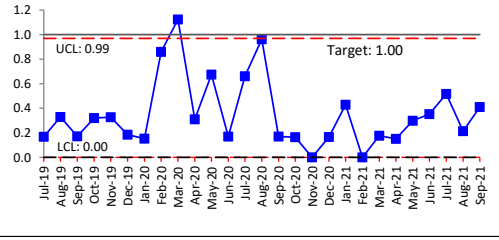
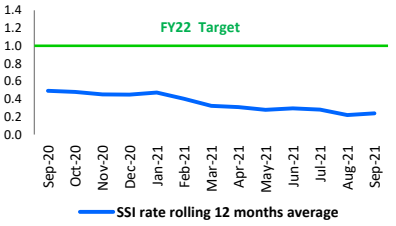
		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
1	*Organizational Goal **Readmission Index (All Patient All Cause Readmit)** ***Observed/ Expected*** ***Premier Standard Risk Calculation Mode*** ***Latest data month: August 2021	1.00 (8.29%/8.28%)	1.04 (8.68%/8.32%)	0.93	0.92		
2	*Organizational Goal **Serious Safety Event Rate (SSER) per month** # of events/ FYTD rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* ***Latest data month: August 2021	6	2.54 (44/173340)	3.13 (Dec 2019 - Jun 2021)	2.97		
3	**Actual # of Medication Precursor Safety Events (MPSE) per month/** FYTD rolling 12 month average ***Latest data month : August 2021	15	23.8/ mo. (12 month rolling average)	320 (25/month) *(April 2020 to April 2021)*	304 (23/month) *(5% reduction from baseline)*		
4	* Strategic Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Latest data month: September 2021*	0.98 (1.60%/1.64%)	0.99 (1.62%/1.63%)	0.86	0.90		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2021 (unless otherwise specified)

Month to Board Quality Committee:
November, 2021

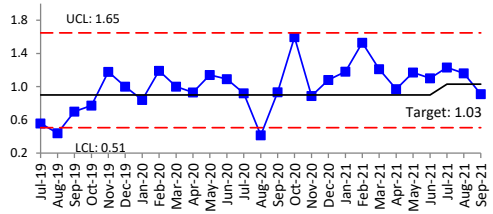
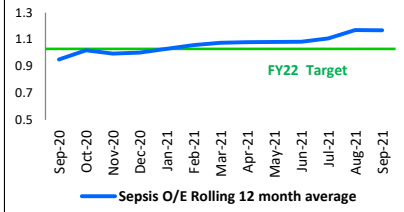
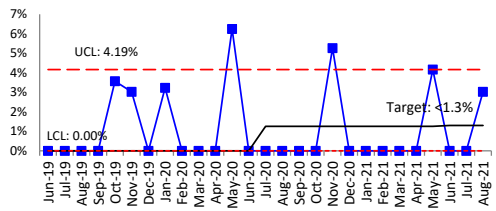
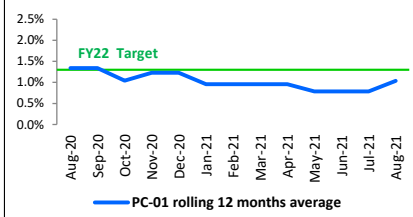
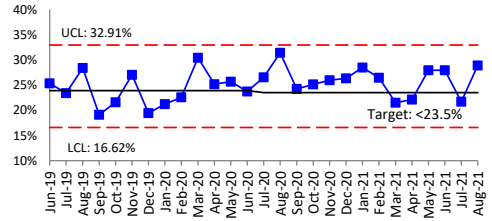
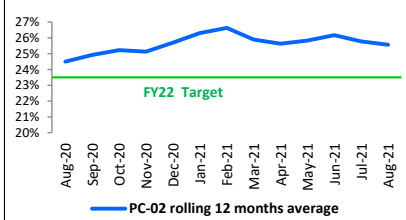
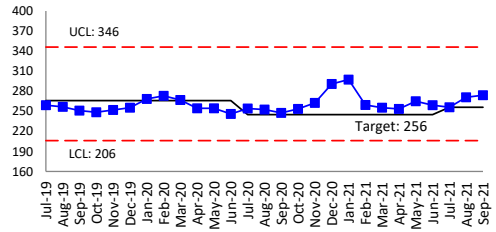
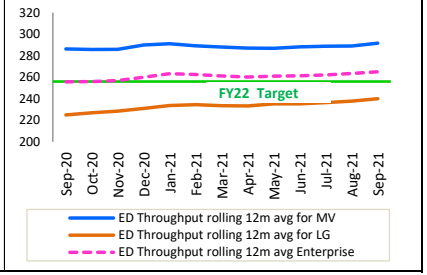
		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend *(showing at least the last 24 months of **available** data)*	Rolling 12 Month Average
		Latest month	FYTD				
5	*Organizational Goal **IP Units - HCAHPS Likelihood to Recommend -** *exec MBU,* **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: September 2021*	79.4	82.0	79.6 (n=1983)	79.7		
6	**ED Likelihood to Recommend** **Top Box Rating of 'Yes. Definitely Likely to Recommend.' %, Adjusted** *Latest data month: September 2021*	73.5	73.1	76.1 (2347)	76.5		
7	* Organizational Goal **ECH MD : Likelihood to Recommend Care Provider** (SVMD only) **Top Box Rating of 'Yes, Definitely Likely to Recommend' %, Adjusted** *Latest data month: September 2021*	73.4	74.1	76.0 (n=15,330)	77.4		
8	**Surgical Site Infections (SSI)- Enterprise** **SSI Rate = Number of SSI / Total surgical procedures x 100** *Latest data month: September 2021*	0.41 (2/487)	0.39 (6/1534)	0.30 (21/7016)	SIR Goal: <=1.0 CDC NHSN Risk Adjusted Ratio (not an infection rate)		

El Camino Health

Enterprise Quality, Safety, and Experience Dashboard

September 2021 (unless otherwise specified)

Month to Board Quality Committee:
November, 2021

		FY22 Performance		Baseline FY21 Actual	FY 22 Target	Trend (showing at least the last 24 months of ***available*** data)	Rolling 12 Month Average
		Latest month	FYTD				
9	**Sepsis Mortality Index, based on ICD-10 codes** *(Observed over Expected)* *Latest data month: September 2021*	0.91 (9.77%/10.70%)	1.06 (10.88%/10.24%)	1.08 (12.86%/11.87%)	1.03		
10	**PC-01: Elective Delivery Prior to 39 weeks gestation** (lower is better) **Latest data month: August 2021*	MV: 3.6% (1/28) LG: 0.0% (0/5) ENT: 3.0% (1/33)	MV: 1.6% (1/62) LG: 0.0% (0/10) ENT: 1.4% (1/72)	MV: 0.41% (1/244) LG: 1.32% (1/76) ENT: 0.63% (2/320)	1.3%		
11	**PC-02: Cesarean Birth** (lower is better) **Latest data month: August 2021*	MV: 29.5% (44/149) LG: 26.3% (10/38) ENT: 28.9% (54/187)	MV: 26.3% 75/285) LG: 22.1% (17/77) ENT: 25.4% (92/362)	MV: 27.58% (422/1530) LG: 20.69% (72/348) ENT: 26.30% (494/1878)	23.5%		
12	***Strategic Goal** **Patient Throughput- Median Time from Arrival to ED Departure** *(excludes psych patients, patients expired in the ED, Newborns, and transfer between sites)* *Latest data month: September 2021*	MV: 302 min LG: 246 min Ent: 274 min	MV: 291 min LG: 242 min Ent: 267 min	MV: 288 min LG: 239 min Ent: 264 min	MV: 263 min LG: 227 min Ent: 256 min		

** Readmission, SSE, MPSE, PC-01 and PC-02 data available up to August only

Report updated: 10/25/21

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CAO
Date: November 1, 2021
Subject: Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): The Safety Committee and the Emergency Management Committee of the Hospital recommends that the Board Quality Committee approve the Annual Report, Evaluation of the Environment of Care & Emergency Management.

Summary:

1. Situation: Despite the challenges presented by a global pandemic the management of the environment of care, the safety program with all its elements and the emergency management plan produced solid results. Highlights include:

a) The goal of reducing employee injuries related to assisted falls by 25% was achieved and an overall a reduction in employee injuries resulted in the fewest injuries in seven years.

b) A 16% decrease in the number of Workplace Violence incidents reported to CAL_OSHA.

c) There were no Reportable Hazardous Material Incidents or Waste Water Discharge violations.

d) The planned maintenance for high-risk medical equipment was maintained at 98% completion rates, a 10% improvement over the prior year.

e) Successful Emergency Management Drills were conducted, testing our readiness for Power and Technology failures.

There were also elements of the safety program that warrant continued effort and attention.

a) While there was a reduction in workplace violence incidents, there is still a need to improve and reduce the total number of incidents.

b) Staff education regarding horizontal and vertical evacuations needs improvement.

2. Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.

3. Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

4. Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement. The resources and prior planning and drilling helped to ensure a positive response to an unprecedented situation with a global pandemic and concurrently identifying areas in which we can improve our preparations for future events.

5. Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.

6. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-21.

List of Attachments:

1. Full Report – Evaluation of the Environment of Care & Emergency Management

El Camino Health

FY-2021 Evaluation of the Environment of Care and Emergency Management

Prepared by:

Steve Weirauch
Manager, Environmental, Health & Safety

Matt Scannell
Director, Safety and Security

Created: 08/19/2021

Table of Contents

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 Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing, Safety / Security and Human Resources.

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

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

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

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2021. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

Executive Summary

Safety Management

Key indicators were identified to establish goals for FY-21 with opportunities to improve Safety Management within the Environment of Care.

FY 21 Goals

1) Reduce employee injuries relate to assisted patient falls
   - **Measurement of success**: Reduce employee injuries related to assisted falls by 25%
     - **This *goal was accomplished.*** In FY21, we reduced employee injuries related to assisted falls by 25%. In F/Y21, we had six injuries related to patient falls compared to eight in FY20.
2) Deploy new AIER injury reporting system under RLDatix
   - **Measurement of success**: We expect this implementation will increase end user satisfaction. Increase injury investigation completion within 3 days after the injury by 10%.
     - **This *goal was not accomplished.*** Due to COVID-19 priorities, we were not able to implement RLDatix. We are currently testing the forms and processes created in the system and expect to deploy in F/Y22.

Security Management

Effectiveness

Key performance indicators were identified in the FY-21 to improve Security Management within the Environment of Care.

FY-21 Goals

1) 90% non-medical emergency security response time less than 3 minutes-
   - **This goal was met**
2) 15% reduction in number of reportable workplace violence incidents- In FY-21 there was a 16% decrease in the number of Workplace Violence reports submitted to CAL-OSHA.
   - **This goal was met.**
3) Reduce the number of reported thefts on both campuses by 10% over FY-20 totals- In FY-21 there were total of 5 reported thefts (4 in MV and 1 in LG) for a 75% decrease over FY-20.
   - **This goal was met.**

Hazardous Material Management

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[1] training course.

[1] HAZWOPER: Hazardous Waste Operations and Emergency Response

Executive Summary

Key indicators were targeted to establish goals for FY-21. The following goals presented opportunities to improve hazardous materials & waste management.

FY-21 Goals:

1. Review and revise the Hospital Hazardous Waste Guide (2021) with an emphasis on the RCRA List reflecting knowledge gained from USP800/NIOSH process.
   - **Measurement of success**: Completion and distribution of new guides. Training for all required staff
     - **This goal was accomplished.**
2. Review and update Online Spill Form to include department of occurrence completion with Corrective Actions/Comments section and the ability of Hazardous Work Group Chair to update/edit as needed.
   - **Measurement of Success**: 100 percent compliance of Recordable Hazardous Materials incidents to the online reports for FY-21 completed by designated staff of unit of occurrence and completion of Corrective Actions/Comments section.
     - **This goal was accomplished**.

Fire Safety Management

Effectiveness

Based on opportunities for improvement identified in FY-20 annual EOC evaluation the FY-21 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Fire Prevention	Staff knowledge of the acronym RACE for responding to a fire situation	Engineering, Security and Department Managers	>90%	95%
Fire Prevention	Staff knowledge of the acronym PASS for using a fire extinguisher	Engineering, Security and Department Managers	>90%	95%
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	>90%	89%

Note: Staff knowledge on horizontal and vertical evacuation was not met. This will be a carryover indicator in FY-22 and will be a focus during EOC rounds with staff.

Medical Equipment

Effectiveness

FY-21 Performance Indicators

1. Improve the confidence level of the active assets in the inventory to greater than 90%.
   - **Measurement of Success**: Currently we are at an 84% confidence level of assets active in the database. This will be accomplished by tracking scheduled work orders

on an asset by various sub status codes to assure the asset is a valid active asset and should remain in the inventory.

- **This goal was accomplished**. We reach and exceeded our goal. Through a process of identifying, documenting and communicating with department for assistance in locating assets in the database we were able to able to attain a 95% confidence level in our inventory.

2. Develop 2 network indicators that will alert potential monitoring network failures.
   - **Measurement of Success**: These indicators will provide solutions to preemptively resolve potential issues within the networked monitoring system. Previously, we only had Philips HL7 as an alert but in collaboration with Philips interface engineer and our hospital interface engineering, there were rules put in place to notify us with 15min of inactivity.
   - **This goal was accomplished**. We setup an alerts for our interfaces where various IT team members and Clinical Engineering get notified via email for the following interfaces to preemptively resolve any networking issues affecting patient care;
     - Philips ADT Philips HL7
     - Philips VS30 Communication
     - Philips Intellispace HL7
     - Philips Intellispace ADT
     -

Utility Systems

Effectiveness

Key indicators were targeted to establish goals for FY-21. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Management	Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment	Engineering, Security and Department Managers	>90%	100%
Utility Management	Staff can describe who has the authorization to turn off medical gas controls.	Engineering, Security and Department Managers	>90%	100%

Emergency Management

Effectiveness

Key indicators were targeted to establish goals for FY-21. The following goals presented opportunities to improve emergency management.

FY-21 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY-20)

Executive Summary

- **Measurement of Success**
  - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
  - Evaluate and set up logical groups and rules for notifications.
  - Train key staff to be able to use/send alerts
- **This *goal was accomplished*.**
  - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
  - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
  - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.

2. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
   - ***This goal was accomplished.*** All exercises have been expanded to include all pavilions in planning and participation.
3. Revise Hospital Surge Plan.
   - ***This goal was accomplished.*** The Hospital COVID-19 Pandemic Plan was used as a reference to revise the Hospital Surge Plan. The plan was reviewed and approved by the Emergency Management Committee.

EC 1.0 - Safety Management

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

Scope

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

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

Performance

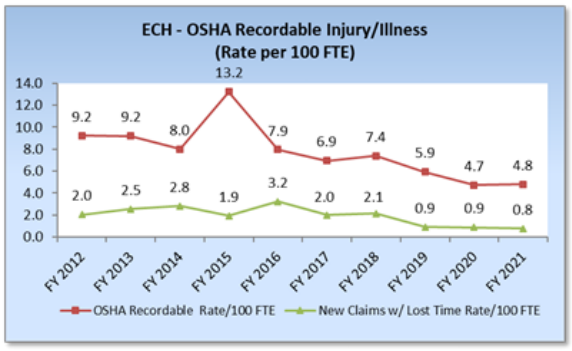
Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-21. 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 slightly increased in FY-21 to 4.8 as compared to 4.7 in FY-20. The total number of recordable incidents increased to 126 compared to 120 in FY-20.

The rate of lost workdays for all open claims (per 100 FTEs) decreased to 0.8 in FY-21 compared to 0.9 in FY-20. **This is the lowest rate in the last ten years!**



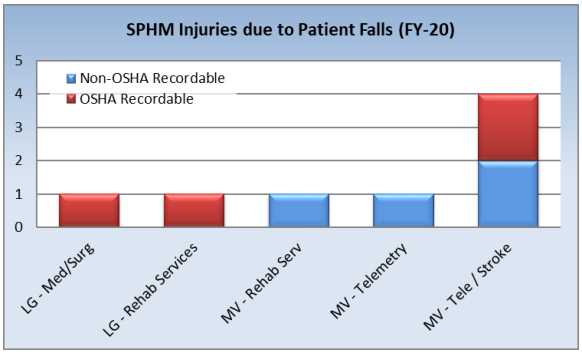
Analysis

- In FY-21, we had a **0.1% increase** in OSHA recordable injuries compared to FY-21 but we **decreased our loss time rate by 0.1% compared to FY-20**.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were **Musculoskeletal Disease (MSD)-not related to patient handling at 31%, exposures at 17% followed by falls at 15%.**
- In FY-21 Bloodborne pathogen exposures due to needle sticks were reduced by 48% in comparison to FY-20. Improvement strategies will be explained in the Bloodborne Pathogens Exposures section below.

EC 1.0 - Safety Management

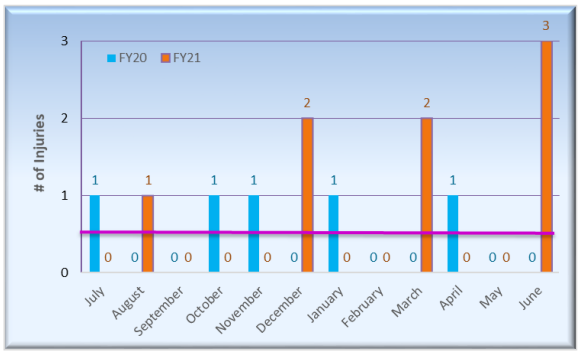
Improvement Strategies:

Patient fall prevention/assistance continues to be the most common, and rising, cause of injury, accounting for 35% of those reported in FY-20.



- EWHS continued to collaborate with the Patient- and Employee- Fall Prevention Committees to identify opportunities for prevention.
    - After a fall, a huddle/report is under consideration.
    - Training and provision of gait belts is being evaluated; s
    - Sit/stand/walk aids encouraged
    - Three low frame beds are now available for fall risk patients.
- Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication is being strategized to promote equipment use and fall prevention.

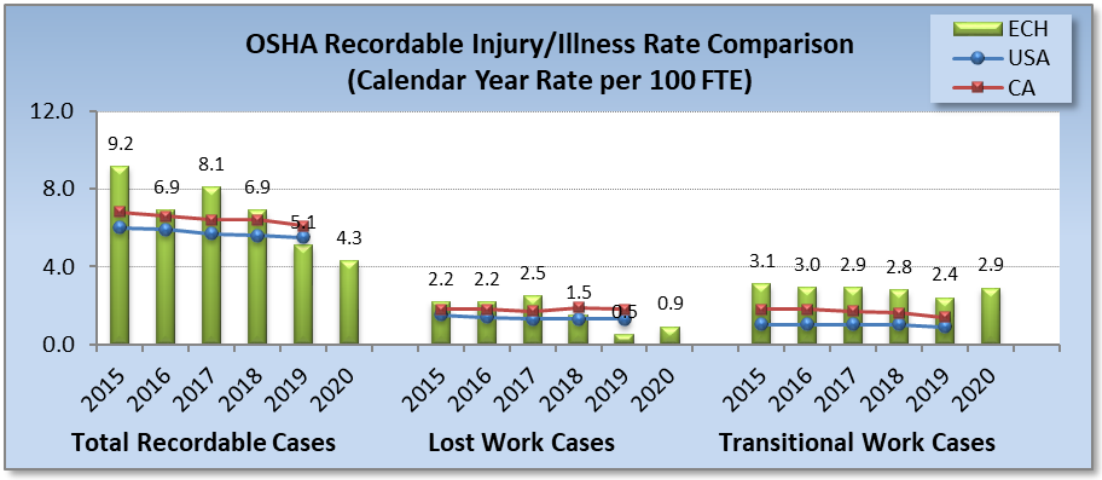
We monitored this metric as part of the Patient & Employee Safety Committee dashboard (baseline 8 injuries with six injuries as target). **We are happy to report that we met our target with six SPHM injuries related to patient assisted falls; a 25% reduction.**



EC 1.0 - Safety Management

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

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[2].



The ECH injury/illness rate in ***calendar year 2020*** was 4.3, which is below the state and national averages in 2019 (the most recent year available from the BLS). The ECH lost work cases rate was 0.9, which is below national average and below state average. Our lower rate in loss time cases is due to our Safe Patient Handling & Mobility Program and our success in reducing injuries among our Environmental Services staff.

El Camino Health's robust Transitional Work Assignment Program shows a commitment to getting people back to work as quickly as possible after an injury or illness explaining our slight above average transitional work cases (2.9) compared to the national and state averages.

C. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **increased in FY-21, from 0.4 in FY-20 to 0.9 in FY-20.**
- **Total Injuries**: The persistent downward trend in both the total number of SPHM injuries and those that are OSHA-recordable was not maintained this fiscal year. Instead, more than double the amount of both total injuries and those that are OSHA-recordable were reported as compared to FY-20.

SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 14-21)

SPHM Injuries	2015	2016	2017	2018	2019	2020	2021
Total Reported	38	48	44	41	29	23	50
OSHA-recordable	29	34	29	23	16	10	26
% OSHA	76%	71%	66%	56%	55%	43%	52%

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

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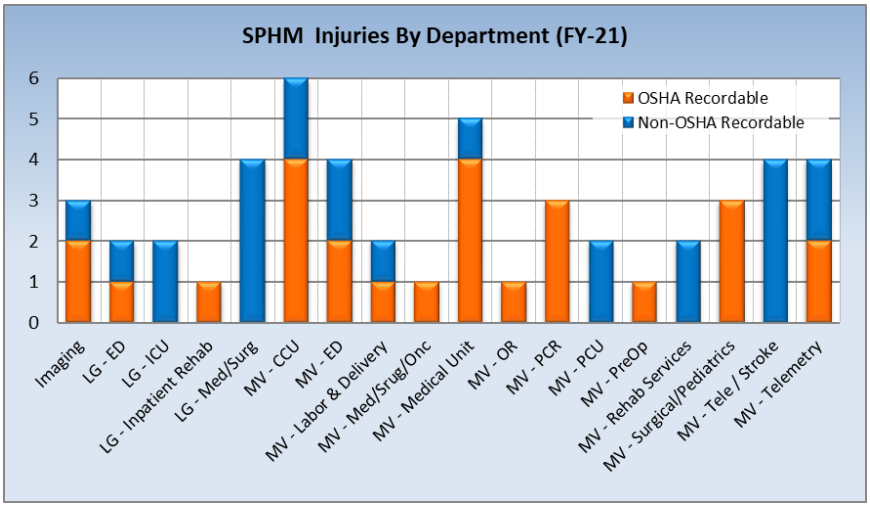
- **Lost/Restricted Days due to SPHM Injuries:** Another record low number of lost days (3 during the fiscal year) was achieved again this year. The total number of restricted days more than tripled that of last year.

SPHM Injuries by Type, Fiscal Years 15 – 21

Activity	2015	2016	2017	2018	2019	2020	2021
Combined Transfer	6	8	6	5	5	**2**	**3**
Cumulative Pt Handling	5	1	5	4	0	**1**	**2**
Lateral Transfer	8	6	8	1	5	**3**	**9**
Patient fall/prevention	5	6	5	9	8	**8**	**10**
Car extraction	0	0	0	0	0	**1**	**2**
Pt Holding	2	3	2	3	2	**1**	**5**
Turning/Pulling	12	12	12	16	5	**6**	**17**
Vertical Transfer	5	12	5	3	4	**1**	**2**

  - There was a surge of SPHM injuries due to patient repositioning: turning and pulling up in bed, accounting for 1/3 of the total, with rates like those seen prior to 2019.
  - The rising and persistent trend of employee injuries in preventing/assisting patient falls continues; accounting for 20% of those reported.

- **Injuries by Department**



  - Critical Care and the Medical units incurred the most injuries, but almost no department was spared. CCU historically has high rates; their improvement last year was not reproduced.
  - The Mother/Baby Units in both hospitals has continued with no SPHM injuries since the emphasis on the use of SARA Stedy and HoverMatts.

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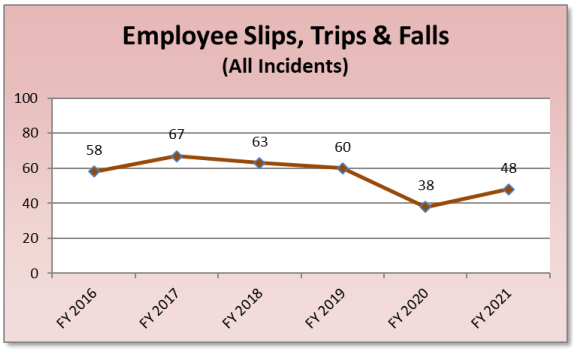
Improvement strategies:

- Maintenance of a robust SPHM program and education has been challenging in the setting of a pandemic, with competing demands and monthly meetings and in-person trainings postponed. Reliance on meeting remotely through Zoom has improved attendance and involvement.
- Performance of the PMAT (Patient Mobility Assessment Tool) has been mandated and improving communication continues to promote both equipment use and fall prevention.
- The organization continues to be confronted with identifying means to train and empower Safe Patient Handling Unit champions to continue progress in injury reduction during a pandemic demanding social distancing.
- Consideration of an alternative friction-reducing transfer product must be evaluated in light of the increase in injuries due to repositioning and the lack of use of the current device.

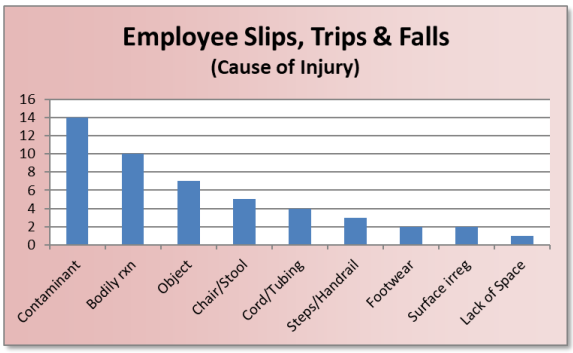
D. Slips, Trips, Falls Injuries

Analysis:

- **Injury Incidence**: Targeted interventions to reduce Slip, Trip Fall (STF) injuries were initiated in FY-17 due to the consistently rising incidence. There was a slight decline in FY-19, followed by significant reduction in FY-20. Although the rate reduction was not maintained in FY-21, the total number of STFs reported remained lower by 10 or more as compared to pre-FY-20.



- **Injury Types:**
  - Contaminants/slippery floor continues to be the most significant cause of STFs.
  - Bodily reaction, or "I just fell" was the second most common cause, with a higher rate as compared to all prior years. Half of the total occurred in May and June.



  - Shoe covers were reported as a factor in 2 of the injuries despite a targeted intervention with a trial and roll-out of skid-resistant soles previously.

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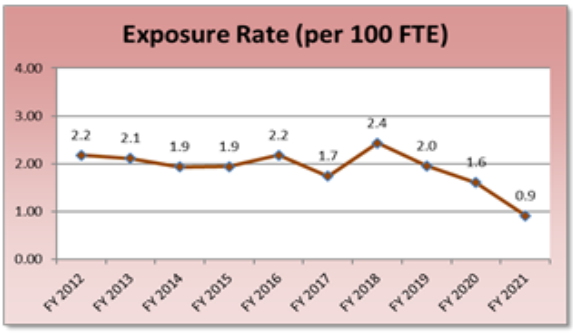
Improvement Strategies:

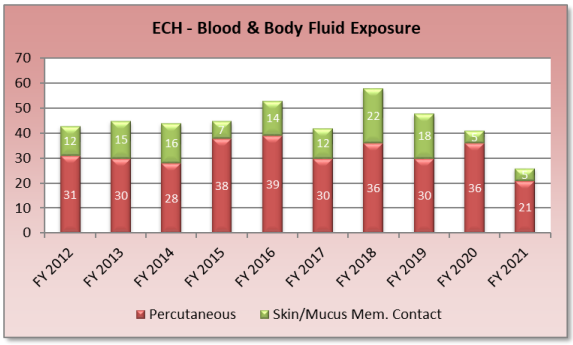
- Task force attendance has improved since meeting by Zoom to investigate all accidents.
- Partnership with Facilities and annual outside stair maintenance continues to contribute to a reduction in STFs on stairs, down to 3 from a high of 8 in FY-19.
- New landscaping and signage has effectively and significantly reduced falls outside by more than 50% as compared to all of the prior 4 years.
- A renewed awareness campaign promoting the availability of ordering cord clamps rolled out due to an increase from 2 to 4 falls due to cords/tubing.
- Safety awareness and reducing distractions is targeted for next year since most of the 29 STFs that occurred due to bodily reaction, falls from chairs and on wet floors may have been prevented with greater attention to the physical environment.
- Similarly, strategies to provide/encourage skid resistant shoes is a priority, as the bulk of STF injuries continues to be due to slippery surfaces, foot coverings, and bodily reactions that may have been prevented.
- Partnering with Purchasing to confirm that only skid-resistant shoe coverings are available for use, and an evaluation of size options.

E. Blood-borne Pathogen (BBP) Exposures

The rate of blood-borne pathogen exposures per 100 FTE **<u>decreased to 0.9 in FY-21 compared to 1.6 in FY-20.</u>** The total number of exposures for both campuses decreased to 25 exposures in FY-21 compared to 41 in FY-20. Of these, 21 were percutaneous exposures and four were body fluid exposures due to splashes.



Analysis:



- In October 2019, a full needle conversion was implemented at both campuses, based on findings by our Sharp Taskforce and to reduce variation among floors and among campuses.
- **<u>In FY-21 there was a 42% reduction in needle sticks compared to FY-20</u>**
- The implementation of universal masking and eye protection programs due to COVID-19 directly contributed the **<u>decrease in BBP exposures due to splashes by 74% in 15 months</u>**.

Improvement Strategies:

- Continue Sharps Training as part as Nursing Orientation/GHO
- Continue to meet one on one with injured employees to identify preventable root causes
- Will continue to advocate for universal eye protection beyond the COVID-19 pandemic as it has significantly reduced our exposures due to splashes
- EWHS continues to collaborate with Clinical Education to explore ways to increase awareness and possible education among our nursing new graduates.

F. TB Conversions

There were no known occupational exposure conversions during FY-21.

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. All employees complete new employee orientation upon hire. Annual regulatory review courses are required for all employees and provided as on-line modules. The topics including fire, evacuation, hazardous materials, and other safety topics. The compliance rates for FY--21 are:

- New employee orientation: 100% (Target: 100%)
- Annual Regulatory Clinical Review: 91% (Target: 95%)
- Annual Regulatory Non-Clinical Review: 93% (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 calendar year 2020 involved:

Problem Type	*Category*
Are all ceiling tiles in place and in good condition (unbroken, free of dirt, mold, dust, water stains)?	*General Safety*
Are all walls in good condition (undamaged, free of holes or water damage)?	*General Safety*
Is soiled linen found only in hampers, not on floors?	*Hazardous Material Mgmt.*
Are items stored at least 18 inches below sprinkler heads?	*Fire Safety*
Are all electrical panels accessible – not blocked by carts, boxes, trash cans, or other items?	*Utility Management*
Do all fire extinguishers have 3-foot clearance?	*Fire Safety*
Is paper signage laminated or in plastic sleeves?	Infection Prevention
Are inspection stickers on patient-related equipment current? (check two items)	*General Safety*

EC 1.0 - Safety Management

Effectiveness

Key indicators were identified to establish goals for FY-21 with opportunities to improve Safety Management within the Environment of Care.

FY 21 Goals

1) Reduce employee injuries relate to assisted patient falls
    - **Measurement of success**: Reduce employee injuries related to assisted falls by 25%
        - **This *goal was accomplished.*** In FY21, we reduced employee injuries related to assisted falls by 25%. In F/Y21, we had six injuries related to patient falls compared to eight in FY20.
2) Deploy new AIER injury reporting system under RLDatix
    - **Measurement of success**: We expect this implementation will increase end user satisfaction. Increase injury investigation completion within 3 days after the injury by 10%.
        - **This *goal was not accomplished.*** Due to COVID-19 priorities, we were not able to implement RLDatix. We are currently testing the forms and processes created in the system and expect to deploy in F/Y22.

EC 2.0 - Security Management

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

Scope

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

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

The Workplace Violence Prevention Plan is required by Cal-OSHA (Section 3342 of Title 8 of the California Code of Regulations). This plan is specifically for healthcare workers. The WPVP program at El Camino Health is overseen by the Workplace Violence Prevention Committee. There are four required elements to the plan:

1. Written Plan: The plan is reviewed and updated annually.
2. Response: The plan includes a comprehensive violent incident investigation process.
3. Training: The hospital has developed two levels of training.
    - **AVADE** – Computer based training module assigned annually to most staff.
    - **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
        - Charge Nurses/Clinical Managers
        - Assistant Hospital Managers (Hospital Supervisors)
        - Security
        - Course is also available as an option to all staff.

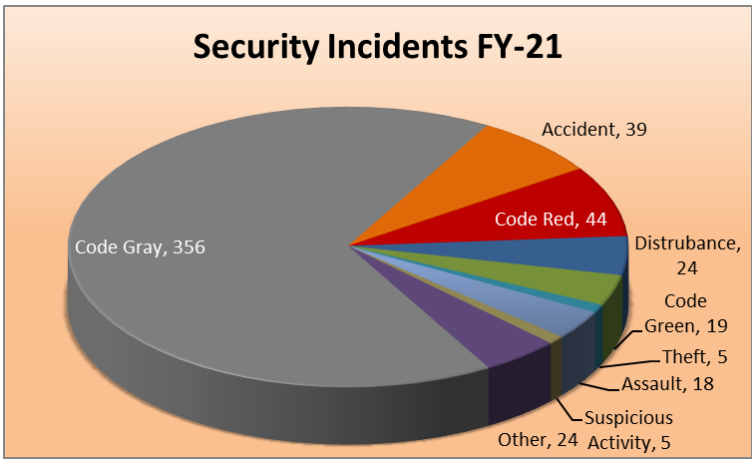
    Note- Due to COVID-19 we suspended in person hands on training and went to on-line only curriculum.

EC 2.0 - Security Management

4. Reporting: An ongoing WPV Reporting team ensures reporting is completed as required.
    - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
    - In FY-21, 53 incidents were reported to OSHA. 51% (27) of the incidents resulted in no injury. The remaining events were minor injuries with 46% being bruises or abrasions. No major injuries were reported.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY-21. The data includes activity from both campuses.



There were a total of 534 reported security incidents for FY-21 requiring immediate response. This is a slight increase from the FY-20 of 528.

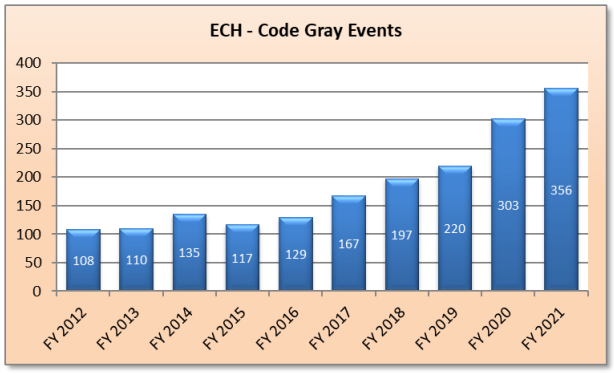
Review of the major FY-21 incidents showed:

- There were 53 Workplace Violence (WPV) incidents reported to CA-OSHA. This is a 16% decrease from FY-20. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
    - More focus on the root causes of workplace violence events in the WPV committee.
    - Better communication and preparedness between clinical departments on patients that have already been combative during their Hospitalization.
    - A renewed focus on strategies to deal with elderly dementia patients that showed an increase in the number of reportable workplace violent reports in FY-20
    - More proactive use of the combative patient flagging tool in Epic.
    - An overall decrease in the number of patients and visitors
    - Daily communication between the clinical staff and the security staff on patients that have the potential to be combative.

EC 2.0 - Security Management

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY-21 was 356 compared to 303 in FY-20.



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 Emergency Dept. (ED) – 27%
- MV Medical Unit (2C) – 14%
- MV Telemetry/Stroke (3C)-13%
- MV Progressive Care unit (PCU) – 13%

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

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

B. Bulletins, Alerts & Presentations

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

C. Patient Belongings

Security Officers performed 6,115 chain-of-custody transactions involving patient's belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 2,340 patient watches, standbys and restraints. This was an increase over FY-20 (1968). Hospital Supervisors notify Security of these events, which can last several hours. They primarily occur in the Emergency Department, Mental Health and Addiction Services (MHAS) and on the Medical Units. Patient watches are also handled by ED Technicians, Patient Safety Attendants (PSAs), and others which may not be included in these numbers.

E. Fire Drills / Fire Watches

Security Officers conducted 99 fire drills and are 100% up-to-date. A total of 5 fire watches were performed in FY-21.

EC 2.0 - Security Management

F. General Assistance

Security Officers performed 44,277 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 1,841 Photo ID Badges with access and barcoding technology to staff, physicians, auxiliary, contractors, and students. 1,231 temp badges were issued.

H. Investigations & Audits

Security Services performed 107 investigations and audits including but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

I. Lost and Found

Security Officers performed 417 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 84,172 inspections (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

K. Loitering

Security Officers responded to 356 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

L. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 95 vehicle-related services including jump-starts, door unlocks and tows. 253 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 150 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

EC 2.0 - Security Management

N. Statistics –Police Department Crime Data

Estimated MVPD Annual Report

Square Miles:	12	11.25
Population:	83,377 (County of Santa Clara 1,945,940)	30,516
Personnel:	148	59 (39 sworn & 20 non-sworn)
Total Calls for Service	6,860	35,524
Statistics ***UCR data includes attempts and actual crimes***		
Part I UCR:	2274 (2103 Property vs. 171 Violent)	488 (477 Property vs. 11 Violent)
Previous Year	2164 (1976 Property vs. 188 Violent)	598 (583 Property vs. 15 Violent)
Part II UCR:	2497	Not Collected
Previous Year	2800	Not Collected
Arrests-Misdemeanor:	1235 (1177 Adult vs. 58 Juvenile)	Not Collected
Previous Year	1553 (1465 Adult vs. 88 Juvenile)	Not Collected
Arrests-Felony:	386 (347 Adult vs. 39 Juvenile)	Not Collected
Previous Year	375 (353 Adult vs. 22 Juvenile)	Not Collected
Traffic Collisions:	467	281
Previous Year	550	Not Collected
Moving Violations:	Not Collected	Not Collected
Previous Year	1827	Not Collected
Non-Moving Violations:	Not Collected	Not Collected
Previous Year	2199	Not Collected
Indexes ***Per 1,000 current year population***		
Violent:[3]	2.11	0.35
Previous Year	2.33	0.48
Property:[4]	26.29	15.53
Previous Year	24.46	18.98

Effectiveness

Key performance indicators were identified in the FY-21 to improve Security Management within the Environment of Care.

FY-21 Goals

1) 90% non-medical emergency security response time less than 3 minutes-
   - **This goal was met**
2) 15% reduction in number of reportable workplace violence incidents- In FY-21 there was a 16% decrease in the number of Workplace Violence reports submitted to CAL-OSHA.
   - **This goal was met.**
3) Reduce the number of reported thefts on both campuses by 10% over FY-20 totals- In FY-21 there were total of 5 reported thefts (4 in MV and 1 in LG) for a 75% decrease over FY-20.
   - **This goal was met.**

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

EC 3.0 - Hazardous Materials & Waste Management

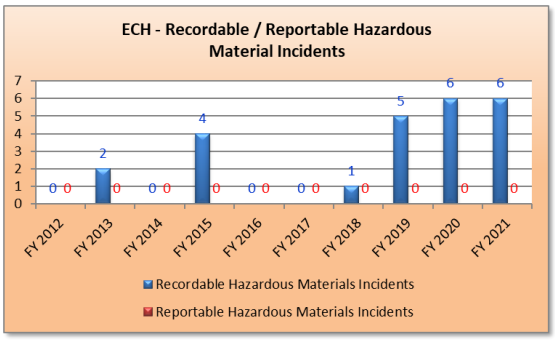
Work Group Chair: ***Lorna Koep***

Scope

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

Performance

A. Hazardous Material Incidents



The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

- **Recordable Hazardous Material Incidents**[5]**:**

1) Rapicide spill-MV Endoscopy Equipment Room – Lid Seal malfunction/not stored in the upright position, contained in secondary container. Cleanup was handled safely. Reviewed procedures for Formalin storage/handling.
2) Xylene spill – MV Receiving and Supplies Dock – 1 Gallon Lid Seal malfunction, cap broken during transportation. Container slipped from staff member's grasp and fell to Loading dock cement surface. RCA performed, gap identified, staff re-trained. Cleanup was handled safely.
3) Formalin spill- MV Endoscopy Center Core - Lid Seal malfunction/not stored in the upright position, contained in secondary container. Cleanup was handled safely. Reviewed procedures for Formalin storage/handling.
4) Buffered 10% Formalin spill MV OR #3 – Lid Seal malfunction/not stored in the upright position, contained in secondary container. Cleanup was handled safely. Reviewed procedures for Formalin storage/handling.
5) Buffered 10% Formalin- Storage box in CT Control Area – Lid Seal malfunction/not stored in the upright position, contained in secondary container. Cleanup was handled safely. Reviewed procedures for Formalin storage/handling.
6) Formalin spill- Outside Labor and Delivery OR#2 - Contents of one placenta bucket spilled when RN went to obtain bucket. Improper storage technique of stacking buckets. Cleanup was handled safely. Reviewed procedures for Placenta Formalin Bucket storage/handling.

- **Reportable Hazardous Material Incidents** – No reportable spills.

[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.

EC 3.0 - Hazardous Materials & Waste Management

B. Waste Water Discharge Violations:

- **No Waste Water Discharge Violations**

C. Monitoring and Inspections

- **Hazardous Waste Inspections** – No Inspections for FY-21
- **Santa Clara County Annual Medical Waste Inspections** – No Inspections for FY-21
  - 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.

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-21. The following goals presented opportunities to improve hazardous materials & waste management.

FY-21 Goals:

1. Review and revise the Hospital Hazardous Waste Guide (2021) with an emphasis on the RCRA List reflecting knowledge gained from USP800/NIOSH process.
   - **Measurement of success**: Completion and distribution of new guides. Training for all required staff
     - **This goal was accomplished.**

[6] HAZWOPER: Hazardous Waste Operations and Emergency Response

EC 3.0 - Hazardous Materials & Waste Management

2. Review and update Online Spill Form to include department of occurrence completion with Corrective Actions/Comments section and the ability of Hazardous Work Group Chair to update/edit as needed.
    - **Measurement of Success**: 100 percent compliance of Recordable Hazardous Materials incidents to the online reports for FY-21 completed by designated staff of unit of occurrence and completion of Corrective Actions/Comments section.
        - **This goal was accomplished**.

EC 4.0 - Fire Safety Management

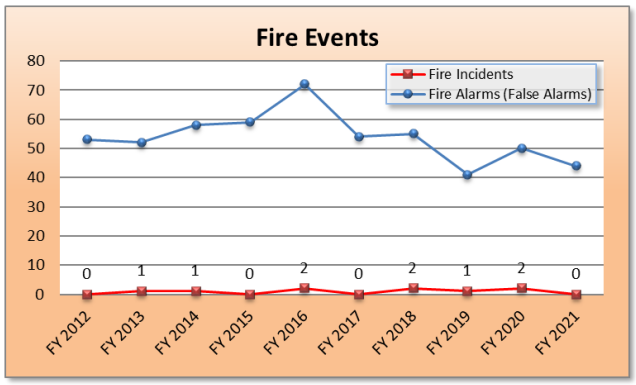
Work Group Chair: ***John Folk***

Scope

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

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY-21.



A. Fire Incidents

There were zero reported fire incidents in FY-21.

B. Fire Alarm Events

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

The total number of events in FY-21 **(44**) was slightly higher than FY-20 **(41**). There were 41 events in Mountain View and 3 in Los Gatos. This was accomplished despite heavy construction activity at both hospitals during FY-21. The reduction can be linked to the development of an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.

C. Fire Drills Completed / Scheduled

All required fire drills (99) were completed in FY-21. For all drills, there were 24 required actions by staff. All issues were fully corrected either on the spot or with further education by the dept. Manager.

EC 4.0 – Fire Safety Management

Effectiveness

Based on opportunities for improvement identified in FY-20 annual EOC evaluation the FY-21 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Fire Prevention	Staff knowledge of the acronym RACE for responding to a fire situation	Engineering, Security and Department Managers	>90%	95%
Fire Prevention	Staff knowledge of the acronym PASS for using a fire extinguisher	Engineering, Security and Department Managers	>90%	95%
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	>90%	89%

Note: Staff knowledge on horizontal and vertical evacuation was not met. This will be a carryover indicator in FY-22 and will be a focus during EOC rounds with staff.

EC 5.0 - Medical Equipment Management

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

Scope

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

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

Performance

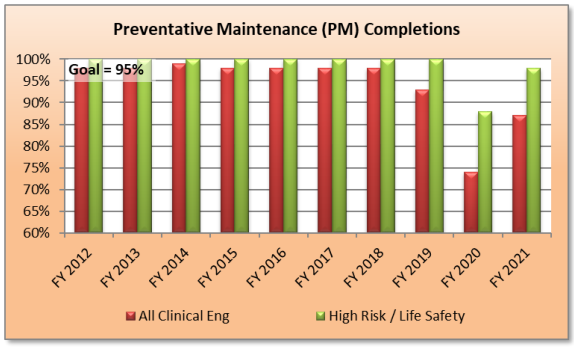
Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-21.

A. Reports to the FDA –

There were 8 reports through the Medwatch[7] system in FY-21. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

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



- The completion rate for Clinical Engineering achieved 87% for FY-21. A 13% improvement from FY-20. All devices were 100% managed through a communication process to locate all devices.
- All high risk, life safety equipment was maintained at 98% completion rates. A 10% improvement from FY-20. All devices were 100% managed through a communication process to locate all devices.

C. Product Recalls Percentage Closed / Received

For FY-21, there were 73 recorded equipment recalls; 10 still open.

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

EC 5.0 – Medical Equipment Management

D. Effectiveness

FY-21 Performance Indicators

1. Improve the confidence level of the active assets in the inventory to greater than 90%.

    - **Measurement of Success**: Currently we are at an 84% confidence level of assets active in the database. This will be accomplished by tracking scheduled work orders on an asset by various sub status codes to assure the asset is a valid active asset and should remain in the inventory.

        - **This goal was accomplished**. We reach and exceeded our goal. Through a process of identifying, documenting and communicating with department for assistance in locating assets in the database we were able to able to attain a 95% confidence level in our inventory.

2. Develop 2 network indicators that will alert potential monitoring network failures.

    - **Measurement of Success**: These indicators will provide solutions to preemptively resolve potential issues within the networked monitoring system. Previously, we only had Philips HL7 as an alert but in collaboration with Philips interface engineer and our hospital interface engineering, there were rules put in place to notify us with 15min of inactivity.

        - **This goal was accomplished**. We setup an alerts for our interfaces where various IT team members and Clinical Engineering get notified via email for the following interfaces to preemptively resolve any networking issues affecting patient care;

            - Philips ADT Philips HL7
            - Philips VS30 Communication
            - Philips Intellispace HL7
            - Philips Intellispace ADT

EC 6.0 - Utilities Management

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

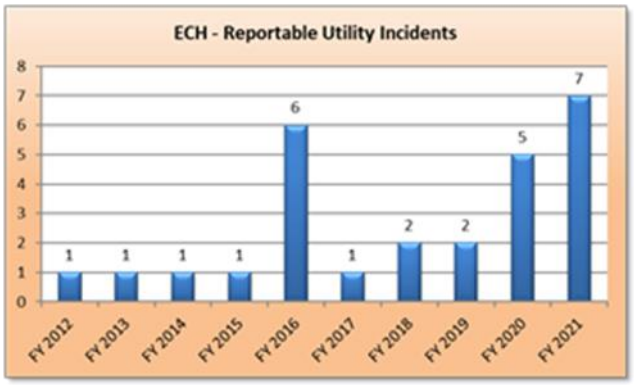
Scope

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

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-21.

A. Utility Reportable Incidents



There were seven reportable incidents in FY-21. All were electrical outages or voltage fluctuations.

- In August, April, May, and June, Los Gatos had a momentary loss of electrical utility (PG&E) campus wide.
    - The August, April and May events activated the emergency generators.
- In March, Mountain View had a loss of electrical to the campus due to a PG&E mechanical malfunction.

B. PM Completion Rate % completed/ scheduled

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

C. Generator Test % completed/scheduled

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

EC 6.0 - Utilities Management

Effectiveness

Key indicators were targeted to establish goals for FY-21. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Management	Staff can describe the proper way to store oxygen cylinders as well as the amount per smoke compartment	Engineering, Security and Department Managers	>90%	100%
Utility Management	Staff can describe who has the authorization to turn off medical gas controls.	Engineering, Security and Department Managers	>90%	100%

EM – Emergency Management

Committee Chair: ***Steve Weirauch***

Scope

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

Performance

Performance indicators for the Emergency Management program are reported through the monthly meetings. Significant events are presented quarterly to the Central Safety Committee. The following Emergency Management indicators were reported in FY-21.

A. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY-21 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. **Network Outage – Enterprise (11-29-20)** – at approximately 11:50 AM issues with telephone operations were reported. This was predominantly a loss of outside phone access. Internal communications were mostly operational. A data storage issue was determined to be the source of the outage. Systems were completely back on line by approximately 18:00. Command team met in the HCC to ensure continued operations
2. **Network Outage – Enterprise (02-15-21)** – a planned network upgrade at approximately 09:00 caused an unanticipated network outage of computers, communications systems, and some door security systems. The command center was briefly opened to ensure all areas were secured and backup systems were operational. The outage lasted approximately 1 hour.

B. Events / Emergencies

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

1. **Public Safety Power Shut Off –** PG&E activated *Public Safety Power Shutoff* (PSPS) events during the fall of 2020. Neither campus was impacted by the events, however plans were reviewed and updated to ensure continued operations should power be interrupted.
2. **Power Outage – Mountain View Campus (12-19-20)** – high winds and downed tree branches in a local neighborhood resulted in a 2-hour power outage at the Mountain View campus. Generators and backup power came online causing minimal impact to hospital operations.

EM – Emergency Management

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY-21, this was met through separate planned exercises at both campuses (see below) and the continuing COVID-19 pandemic response. The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

Note, during most years, the hospitals participate in a statewide medical and health exercise in November. Due to COVID-19 pandemic, the statewide event was cancelled.

a. **Public Safety Power Shut-Off (PSPS) Exercise (09/24/20)** – In preparation for the coming fire season and the potential for PG&E to initiate Public Safety Power Shutoff events in the area, a functional exercise was conducted at each campus to test procedures and plans should the hospitals be directly or indirectly affected by one of these events.

b. **When Technology Fails (WTF) Tabletop Exercise (05/20/21)** – The WTF-tabletop exercise was designed to establish a learning environment for players to exercise plans and procedures for responding to a network and communication systems outage, in this case a simulated ransomware attack.

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

- **Code Pink Drills – Mountain View & Los Gatos** - Exercises were conducted at both campuses to test staff's ability to respond to an infant security band alert.

D. Emergency Management Training

- **New hire orientation** (100% for all employees)
- **Safety coordinator meetings** (72% attendance overall for the quarterly meetings). Safety Coordinator meetings are presented in-person and on Zoom. Recordings of the meetings are also available for staff unable to attend live.
- **CHA Disaster Preparedness Conference –** the CHA hosts an in-depth conference related to disaster response and preparedness each year in September. The hospital has always sent a contingent to this conference. This year, the conference was streamed live so additional staff were able to attend remotely.

EM – Emergency Management

E. Community Involvement

The hospital continues to be an active participant in the Santa Clara County Hospital Emergency Preparedness Partnership (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives of all Santa Clara County hospitals and the county EMS. The emphasis is creating 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 Education Committee chairperson of Santa Clara County EPHC and has participated in several conferences sharing the experiences and benefits of developing regional coalitions.

F. Hazard Vulnerability Assessment (HVA)

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

- There were several changes to the HVAs at both campuses in FY-21 based upon real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Mass Casualty - Medical/Infectious	(2) Information System Failure
(3) Person with a Weapon	(3) Communication System Failure
(4) Cyberattack	(4) Electrical Power Failure
(5) Information Management System Failure	(5) Seasonal Influenza

EM – Emergency Management

G. Effectiveness

Key indicators were targeted to establish goals for FY-21. The following goals presented opportunities to improve emergency management.

FY-21 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY-20)
   - **Measurement of Success**
     - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
     - Evaluate and set up logical groups and rules for notifications.
     - Train key staff to be able to use/send alerts
   - **This *goal was accomplished.***
     - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
     - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
     - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
2. Incorporate and expand emergency exercises in the new facilities at El Camino Health – Los Gatos Cancer Center, Taube Pavilion, Sobrato Pavilion, and Willow Outpatient Surgery.
   - ***This goal was accomplished.*** All exercises have been expanded to include all pavilions in planning and participation.
3. Revise Hospital Surge Plan.
   - ***This goal was accomplished.*** The Hospital COVID-19 Pandemic Plan was used as a reference to revise the Hospital Surge Plan. The plan was reviewed and approved by the Emergency Management Committee.

Attachment 1 - Employee Health Services Definitions

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

Attachment 2a - Safety Trends

	Indicators	FY-15	FY-16	FY-17	FY-18	FY-19	FY-20	FY-21
E.C. 1.0 - SAFETY MANAGEMENT								
Employee Safety								
1.	Total Injury/Illness Incident Reports	618	428	470	411	439	305	299
2.	OSHA Recordable Injury/Illness (Total)	306	193	164	176	145	120	124
	a. Lost Time	38	78	45	51	22	22	17
	b. No Lost Time	268	113	119	125	133	98	107
3.	Patient Lift/Transfer Injuries (OSHA Recordable)	27	37	28	23	16	10	26
4.	Patient Lift/Transfer Injuries	37	48	43	41	29	23	49
5.	Trip/Slip/Fall	41	58	67	63	60	38	49
Infection Control								
8.	TB Conversions (mo.)/qtr. %	0	0	0	0	0	0	0
9.	Blood & Body Fluid Exp.	45	53	42	58	48	41	26
	a. Percutaneous	38	39	30	36	30	36	21
	b. Skin/Mucus Membrane Contact	7	14	12	22	18	5	5
E.C. 2.0 - SECURITY MANAGEMENT								
1.	Code Grey Incidents	117	129	167	197	222	303	356
2.	Security Response Time < 3minutes (Goal: >90%)	N/A	N/A	N/A	N/A	82%	98%	100%
3.	Reportable Workplace Violence Incidents	N/A	N/A	N/A	61	51	63	56
E.C. 3.0 - HAZARDOUS MATERIAL MANAGEMENT								
1.	Reportable Hazardous Material Incidents	0	0	0	0	0	0	0
2.	Recordable Hazardous Material Incidents	4	0	0	1	5	6	6
3.	Waste Water Discharge Violations	0	0	0	0	1	0	0
4.	Staff ability to locate SDS online	N/A	N/A	N/A	N/A	95%	100%	100%
5.	Staff know eyewash rinse time if exposure is 15 minutes	N/A	N/A	N/A	N/A	79%	100%	73%
E.C. 4.0 LIFE SAFETY								
Fire Safety								
1.	Fire Incidents -Actual	0	2	0	2	1	2	0
2.	Fire Alarm Events	59	72	54	55	41	50	44
3.	Fire Drills comp/scheduled	100%	100%	103%	103%	118%	113%	102%
4.	Staff ability to define RACE and PASS	100%	100%	100%	100%	91%	100%	95%
5.	Staff ability to locate fire extinguishers and pull stations					96%	100%	99%
6.	Staff can define horizontal and vertical evacuations					91%	99%	89%
Life safety & Regulatory Compliance Goals: Performance data - TMS								
1.	Utility Reportable Incidents	1	6	1	2	2	4	7
2.	% of Life Safety Work Order Completions	100%	100	100	100%	90%	100%	89%
3.	PM Completion Rate % completed/scheduled	90.9%	97%	90%	89%	95%	95%	84%
E.C. 5.0 - MEDICAL EQUIPMENT MANAGEMENT								
1.	Reports to FDA	6	3	6	15	16	8	9
2.	PM Completion Rate %							
	a. ECH High Risk/Life Support PMs*	N/A	N/A	N/A	N/A	N/A	88%	98%
	b. ECH Non High Risk/Life Support PMs*	N/A	N/A	N/A	N/A	N/A	74%	86%
	c. ECH Overall PM completion*	N/A	N/A	N/A	N/A	N/A	75%	87%
3.	Equipment Unable to Locate	88%	78%	95%	82%	10%	23%	13%

*New trend in FY-20. No previous year's data.

Attachment 2b - Safety Trends Definitions

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

Safety Trends Definitions

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

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

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	Ongoing
3	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	Ongoing
4	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	Ongoing

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: November 1, 2021
Subject: FY 2022 CDI KPI Dashboard for November Meeting

Recommendation(s): Approve this report

Summary: 1. Provide the Committee with the Key Process Indicators for assessing ECH's Clinical Documentation Integrity (CDI) program.
2. Annotation is provided to explain actions taken affecting each metric.

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

2. Background: The CDI Steering Committee provides guidance to the manager in the selection of these key metrics, in the setting of the metric goals and assesses productivity monthly.

3. Assessment:

- Reviewing 94% of Medicare patients with goal increased in FY 22 from 88% to 90%
- All payor patients reviewed at 70%, the goal of 80%, reduction due to loss of one Full-time staff member in June, and not yet replaced. Medicare and DRGs payors are the priority.
- Physician Response Rate to CDI queries remains at 100%, with an agreement at 86%
- CDI query volume down due to temporary staff shortage.
- Slight reduction in both the Medical and Surgical Complications/MCC capture rate.

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

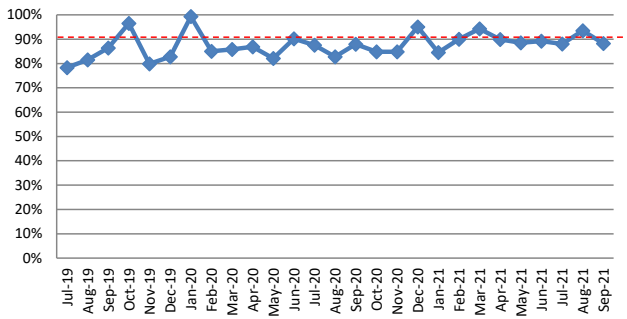
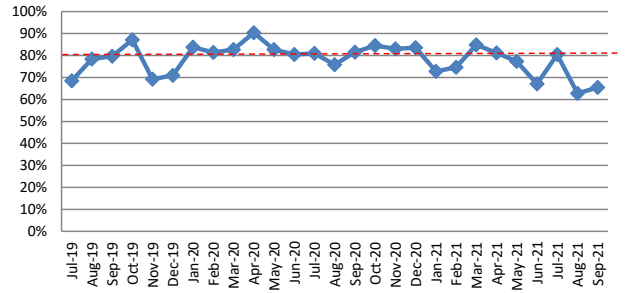
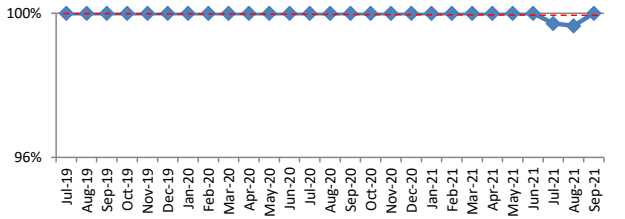
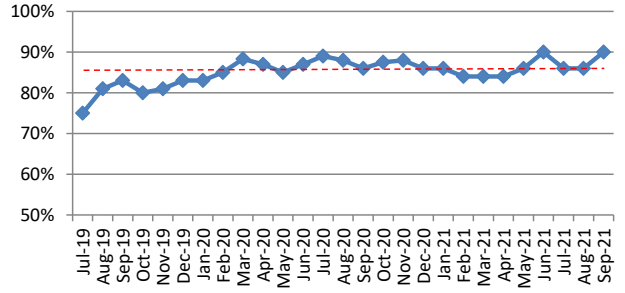
5. Outcomes: N/A

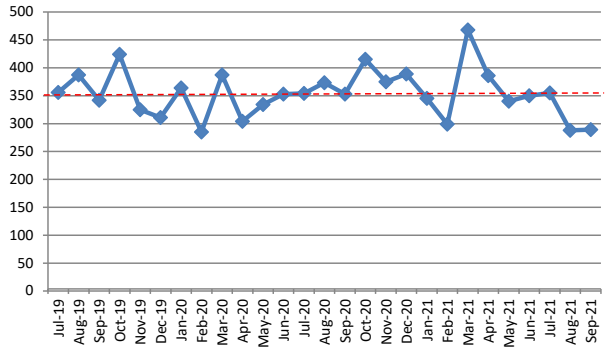
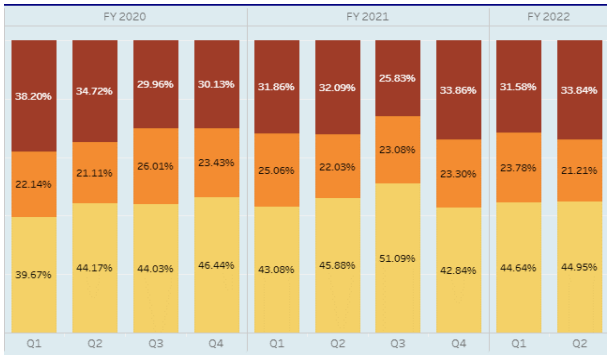
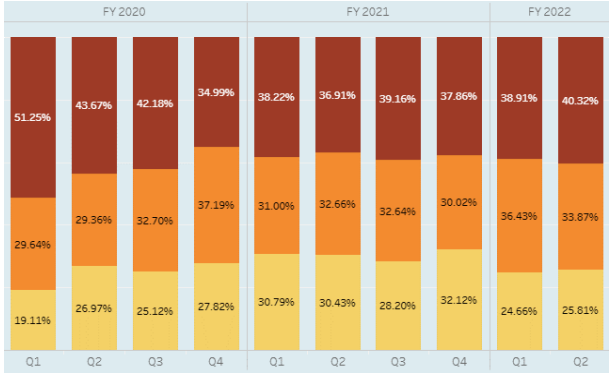
Suggested Committee Discussion Questions: N/A

List of Attachments: FY 22 September CDI KPI Dashboard

El Camino Health

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

As of Oct 15, 2021				Baseline	FY22 Goal	Trend	Comments
CDI Coverage		Performance		FY2021	FY2022 goal		
1	**Medicare** *Source: iCare CDI Productivity report	**Sep 2021** 442/501 **94%**	**FYTD** **90%**	88%	90%		CDI team continues to prioritize Medicare accounts despite having one team member resign and impacted by some intermittent LOAs. The coverage rate remains at 90% FYTD within the goal established for the year. CDI manager is focused on hiring one FTE for the replacement and an additional FTE for expanding the program in the outpatient settings.
2	**All Payor** *Source: iCare CDI Productivity report	**Sep 2021** 743/1135 **70%**	**FYTD** **70%**	79%	80%		Although the priority of the CDI department is to cover the entire Inpatient population, that benefits the quality scores a lot, at this time, due to short staff prioritization is on Medicare and Medicare Advantage payers (DRG based) and the All-Payer coverage had a downtrend. Once the new staff is hired, the numbers should show uptrend back.
Physician Response		Performance		FY2021	FY 2022 goal		
3	**Query Response Rate** *Source: iCare CDI Query report	**Sep 2021** **100%**	**FYTD** **100%**	100%	100%		Response rate remains at 100% mainly due to solid adherence to Physician Query policy, escalation protocols and robust physician engagement. The rate is the highest compared to similar programs around the nation. The rate dropped once in June but is mainly attributed to physician burnout and busy operations on the floor in the middle of the summer COVID-19 surge. As for FY 2022 Q1 the Response rate bounced back to 100%.
4	**Query Agree Rate** *Source: iCare CDI Query report	**Sep 2021** **86%**	**FYTD** **87%**	87%	89%		Agreement rate achieved for the second time the milestone of 90%. There is a direct correlation between a lower number of queries and a better response rate. Nonetheless, I think the last results also have to do with the high visibility of the CDI department with medical staff and some optimizations to the query templates that mainly intend to bring the response rate to a higher level than ever before.

#	Queries volume	Performance		FY2021	FY 2022 goal		
5	**Query volumes** **Source: iCare CDI Query report*	**Sep 2021** **289** **39**% of of all reviewed accounts	**FYTD Avg.** **322** **42**% of all reviewed accounts	Queries Avg. **370**	Query 40% of all reviewed accounts		The query rate sustained a contraction mainly attributed to a temporary staff shortage, and some Epic disruptions of the query process suffered at the beginning of FY 2022. Epic processes have been implemented to avoid future crises and the plan is also to bring new staff that can support a healthy number of queries placed to the medical staff.
6	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Source: Tableau CDI Dashboard* *Higher MCC/CC Capture Rate better reflects severity of population*	**Sep 2021** **MCC** 45% **CC** 21% **NCC** 33%	**N/A**	**Nat 80th% CMS 2018** MCC 48% CC 25% No CC 26%	**Nat 80th% CMS 2019**		The Medical CC/MCC rate dropped from the historic high of the severe COVID-19 cases frommQ3 FY 2022. Nevertheless, it continues to stay higher than previous years, denoting a mature CDI program and successful medical staff education regarding clinical documentation concepts.
7	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient) *Tableau CDI Dashboard* *Higher MCC/CC Capture Rate better reflects severity of population*	**Sep 2021** **MCC** 26% **CC** 34% **NCC** 40%	**N/A**	**Nat 80th% CMS 2018** MCC 28% CC 31% No CC 41%	**Nat 80th% CMS 2019**		Surgical cases make up 20-30% of our Medicare patient volume. The most significant impact in reimbursement, CMI, GMLOS will be increased Surgical CC/ MCC rate. The numbers dropped for the last two quarters mainly due to fewer volumes in the surgical population and an increase in orthopedic volumes that tend to express less severe comorbidities.

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Catherine Carson, MPA, BSN, RN, CPHQ
Sr. Director/Chief Quality Officer
Date: November 1, 2021
Subject: FY 2021 Core Measure Dashboard for November Meeting

Recommendation(s): Approve this report

Summary: 1. Provide the Committee with the current CMS and TJC required clinical core measure data results; 2 Annotation is provided to explain actions taken affecting each metric. 3.These core measure results are applied by CMS to several programs: CMS Value-based Purchasing program (VBP), CMS Star Ratings, Leapfrog Safety Grade, and Public Hospital Redesign and Incentives in MediCal (PRIME) program.

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

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

3. Assessment: CMS has 2 sets of Core Measures: one covers acute hospitals and the second only applies to acute hospitals with inpatient behavioral health units, which is called HBIPS (Hospital-based Inpatient Psychiatric Services).

A. NON HBIPS Core Measures

- **PC-01 Elective Delivery Prior to 39 weeks gestation**: MCH continues to prospectively track EED and reach out to providers to reschedule as needed. When an EED occurs and was seemingly not indicated primary provider is contacted and informed that we are tracking and request is made to closely monitor and avoid unindicated EED.
- **PC-02 Cesarean Birth,** Target goal of 23.9%; FY 2021 Performance is 26.05%. *Leapfrog is following Healthy People 2020 NTSV cesarean birth rate target of 23.9%. The new target will be 23.6% or less by 2030.* MCH is continuing to trend. Ongoing OB Task Force work to evaluate where we can make system improvements to reduce unnecessary NTSV. 1 provider currently under close tracking and monitoring for the next 6 months to evaluate that individual @ MV campus. Have spoken with other provider groups to encourage they independently look at NTSV rates as evaluate any necessary changes.
- **PC-05 *Exclusive Breast Milk Feeding*** *- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; Fy21 Performance: 61.87% ;) MV 57.62%; LG 80%; Senate Bill 402, De Leon, Health and Safety Code 123367; Requires all general acute care hospitals and special hospitals with perinatal units to adopt, by January 1, 2025, The Ten Steps to Successful Breastfeeding adopt baby friendly 10 steps to successful breastfeeding*
- ***PC06- Unexpected Complications in Term Newborns*** *- TJC's new core measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is 0%; FY 2021 Performance: 1.59% ; MV 1.22%; LG 3.22%*

- ***OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients-*** *Median time patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; Fy 2021 rate is ENT:172.5 mins; MV:185 mins; LG:123 mins*
- ***OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke-*** *Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival. Target goal is 100%; FY21 is 61.5% (8/13) The subset of patients remains low as the metric only includes patients who arrive within 2 hours of last known well & we continue to transfer certain cases to align with insurance and/or for higher level of care (primarily SAH cases in MV, and possible thrombectomy cases in LG.)*

B. **HBIPS Core Measure Summary**

- **IMM-2 Flu Immunizations:** excellent results during flu season, better than benchmark
- **HBIPS-5 Pts discharged on multiple antipsychotic meds:** better than benchmark, physicians don't always agree that med is an antipsychotic.
- **PC-TOB –tobacco perfect care –** poor compliance due to lack of referrals for counseling
- **TR-1 – Transition record –** above benchmark and good compliance
- **TR-2 - Screening for metabolic disorders**, great compliance
- HBIPS: Flu Immunization improved, Discharges on Multiple Antipsychotic medication are below benchmark, struggle continues with the all or nothing Tobacco use measure. Transition record, timely transmission of transition record is above benchmark and screening for metabolic disorders is below benchmark. Restraint and seclusion use are very low and below benchmark.

4. Other Reviews: N/A

5. Outcomes: N/A

Suggested Committee Discussion Questions: None.

List of Attachments: FY21 Core Measure Dashboards

El Camino Health

FISCAL Year 2021- HBIPS Core Measure Summary Report

Goal Near goal Below goal

Hospital Based Inpatient Psychiatric Services (HBIPS) Measure Name		ECH Goal	FY 2020	FY 2021														
				JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FY 2021	External Benchmark (IBM All Core Measures Hospital)
				2020						2021							
IMM-2	Influenza Immunization	100%	91.6 %	Not Flu Season	Not Flu Season	Not Flu Season	94.6%	93.4%	98.7%	98.4%	100%	98.6%	Not Flu Season	Not Flu Season	Not Flu Season	97.4%	86.8%
HBIPS-5	Patients Discharged on multiple antipsychotic medications with appropriate justification	80%	80.5%	77.8%	62.5%	75%	77.8%	100%	90.9%	66.7%	55.6%	72.7%	69.2%	62.55	50%	71.2%	50.2%
PC-TOB	Perfect Care - Tobacco Use	80%	28.1%	0%	18.2%	16.7%	33.3%	0%	33.0%	16.7%	66.7%	33.3%	O%	0%	50%	23.7%	70.0%
PC-SUB	Perfect Care - Substance Abuse	80%	96.5%	100%	100%	100%	85.7%	100%	60%	83.3%	100%	100%	66.7%	100%	83.3%	92.8%	68.6%
TR-1	Transition Record with Specified Elements Received by Discharged Patients	75%	87.9%	90.0%	85.3%	94.7%	98.2%	93.4%	87.0%	89.6%	91.1%	93.1%	91.8%	96.6	93.7	91.7%	66.0%
TR-2	Timely Transmission of Transition Record	75%	74.2%	80.0%	81.3%	75.4%	89.1%	83.6%	72.7%	77.6%	83.9%	63.9%	65.8%	74.1%	68.3%	75.8%	56.7%
MET-1	Screening For Metabolic Disorders	75%	94.8 %	85.7%	90.0%	93.2%	97.4%	89.4%	90.0%	93.0%	94.6%	95.8%	83.9%	100%	92.6%	91.9%	88.1%

El Camino Health

FISCAL Year 2021- HBIPS Core Measure Summary Report

Goal Near goal Below goal

Restraints and Seclusions		ECH Goal	FY 2020	FY 2021													
				JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	FY 21	External Benchmark (TJC)
				2020						2021							
HBIPS-2	Hours of Physical Restraint Use (per 1000 patient hours) (lower=better) Numerator: The total number of hours that all psychiatric inpatients were maintained in physical restraint Denominator: Number of psychiatric inpatient days	0.0004	0.0002	0.0003	0.0008	0.0003	0.0015	0.0001	0.0001	0.0005	0.0003	0.0003	0.0000	0.001	0.0004	0.0005	0.0006
			34.416/ 159528	4.75/ 14256	14.133 /17040	6.65/ 21072	28.266/ 19488	2.166/ 19776	1.833/ 19896	8.8667 /18936	5.5/ 16248	6.1833 /21216	0.766/ 27432	20.0833/ 19440	10.833/ 24888		
HBIPS-3	Hours of Seclusion Use (per 1000 patient hours) (lower=better) Numerator: The total number of hours that all psychiatric inpatients were held in seclusion Denominator: Number of psychiatric inpatient days *Note: Event measures (HBIPS-2 and 3) are calculated by event occurrence date.	0.0003	0.0003	0.0003	0.0015	0.0002	0.0000	0.0003	0.0000	0.0002	0.0005	0.0002	0.0004	0.0016	0.0003	0.0004	0.0003
			55.5333 /159528	4.333/ 14256	25.5/ 17040	4.916/ 21072	0/ 19488	1.95/ 19776	0/ 19896	4/ 18936	8.35/ 16248	4.9167 /21216	5.3667 /27432	31.0667/1 9440	6.4 /24888		

El Camino Health

Goal Near goal Below goal

FY 2021 Core Measure Summary Report

Included in CMS Star Ratings: Included in Leapfrog:

Inpatient Measure name		ECH GOAL	FY 2020	FY 2021												FY 2021	External Benchmark (TJC)
				July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June		
				2020						2021							
PC-01	Elective Delivery Prior to 39 weeks gestation (lower =better)	0%	1.3% (5/389)	0% (0/27)	0% (0/29)	0% (0/14)	0% (0/34)	5.3% (1/19)	0% (0/32)	0% (0/37)	0% (0/23)	0% (0/32)	0% (0/27)	0% (0/25)	O% (0/22)	0.31% (1/321)	1.8%
PC-02	Cesarean Section Rate (lower=better)	≤23.9%	24.1% (461/1916	26.5% (43/162)	31.4% (60/191)	24.2% (39/161)	25.1% (44/175)	25.9% (41/158)	26.3% (35/133)	28.5% (45/158)	26.5% (36/136)	21.5% (34/158)	22.1% (30/136)	25.2% (43/171)	27.9% (45/161)	26.1% (495/1900)	24.7%
PC-05	Exclusive Breast Milk Feeding During Hospital Stay	70%	61.2% (470/768)	61.3% (38/62)	62.7% (47/75)	66.7% (42/63)	61.8% (42/68)	58.3% (35/60)	57.7% (30/52)	63.6% (35/55)	60.4% (29/48)	66.1% (39/59)	55.7% (34/61)	60.9% (42/69)	66.2% (43/65)	61.9% (456/737)	49.7%
PC-06	Unexpected Complications in Term Newborns(lower=better)	0%	1.7% (64/3798)	2.2% (7/323)	1.9% (7/356)	2.3% (7/311)	1.8% (6/331)	1.3% (4/297)	0.39% (1/256)	1.5% (4/270)	1.7% (4/232)	2% (6/300)	0.33% (1/303)	0.90% (3/333)	2.4% (8/330)	1.6% (58/3642)	3.2%

Outpatient Measure name		ECH GOAL	FY 2020	FY 2021												FY 2021	External Benchmark (CMS)
				July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June		
				2020						2021							
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower=better)	<180	169	154	154	168.5	181	212.5	143	173	164	173	182	181	181	172.5	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%	72.7% (8/11)	100% (1/1)	No Cases	100% (1/1)	100% (1/1)	No Cases	No Cases	33.3% (1/3)	66.7% (2/3)	No Cases	100% (2/2)	No Cases	No Cases	61.5% (8/13)	98.9%

Core Measures	*External Benchmark source- IBM Care Discovery Quality Measures July 2020- June 2021
Perinatal (PC)	TJC
Non PC	CMS Standard of Excellence-Top 10% of Hospitals

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board of Directors, El Camino Health
From: Cheryl Reinking, DNP, RN, NEA-BC
Date: October 25, 2021
Subject: Patient Experience feedback from Discharge Phone Call

Purpose: To provide the Committee with written patient feedback that is received from the Press Ganey written comments.

Summary:

1. Situation: These comments are from a patient who received a Press Ganey survey following discharge and commented that an allergy was not recorded in the chart and the patient received an item on the food tray that they were allergic to and did not get to order a preferred breakfast.

2. Authority: To provide insight into one patient's experience and the importance of allergy documentation and food preference ordering.

3. Background: This patient provided very helpful feedback regarding the time of day of admission and the failure to collect important food allergy information.

4. Assessment: This feedback is helpful for us so we can learn and implement a process to insure all allergy information is recorded and available for the clinical and dietary staff. Providing food a patient is allergic to has potentially very serious consequences. In addition, our process should allow for a menu to be selected for the next morning—even if late at night.

5.

6. Other Reviews: None

7. Outcomes: The organization is assessing two technology solutions that may be embedded into our processes to assure this does not happen again. First, a forced food allergy documentation function in the E.H.R. and a methodology to order meals for the next morning even if late at night using E.H.R. functionality and assuring all staff know the process to order early morning means late at night.

8. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. How do you investigate individual feedback through Press Ganey?

2. How do you apply learning from this individual issue to the larger organization?

Press Ganey Survey Comment

I was admitted after dinner and no one asked or looked up food allergies before ordering food. Of course my sandwich came with apple slice to which I'm allergic. I had to have the nurse specially put it in my record so I didn't get apples for breakfast. Also, since I was not able to order what I wanted for breakfast, I got food I didn't like and coffee which I don't drink. I would have liked tea. It would be nice if there were a way to submit a breakfast order if you're admitted after dinner time.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Quality Committee of the Board
From: Mark Adams, MD, Chief Medical Officer
Date: November 1, 2021
Subject: Board Quality and Safety Dashboard

Purpose: To review the FY22 Q1 Board Quality and Safety Dashboard.

Summary:

1. Situation: The Quality Committee reviews the quarterly Board Quality and Safety Dashboard preceding submission to the Board.

2. Authority: This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients.

3. Background: This dashboard is designed to provide the Board with a standardized high level snapshot of overall quality and safety. It is provided on a quarterly basis. Each quarter is scored separately with a FYTD22 total presented in the last column. This dashboard is based on the STEEEP definition of quality and safety that is a national standard adopted by the IHI (Institute for Healthcare Improvement).

4. Assessment: The Board's Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention but the Board will rely on this dashboard as included in the Quality Committee report. The intent is to review those areas of potential concern (in red) and are noted below according to the Quality Domain:

A. Safe Care:
   i. There has been an unexpected spike in CAUTI's during this quarter. The CAUTI incidents were localized to a few specific nursing units. Root cause analysis revealed that there was a lapse in technique in those areas which has been addressed by enhanced education by our infection control nurses.

B. Timely:
   i. ED throughput continues to lag behind target. Contributing factors are increased volume and staffing challenges, increased acuity of the patients seeking care requiring more complex workups, and the need for continued COVID-19 testing. Attempts are being made to ramp up staffing but this takes time in the face of a severe nursing shortage. CA staffing ratio mandates further complicate our ability to respond to volume surges even when staff is present. Hospitalist staffing has increased to try to meet this increased demand. Alternatives to current laboratory COVID testing is being considered such as the rapid lateral assay point of care tool method.

C. Effective Care:
   i. Readmission Index is elevated above the Premier Top Performers benchmark which is now 0.95. A multi-pronged approach has been implemented which includes the following teams: weekly readmission review which provides a Pareto analysis to focus the work, ERAS/Surgical complications, Cancer care, non-ventilator hospital acquired pneumonia, post-acute care and heart failure. This work is also supplemented by the newly initiated Cipher Discharge Phone Calls and the Care Companion.
   ii. Sepsis Mortality Index continues to be elevated. Premier Top Performers benchmark is now 1.05. There is now an additional sepsis coordinator to identify and follow sepsis

patients. Sepsis Order Set composition is being adjusted and it's use emphasized as this correlates with improved successful treatment.

iii. PC-02 C/S rate: this has remained above target of 23.5%. There is a wide variation among practitioners with some well below target and some approaching 50%. Efforts are being made to counsel those above the target.

D. Efficient Care: No issues

E. Equitable Care: No issues

F. Patient-Centered Care:

i. Trends are positive but still below the new FY22 targets. Interventions now underway include Leader Rounding, Discharge Phone Calls, Nurse Leader Rounding, WeCare Service Standards, Active complaints and grievances processing and resolution, Care Team Coaching, Physician Partnership, Service Recovery Training, Digital Strategy, and Texting to Patients.

5. Other Reviews: None

6. Outcomes: The Quality Committee will be in a position to report to the Board on the current state as of FY22 Q1 and FYTD.

List of Attachments:

1. Q1 STEEEP dashboard

Suggested Committee Discussion Questions:

1. Are there any questions regarding the "red" metrics?

2. Would the Committee like to use findings on this dashboard to drive agenda items for more in depth reviews going forward?

3. What additional supporting information would be useful to the Committee to assist in evaluating the metrics?

4. What educational support might be useful to convey to the Board to help with interpretation of this information?

El Camino Health

Month to Quality Committee of the Board: November 2021

Quarterly Board Quality Dashboard (STEEEP Dashboard) FYTD 22 DRAFT (unless otherwise specified by*)

Quality Domain	Metric	Baseline	Target	Performance				
		FY 21	FY 22	FY22, Q1	FY22, Q2	FY22, Q3	FY22, Q4	FYTD22 Total
Safe Care	Serious Safety Events Rate (Rolling 12 month)	3.13	2.97	2.54				2.54
	Surgical Site Infections (SSI)	0.30	1.0 (SIR)	*0.39				0.39
	Catheter Associated Urinary Tract Infection (CAUTI) - HAI	0.37	<= 0.75	1.32				1.32
	Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.53	<= 0.50	0.35				0.35
	Modified PSI-90 CMS HAC Reduction Program (composite)	0.919	0.90	0.846				0.846
Timely	HVI STEMI % 1st Medical Contact to Device Time w/I 90 minutes	100%	100%	data available up to June as of 10/25				NA
	Patient Throughput - Median Time Arrival to ED Departure	264 min	256 min	267 min				267 min
	Stroke: tPA <= 30 minutes	57.5% (23/14)	50%	25% (1/4)				25%
	Stroke: Door-to-Groin <= 75 minutes	16.7% (3/18)	50%	50% (1/2)				50%
Effective	Risk Adjusted Readmissions Index	0.93	0.92	*1.04				1.04
	Risk Adjusted Mortality Index	0.86	0.90	0.99				0.99
	Sepsis Mortality Index	1.08	1.03	1.06				1.06
	PC-01 Elective Delivery Prior to 39 Weeks Gestation	ENT: 0.63%	1.3%	*1.4%				1.4%
	PC-02 NTSV C-Section	ENT: 26.3%	23.5%	*25.4%				25.4%
	ECHMN: CMS 165 Controlling High Blood Pressure	59.0%	<= 59%	57.5%				57.5%
	ECHMN: CMS 122 Diabetes Hemoglobin A1c Poor Control	30.0%	<= 30	28.3%				28.3%
Efficient	Arithmetic Observed LOS/ Geometric Expected LOS	1.23	1.00	0.96				0.96
	MSPB-1 Medicare Spending per Beneficiary (CMS)	0.99 (CY 19)	<=1	0.99				0.99
Equitable	Hospital Charity Care Support	$19.7 mil	NA	7.2 mil				7.2 mil
	Clinic Charity Care Support	$14.9k	NA	7.5k				7.5k
	Language Line Unmet Requests	0.72%	<1%	0.62%				0.62%
	Length of Stay Disparity (Top 3 races) 40% patients did not report their race	Black: 4.0	NA	4.3				4.30
		White: 3.89		3.77				3.77
		Asian: 3.57		3.59				3.59
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.6	79.7	82.0				82.0
	ED - Likelihood to Recommend (PG)	76.1	76.5	73.1				73.1
	ECH MD - Likelihood to Recommend Care Provider (NPS)	96.0	77.4	74.1				74.1
	MCH - HCAHPS Likelihood to Recommend	81.8	82	79.4				79.4
	OAS - HCAHPS Likelihood to Recommend	85.7	86.1	85.5				85.5

Report updated 10/25/21

*data available up to August only

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

EL CAMINO HOSPITAL

COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Vince Manoogian, Interim President ECHMN and Ute Burness, RN, VP of Quality, ECHMN
Date: October 21, 2021
Subject: ECHMN Quarterly Quality Report

Purpose: Provide the Board Quality Committee with a quarterly update on the status of ECHMN quality.

Summary:

1. Situation: The system Board of Directors is very interested in understanding and tracking the quality and service performance of the various components of ECHMN. It was agreed that the Board Quality Committee would review the status of quality and service performance within ECHMN on a quarterly basis.

2. Authority: This is an area of concern for the governing board as this directly and indirectly impacts the quality of the care delivered to El Camino patients.

3. Background: ECHMN is a wholly owned subsidiary of El Camino Hospital established as a separate corporation with its own tax ID number. It was established to develop an ambulatory care capability so that the El Camino Health continuum of care could extend beyond the traditional hospital acute care and hospital based out patient care.

4. Assessment: There are three key areas of focus for ECHMN with respect to quality and service:

A. HEDIS (Healthcare Effectiveness Data and Information set)
B. MIPS (Medicare Incentive Payment System)
C. NPS (net promoter score)

ECHMN has established true north pillars, one of which is quality and service. For quality, the goals are: achieve top decile HEDIS composite score by end of calendar year 2023 and achieve MIPS composite exceptional rating annually. 8 MIPS metrics have been selected based on importance to patient care and impact on financial reimbursement as the Quality Measures. The results for FY 22 Q1 is a composite score of 3.4. The target composite score for FY22 is 3.6. ECHMN has added "soft stops" to some of the measures, updated the "tip sheets" for the staff and providers and we are retraining the staff. ECHMN has been working with the EPIC ICare team to implement "Heathy Planet" which will allow us to do population health management. We are also working on implementing the EPIC "Hedis Module" for our fully capitated health plans. We anticipate going live with both of these products in early 2022.

The Net Promoter Score for ECHMN continues to be monitored. NPS is calculated by asking patients to rate on a 1 to 10 scale their likelihood to recommend. The percent of 9's and 10's is reduced by the number of 1's through 5's. (6, 7, and 8's do not count). The Net Promoter Score for August 2021 was 73.7, which is down from the previous month of 75.6; ECMHN is in the process of implementing Press Ganey as the patient satisfaction tool.

ECHMN submitted the 2020 MIPS quality data in March. CMS announced in August, that ECHMN scored 100%.

ECHMN has also received Credentialing Delegation status from Blue Shield effective October 1, 2021. The credentialing department has approved 37 initial appointments and 8 reappointments in the first quarter of FY22.

5. Outcomes:

6. List of Attachments:

Power Point background material to pre-read to facilitate the discussion and use as a reference for discussion.

Memo sent out to all Physicians and Staff

Suggested Committee Discussion Questions:

What additional information would be helpful for the committee to have to satisfy any concerns about quality and service in ECHMN?

Silicon Valley Medical Development

Date: September 29, 2021

To: SVMD Clinic Staff, El Camino Medical Associates and San Jose Medical Group Providers

From: Mark Kuntz, COO

RE: Quality Improvement Activities at SVMD

One of our organization-wide goals is to improve the quality of care that we provide to our patients. In order to achieve those goals, SVMD's Quality Committee and Board of Managers have agreed to focus on improving our Metric-Based Incentive Payment System (MIPS) score and improving on the eight healthcare metrics identified below:

1. Documentation of Current Medications in the Medical Record – *must be done at each visit.*
2. Body Mass Index (BMI) Screening and Follow-up Plan – *must be done once a year and if the patient is above 18.5% BMI, then a follow-up plan must be documented in the chart*.
3. Diabetes: Hemoglobin A1C less than 9% - *must be done once a year.*
4. Breast Cancer Screening – *must have a mammogram in the chart every 24 months.*
5. Colorectal Cancer Screening – *must have colonoscopy every 10 years or other cancer screening metric.*
6. Tobacco Screening and Cessation Intervention for Tobacco Users – *must be done for all patients and if they are a smoker, a cessation plan must be documented.*
7. Falls: Screening for Future Fall Risk for patients 65+ years of age – *must be done at every visit.*
8. Controlling High Blood Pressure - *For those patients diagnosed with high blood pressure, the blood pressure must be in control at the visit.*

For our MIPS submission, we also need to focus on providing the flu shot to all patients who come to our clinics/practices from October 1st through March 31st. We must document in the chart that the patient has had a flu shot and if they did not get the flu shot at SVMD, then we must document the date and place where they previously received the flu shot. One of the MIPS measures for promoting interoperability is to reconcile the outside medical records of a patient, which must be done at every visit. These are two areas of focus for this last quarter.

We monitor the metrics very closely and identified we currently have many care gaps so we will need to focus on achieving our goals for the last quarter of 2021. Throughout this year, we have added soft stops to EPIC to remind the providers and staff before they close the charts and will continue to look at more opportunities to do so in the coming months.

There are short-term and long-term plans for achieving our targets. The focus over the next three months will be on the short-term plan which includes:

1. Identifying the gaps in care and then providing information to each clinic/practice about their gaps.

Silicon Valley Medical Development

2. Outreach to patients to either gather information via the phone, email, My Chart and/or schedule the patients for an office or telehealth visit to close the gaps.
3. Provider proficiency training with the ICare Physician Training team.
4. Workflow modifications.
5. Clinic/practice meetings to share the data and provide additional training on quality metrics and how to promote interoperability.
6. Daily meetings with the practice managers.
7. Weekly meetings with the team to identify the progress and any challenges that we are having.
8. Providing weekly status reports to assess our gap closure.

This is an aggressive plan and will require the focus of the entire care team to close the gaps. If there are any questions or comments, please contact Ute Burness, R.N. at ute_burness@svmdmed.org and/or Mandeep Khabra, M.D. at mandeep_khabra@elcaminohealth.org or myself at mark_kuntz@svmdmed.org.

El Camino Health Medical Network Quarterly Report

Vince Manoogian, Interim President ECHMN

Ute Burness, RN VP of Quality and Payer Relations

8 Quality Metrics - Overview

- FY21 Composite Final Score: 3.3, FY20 was 2.9
- FY22 Composite Score Target : 3.6, stretch goal is to achieve a 4
- FY22 Q1 Composite Score: 3.5
- Improvements to our performance are based upon:
  - Adding "soft stops" to certain measures in EPIC (BMI, Medication Reconciliation)
  - Retraining staff and providers
  - Updated Tip Sheets
  - Patient outreach to close care gaps
  - Reconciling outside tests and studies (lab and imaging)

Quality Composite Metric Performance - FY22 Q1

- Cancer screening measures have been a struggle nationally due to patients not getting tested during COVID.
- Improvements have been made within EPIC, staff and providers have been retrained, and outreach is being made to patients to close care gaps in order to improve quality of care.

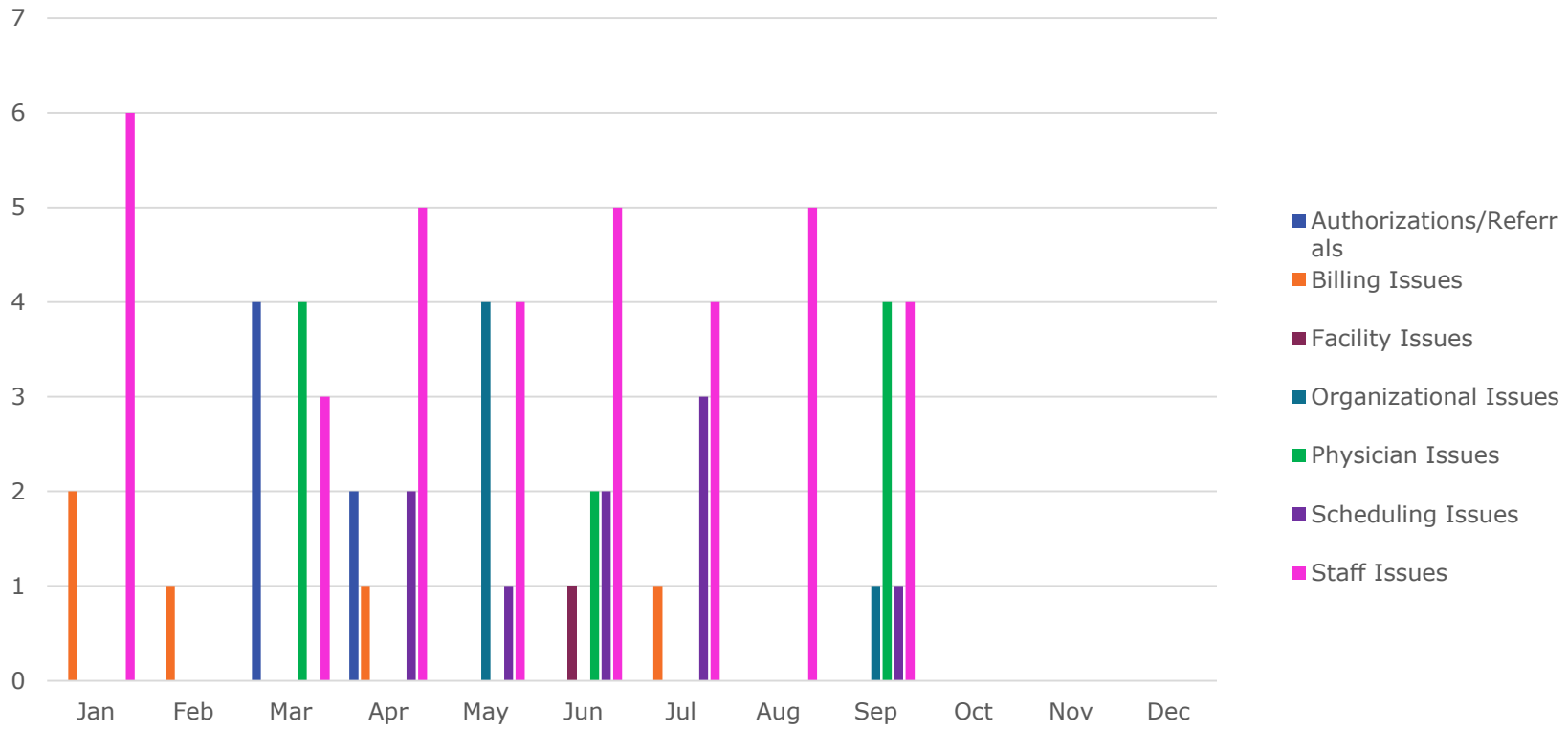
Metric	FY21 Fourth Qtr. Performance	FY22 First Qtr. Performance	Performance from Previous Qtr.
Composite Score	**3.4**	**3.5**	**Improvement**
CMS 68- Documentation of Current Meds (higher % is better)	3 (94%)	3 (98%)	Improvement
CMS 69- Prevention and Screening Body Mass Index – Screening and Follow Up Plan (higher % is better)	3 (43%)	3 (51%)	Improvement
CMS 122- Diabetes: Hemoglobin A1C Poor Control (lower % is better)	5 (31%)	5 (27%)	Improvement
CMS 125- Breast Cancer Screening (higher % is better)	3 (48%)	3 (59%)	Improvement
CMS 130- Colorectal Cancer Screening (higher % is better)	3 (44%)	3 (45%)	Improvement
CMS 138- Tobacco Screening and Counseling (higher % is better)	4 (96%)	4 (96%)	Same
CMS 139- Fall Risk Screening (higher % is better)	3 (85%)	3 (88%)	Improvement
CMS 165- Controlling Blood Pressure (higher % is better)	3 (59%)	4 (60%)	Improvement

2021 MIPS Performance YTD as of September 2021

- MIPS Overall Score: 84.4%
  - Quality Component: 90%
  - Promoting Interoperability: 80%
  - Improvement Activities: 100%
  - Cost: 66.8%
- CMS is allowing COVID Hardship for 2021 Data submission, must be filed by November 30.
- Tip Sheets have been updated and distributed to all staff and providers
- Retraining of staff and providers
- Additional "soft stops" implemented in EPIC
- Outreach to patients to close care gaps
- 2021 Data submission is due March 31, 2022

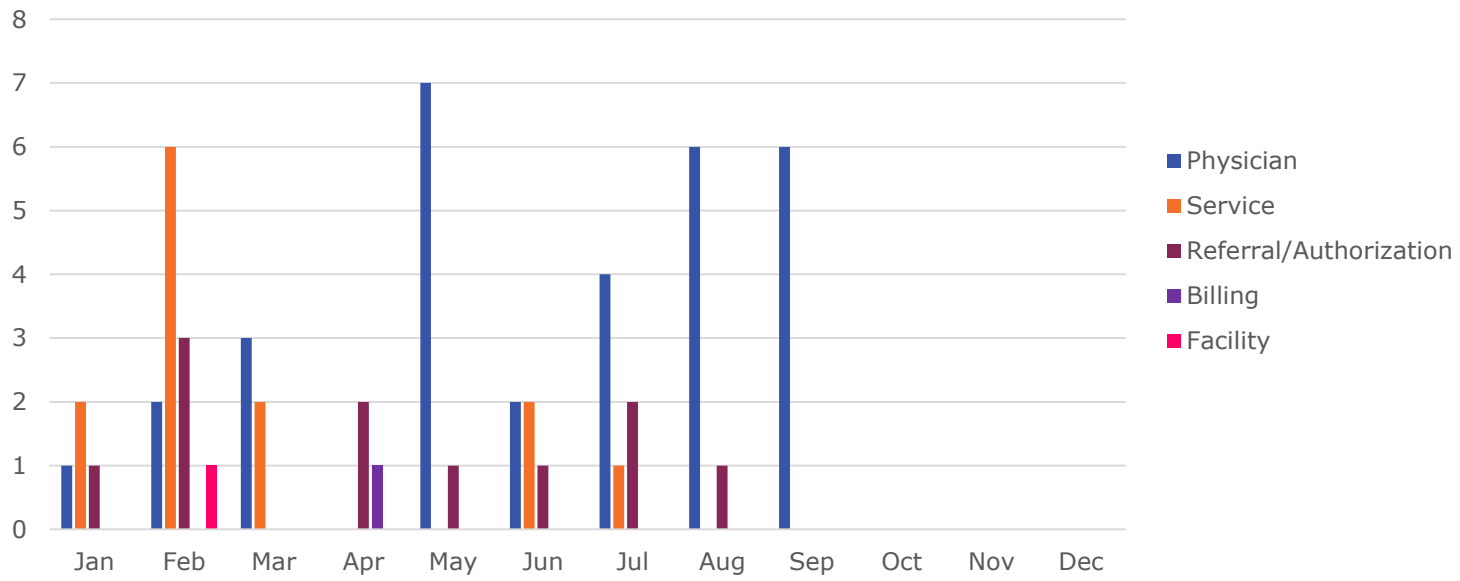
Complaints YTD

- Number of Monthly Complaints are pretty consistent
- Majority of complaints are about staff and physicians



Grievances YTD

- Number of Grievances consistent every month
- Majority of Grievances related to Physician – access and/or service from the physician



Quality Appendix

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CMS 68 – Documentation of Current Medications in the Medical Record

- **Description:** Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.
- **FY21 Performance:** 89.5 % (5th decile, 3 points)
- **FY 22 Target:** 91% (5th decile, 3 points)
- **1st Qtr FY 22 Performance:** 98% (7th decile, 4 points)
- **FY 22 Improvement Activities:**
  - *"Hard stop" has been implemented within EPIC*
  - *Clinical staff have been retrained and must address before closing the chart*

Points for each Decile		1	2	2	3	3	4	4	5	5
Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Documentation of Current Medications in the Medical Record	89.1	`	6.5 - 55.9	66 - 88.8	88.9 - 97.3	97.4 - 99.7	99.8 - 99.9	--	--	100

CMS 69 – Preventative Care and Screening: Body Mass Index (BMI) and Follow Up Plan

- **Description:** Percentage of patients aged 18 and older with a BMI documented within the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal parameters: =>18.5 and <25 kg/m2
- **FY21 Performance:** 46.75% (6th decile, 3 points)
- **FY 22 Target:** 53% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 51% (6th decile, 3 points)
- **FY 22 Activities:**
  - *"Hard Stop" implemented within EPIC*
  - *MA's retrained on the importance of taking height and weight and calculating BMI*
  - *Physician's retrained on the importance of documenting a follow –up plan at least annually*

Points for each Decile		1	2	2	3	3	4	4	5	5	
Measure Title	CMS Benchmark	Measure has a Bench mark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	47.6	Y	<0.4	0.4 - 17.5	17.6 - 23.9	23 - 37.3	37.4 - 73.9	74 - 94.1	94.2 - 98.4	98.5 - 99.9	100

CMS 122 – Diabetes: Hemoglobin A1C Poor Control

- **Description:**. Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
- **FY21 Performance:** 30.75% (10th decile, 5 points)
- **FY 22 Target:** <29%(10th decile, 5 points)
- **1st Qtr FY 22 Performance:** 27% (10th decile, 5 points)
- **FY 22 Improvement Activities:**
  - *Diabetic patient list will be provided to each Physician*
  - *Providers have been retrained to work the Best Practice Alerts (BPA's) to make sure they are closing all care gaps*
  - *Physician will need to order HbA1c tests for any patient who has not had a test within this calendar year*
  - *Any patients with HbA1c over 9, bring the patient in for a visit and assess their plan to get the HbA1c down below 9 and then do repeat test before the end of the year*

Points for each Decile		1	2	2	3	3	4	4	5	5
Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) - Inverse Metric (lower is better)	45.7	>99.5	99.5	99.4 - 92.6	92.5 - 74.5	74.4 - 59.1	59- 46.9	46.8 - 38	37.9 - 31.4	< 31.4

CMS 125 – Breast Cancer Screening

- **Description:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period
- **FY21 Performance:** 51.5% (5th decile, 3 points)
- **FY 22 Target:** 55% (6th decile,3 points)
- **1st Qtr FY 22 Performance:** 59% (6th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of all patients that meet the criteria for mammogram to the PCP and/or Specialist*
  - *Providers will need to order the mammogram and once the test results come back, they need to document in the Health Maintenance section of EPIC*
  - *For those patients that do not have a PCP, ECHMN will designate one of the providers to order the mammogram for the patient*
  - *Reconciliation of outside mammograms*

Points for each Decile		1	2	2	3	3	4	4	5	5
Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Breast Cancer Screening	48.4	<0.3	0.3 - 7.3	7.3 - 27.2	27.3 - 51.5	51.6 - 69.3	69.4 - 81.4	81.5 - 88.2	88.3 - 98.5	>98.5

CMS 130 – Colorectal Cancer Screening

- **Description:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: Fecal occult blood test (FOBT) during the measurement period, Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period, Colonoscopy during the measurement period or the nine years prior to the measurement period, FIT-DNA during the measurement period or the two years prior to the measurement period or CT Colonography during the measurement period or the four years prior to the measurement period
- **FY 21 Performance:** 44.5% (5th decile, 3 points)
- **FY 22 Target:** 45% (5th decile, 3 points)
- **1st Qtr FY 22 Performance:** 45% (5th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of patients who meet the criteria for needed screening to the PCP*
  - *PCP will need to order one of the approved tests and/or send the patient to a specialists to have the study done*

Points for each Decile		1	2	2	3	3	4	4	5	5
Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Colorectal Cancer Screening	45	<0.1	0.1 - 2.5	2.6 - 19.3	19.4 - 45.6	45.7- 70	70.1 - 84.5	84.6 - 90.8	90.9 - 99.4	>=99.4

CMS 138 – Preventative Care and Screening Tobacco Use: Screening and Cessation Intervention

- **Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received tobacco cessation intervention if identified as a tobacco user

- **FY21 Performance:** 98.25% (8th decile, 4 points)
- **FY 22 Target:** 94% (7th decile, 4 points)
- **1st Qtr FY 22 Performance:** 98% (8th decile, points)
- **FY 22 Improvement Activities:**
  - *Quality Department to provide list of patients that meet criteria for needed screening and intervention to the PCP*
  - *PCP needs to screen for tobacco use and that patient received tobacco cessation intervention*

Points for each Decile		1	2	2	3	3	4	4	5	5
Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	59.9	<0.9	0.9 - 7.2	7.3- 24.1	24.2 - 74	74.1 - 90.2	90.3 - 97.1	97.1 - 99.9	--	100

CMS 139 – Falls – Screening for Future Fall Risk

- **Description:** Percentage of patients 65 years of age and older who were screened for future fall risk at least once during the measurement period
- **FY 21 Performance:** 80.75% (6th decile, 3 points)
- **FY 22 Target:** 83% (6th decile, 3 points)
- **1st Qtr FY 22 Performance:** 88% (6th decile, 3 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide PCP with a list of patients that meet criteria for needed screening*
  - *PCP to complete the fall risk screening tool during the visit and to document in EPIC*

Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Falls: Screening for Future Fall Risk	56.6	<0.04	0.04 - 1.3	1.4 - 21.6	21.7- 65.3	65.3 - 90.3	90.4 - 98.1	98.2 - 99.5	99.6 - 99.9	100

CMS 169 – Controlling High Blood Pressure

- **Description:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period
- **FY 21 Performance:** 57.75% (6th decile, 3 points)
- **FY 22 Target:** 57% (6th decile, 3 points)
- **FY 21 Performance:** 60% (7th decile, 4 points)
- **FY 22 Improvement Activities:**
  - *Quality Department will provide list of all patients who meet criteria to the PCP*
  - *Consider having Blood Pressure Clinics in the Winter*
  - *For those patients whose Blood Pressure is too high, bring the patient in for a visit to discuss their treatment plan*

Points for each Decile		1	2	2	3	3	4	4	5	5
Measure Title	CMS Benchmark	Decile 1-2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	63.6	<20	20 - 29.9	30 - 39.9	40 - 49.9	50 - 59.9	60 - 69.9	70 - 79.9	80 - 89.9	>= 90