El Camino Health

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

Monday, November 6, 2023 – 5:30 pm

El Camino Health | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 944 8554 5855#. No participant code. Just press #.

PURPOSE: To advise and assist the El Camino Health (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	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Carol Somersille, MD Quality Committee Chair		**5:30 – 5:32 pm**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Carol Somersille, MD Quality Committee Chair	Possible Motion	**5:32 – 5:33**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Carol Somersille, MD Quality Committee Chair	Information	**5:33 – 5:34**
4.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board Quality Committee at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Carol Somersille, MD Quality Committee Chair	Information	**5:34 – 5:37**
5.	**CONSENT CALENDAR ITEMS** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Carol Somersille, MD Quality Committee Chair	Motion Required	**5:37 – 5:47**
	a. Approve Minutes of the Open Session of the Quality Committee Meeting (09/05/2023) b. Approve Minutes of the Closed Session of the Quality Committee Meeting (09/05/2023) c. Receive FY24 Pacing Plan d. Receive CDI Dashboard e. Receive Core Measures			
6.	**VERBAL CHAIR'S REPORT**	Carol Somersille, MD Quality Committee Chair	Information	**5:47 – 5:52**

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) 988-7609** 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	ACTION	ESTIMATED TIMES
7.	**RECEIVE PATIENT STORY REPORT**	Cheryl Reinking, DNP, RN NEA-BC, Chief Nursing Officer	Motion Required	**5:52 – 6:02**
8.	**RECEIVE SAFETY REPORT FOR THE ENVIRONMENT OF CARE**	Ken King, Chief Administrative Services Officer	Motion Required	**6:02 – 6:17**
9.	**RECEIVE EL CAMINO HEALTH MEDICAL NETWORK REPORT**	Shahab Dadjou, President, El Camino Health Medical Network Ute Burness, VP of Quality and Payer Relations	Motion Required	**6:17 – 6:37**
10.	**RECESS TO CLOSED SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**6:37 – 6:38**
11.	*Health and Safety Code section 32155 – reports of hospital medical quality assurance committee* **QUALITY COUNCIL MINUTES** a. Receive Quality Council Minutes (09/06/2023) b. Receive Quality Council Minutes (10/04/2023)	Carol Somersille, MD Quality Committee Chair	Discussion	**6:38 – 6:42**
12.	*Gov't Code Section 54956.9(d)* – conference with legal counsel – pending or threatened litigation **Q1 FY24 STEEEP DASHBOARD & FY24 ENTERPRISE QUALITY DASHBOARD**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**6:42 – 7:13**
13.	*Health and Safety Code section 32155 – reports of hospital medical quality assurance committee* **Q1 FY24 QUARTERLY QUALITY AND SAFETY REVIEW OF REPORTABLE EVENTS**	Holly Beeman, MD, MBA, Chief Quality Officer	Discussion	**7:14 – 7:24**
14.	*Health and Safety Code Section 32155 and Gov't Code Section 54957 – Report regarding personnel performance of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance committee* **APPROVE CREDENTIALING AND PRIVILEGES REPORT**	Mark Adams, MD, Chief Medical Officer	Motion Required	**7:24 – 7:34**
15.	*Health and Safety Code Section 32155 –* reports of hospital quality assurance committee **RECEIVE SERIOUS SAFETY/RED ALERT EVENT REPORT**	Holly Beeman, MD, MBA, Chief Quality Officer	Motion Required	**7:34 – 7:39**
16.	**ADJOURN TO OPEN SESSION**	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:39 – 7:40**
17.	**RECONVENE OPEN SESSION**	Carol Somersille, MD Quality Committee Chair		
18.	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Carol Somersille, MD Quality Committee Chair	Information	**7:40 – 7:41**

AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
19. COMMITTEE ANNOUNCEMENTS	Carol Somersille, MD Quality Committee Chair	Information	**7:41 – 7:44**
20. ADJOURNMENT	Carol Somersille, MD Quality Committee Chair	Motion Required	**7:44 – 7:45 pm**

Next Meeting: December 4, 2023, February 5, 2024, March 4, 2024, May 6, 2024, June 3, 2024

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
of the El Camino Health Board of Directors
Tuesday, September 5, 2023
El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040

Members Present
Carol Somersille, MD
Krutica Sharma, MD
Melora Simon
John Zoglin
Pancho Chang

Members Absent
Prithvi Legha, MD
Jack Po, MD
Philip Ho, MD

Others Present
Holly Beeman, MD, MBA, CQO
Dan Woods, CEO
Mark Adams, MD, CMO
Christine Cunningham, Chief Experience and Performance Improvement Officer
Cheryl Reinking, DPN, RN, CNO
Shreyas Mallur, MD, ACMO
Daniel Shin, MD
Sheetal Shah, Director, Risk Management and Patient Safety
Lyn Garrett, Senior Director, Quality
Nicole Hartley, Executive Assistant II
Gabriel Fernandez, Coordinator, Governance Services

**via teleconference

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 Health (the "Committee") was called to order at **5:31 pm** by Chair Carol Somersille. A verbal roll call was taken. Dr. Legha, Dr. Ho, Dr. Po and Melora Simon were absent at roll call. All other members were present at roll call and participated in person. Melora Simon joined at **5:33 pm**. A quorum was not present until Melora Simon's arrival at **5:33 pm**. No votes were taken before quorum was present.	Call to order at 5:31 pm
2. CONSIDER APPROVAL FOR AB 2449 REQUESTS	No members of the Committee participated remotely, and no AB 2449 requests were submitted.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Somersille asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
4. PUBLIC COMMUNICATION	There were no comments from the public.	

5. CONSENT CALENDAR	Chair Somersille asked if any Committee member would like to pull an item from the consent calendar. **Motion**: To approve the consent calendar: (a) Minutes of the Open Session of the Quality Committee Meeting (08/07/2023), For information: (b) FY24 Enterprise Quality Dashboard, (c) Progress against FY24 Committee Goals, (d) QC Follow-Up Items **Movant**: Sharma **Second**: Chang **Ayes**: Somersille, Chang, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha, Po, Ho **Recused**: None	***Consent Calendar Approved*** ***Actions***: *Request for the Director of Governance Services to brief the Quality committee on their role when it comes to goal and target setting on the Enterprise Quality Dashboard.*
6. CHAIR'S REPORT	Chair Somersille encouraged members of the committee to attend one of the educational sessions in the chair's report. Chair Somersille discussed the benefits and value that would come from attendance to one of the sessions and presented options that the Committee members could consider attending.	
7. PATIENT STORY	Cheryl Reinking, CNO presented a patient story to highlight our effective enterprise collaboration. The patient had received multiple telehealth visits and the patient's condition was not improving after suggested treatments at another institution. The patient arrived at the ECHMN urgent care and the clinician immediately recognized the significance of the patient's condition and made the referral to the MV Emergency Department for timely, efficient, and effective diagnosis and subsequent treatment. The patient was seen immediately in the MV ED and was admitted for inpatient care. The patient's condition evolved and warranted care by a specialized burn unit, which we do not have at ECH. As a result, the patient was transferred to Valley Medical Center's burn unit, further demonstrating efficient cross continuum collaboration.	

DRAFT

8. PATIENT EXPERIENCE	Ms. Christine Cunningham, Chief Experience Officer, presented the Patient Experience Update to review how El Camino Health's performance compares to peers and national trends. Additionally, Ms. Cunningham overviewed the FY24 targets and current YTD progress for those targets.	***Actions:***
9. REFRESH STEEP MEASURES WITH COMMITTEE FOR FY24	Dr. Holly Beeman, Chief Quality Officer, presented the proposal for the FY24 STEEEP Dashboard Measures based on the findings and methodology evaluated by the assessments completed by the Quality and Executive teams. The committee supports the recommended metrics to be included in the FY24 STEEEP dashboard.	***Actions:*** *Staff to provide clarity on the length of stay metric. Specifically, if is it all inpatients or if any exclusions are applicable.* *Staff to provide measure definitions be included for the STEEEP measures.*
10. ADJOURN TO CLOSED SESSION	**Motion**: To adjourn to closed session at <u>7:07 pm.</u> **Movant**: Chang **Second**: Sharma **Ayes**: Somersille, Chang, Sharma, Simon, Zoglin **Noes**: None **Abstain**: None **Absent**: Legha, Po, Ho **Recused**: None	***Adjourned to closed session at 7:07 pm***
11. AGENDA ITEM 19: RECONVENE OPEN SESSION/REPORT OUT	The open session reconvened at <u>8:21 pm</u>. Agenda items 11-17 were addressed in closed session. During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (08/07/2023) and the Credentialing and Privileges Report by unanimous vote by all committee members present.	***Reconvened Open Session at 8:21 pm***
12. AGENDA ITEM 20: ROUNDTABLE	Chair Somersille asked Ms. Nicole Hartley to recount the action items requested from the committee at the meeting.	
13. AGENDA ITEM 21: ADJOURNMENT	**Motion**: To adjourn at <u>8:24 pm</u> **Movant**: Simon **Second**: Zoglin **Ayes**: Somersille, Chang, Sharma, Simon, Zoglin	***Adjourned at 8:24 pm***

DRAFT

	Noes: None **Abstain**: None **Absent**: Legha, Po, Ho **Recused**: None	

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

____

Gabriel Fernandez, Governance Services Coordinator

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by: Tracy Fowler, Director of Governance Services

DRAFT

El Camino Health

APPROVED BY
QC 4/3/2023

Quality, Patient Care, and Patient Experience Committee
FY24 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Board STEEP Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience			✓						✓			
Health Care Equity						✓						✓
Safety Report for the Environment of Care					✓							
PSI Report						✓						
Sepsis Review						✓						
Value Based Purchasing Report									✓			
Approve Quality Assessment & Performance Improvement Plan (QAPI)												✓
Refresh STEEEP Dashboard measures for FY25		~~✓~~	✓									
Special Topic (Placeholder)			~~✓~~								✓	
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals								✓				
Approve Committee Goals									✓			
Propose FY Committee Meeting dates								✓				
Approve FY Committee Meeting dates									✓			
Propose Organizational Goals									✓			
Approve Organizational Goals											✓	
Propose Pacing Plan								✓				
Approve Pacing Plan									✓			
Review Charter									✓			
Approve Charter											✓	

1: Includes Approval of Minutes (Open & Closed), Current FY Enterprise Quality Dashboard, Med Staff Quality Council Minutes (Closed Session), Progress Against FY Committee goals (Quarterly), Current FY Pacing Plan (Quarterly), QC Follow Up Items, Patient Safety Report (Sept), CDI Dashboard (Semi-Annual), Core Measures (Semi-Annual), Leapfrog (June)

4/4/2023

El Camino Health

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Cornel Delogramatic, Director of Clinical Documentation Integrity and Health Equity
Date: November 6, 2023
Subject: Clinical Documentation Integrity Dashboard FY 2023 - 2024

Purpose: To provide a semi-annual update on the Clinical Documentation Integrity Department activity.

Summary:

1. Situation: From a clinical perspective, CDI ensures accurate descriptions of health conditions and creates electronic documents for every step of the patient's treatment and services that translates into quality outcomes (mortality score, readmission score, complication score, etc.), patient safety measures (PSI rate, HAC rate,) and utilization outcomes (expected LOS, denial rate, clean claim rate, RAF scores, CMI etc).

2. Authority: Quality Committee of the Board is responsible for oversight of Clinical Documentation Integrity Department.

3. Background: The Clinical Documentation Integrity (CDI) department is critical to a hospital because it ensures that clinical documentation accurately tells the patient's story and that the records of each patient and their medical history are maintained for future use. CDI programs can aid in the documentation of diagnoses that are specific and consistent throughout the medical record, which leads to accurate code assignment, better understanding of patient complexity, and improved safety and quality scores. Additionally, a well-trained clinical documentation integrity team will use consistent processes to promote accurate claims, which will reliably result in full reimbursement for rendered care services, reduce denials and improved appeal processes for the organization.

4. Assessment: Each medical record is reviewed by a clinical documentation specialist (CDS) who identifies documentation deficiencies or opportunities and uses a communication tool named "clinical documentation query" to communicate with the physicians to correct the deficiencies or to validate the diagnoses/procedures clinically. The CDI team is also responsible for educating the providers on documentation compliance requirements or newly emerged diagnostic guidelines, clinical classifications, and risk adjustment methodologies. Each query is stored within EMR as a part of the legal medical record.

   In this dashboard each metric that is higher is better and is highlighted in green.

5. Other Reviews:

6. Outcomes:

   A. CDI review coverage rate – Inpatient population; (process measure)
   B. CDI review coverage rate – Outpatient population; (process measure)
   C. CDI query volumes and provider meaningful responses; (process and engagement measure)
   D. PSI/HAC exclusion rates; (outcome measure)
   E. Nv-HAP exclusion rates; (outcome measure)

List of Attachments:

1. CDI Dashboard FY23.

Suggested Committee Discussion Questions: None

El Camino Health

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

As of Apr 15, 2022

				Baseline	FY23 Goal	Trend	Comments
CDI Coverage		Performance		FY2023	FY2024 goal		
1	**All Payer CDI coverage rate** *Source: iCare CDI Productivity report	September 2023 51%	FYTD 62%	69%	71%	ALL PAYER CDI COVERAGE RATE	The comprehensive all-payer coverage is a testament to the efficiency and dedication of the CDI Team. At present, our team consists of 4 FTEs overseeing all adult non-OB patients across both campuses. This translates to approximately 1,300 to 1,500 patients reviewed every month. It's noteworthy to mention that in August 2023, we had a valued senior CDI specialist retire. We are actively seeking to onboard a qualified specialist to fill this pivotal role. Furthermore, as we transition into FY 2024, we are committed to the adoption of advanced technologies to further enhance our productivity.
2	**Observation CDI Coverage Rate** *Source: iCare CDI Productivity report	September 2023 68%	FYTD 68%	62%	65%	OBSERVATION CDI COVERAGE RATE	Observation review is essential for many aspects of the organization. By having clinical documentation specialists review these cases, we ensure that clinical documentation accurately reflects the medical necessity in the medical record and that all comorbidities are coded and clinically validated.
Physician engagement		Performance		FY2023	FY 2024 goal		
3	**Query volumes** *Source: iCare CDI Query report	September 2023 334	FYTD 330	328	350	Query volumes vs. Meaningful Response rate (%)	This metric evaluates physician engagement with CDI initiatives within our health system by comparing the meaningful response rate to the overall query volume. Historically, our CDI programs have demonstrated consistent growth in this metric over the past four years, rising from 67% in FY 2019 to 93% YTD. This upward trend can primarily be attributed to robust collaboration between CDI and medical doctors, coupled with education on the value of superior clinical documentation to the organization. It's noteworthy to mention the observed seasonal dips in meaningful responses from medical doctors during winter and summer vacation periods.
4	**Meaningful Response Rate** *Source: iCare CDI Query report	September 2023 95.8%	FYTD 93%	93%	95%		

CDI Quality Outcomes		Performance		FY2023	FY 2024 goal		
5	nv-HAP exclusion rate *Source: CDI nv--HAP dashboard	Jun 2023 47%	FYTD Avg. 47%	34%	> 34% of misdocumented PNA cases	NV-HAP EXCLUSION (chart)	Nv-HAP is a central component of the HAC Quality Index. CDI team provides support by ensuring that each hospital-acquired pneumonia case is scrutinized and potential documentation challenges are clarified before being final coded and released for data collection. It is one of the many benefits a solid and experienced CDI team brings to the organization's quality and safety of care. A high exclusion rate of "false" labeled hospital-acquired cases of pneumonia positively impacts our HAC Index.
6	PSI/HAC exclusion rate *Source: CDI PSI/HAC Dashboard	Q4 2023 29%	FYTD Avg. 21%	21%	> 30%	PSI/HAC Exclusion Rate (chart)	Another aspect of CDI's impact on the quality of care and how that gets reported publicly is by reviewing Patient Safety Indicator (PSI) labeled cases and hospital-acquired conditions (HAC) and trying to clarify with the physician if any exclusion factors existed that could precipitate such safety events. By continuously monitoring these cases, the CDI team ensured our data gets reported accurately to federal reporting agencies and third-party entities that broadcast hospital ratings to the public. A high exclusion rate of inaccurately documented complications positively impacts our patient's care and the public's image of our institution.

6

NV-HAP EXCLUSION

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
29%	33%	33%	55%	24%	33%	60%	30%	27%	25%	11%	47%

PSI/HAC Exclusion Rate

Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023
29%	37%	22%	24%	31%	18%	15%	31%	32%	29%	10%	40%	22%	15%	22%	23%

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING MEMO

To: El Camino Hospital Board Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett MHA CPHQ
Senior Director of Quality
Date: November 6, 2023
Subject: Calendar Year 2022 Core Measure Dashboard

Purpose:

To update the Quality, Patient Care and Patient Experience Committee on FY 2023 Core Measure Dashboard, Non-Hospital-based Inpatient Psychiatric Services (Non-HBIPS) and Hospital-based Inpatient Psychiatric Services (HBIPS)

Summary: As required under section 1890A(a)(6) of the Social Security Act, Centers for Medicare and Medicaid Services (CMS) assesses the quality and efficiency of care provided to patients through establishing quality standards and programs to improve health care for beneficiaries and all who receive care in the United States. Core measures are designed to be meaningful to patients, consumers and physicians. The America's Health Insurance Plans (AHIP) leads the Core Quality Measure Collaborative (CQMC) which develops the core measures and their specifications. CMS uses core measure performance to inform how we are graded in various quality initiatives such as pay for reporting, value based pay, and public reporting on hospital compare.

1. Authority: The Quality, Patient Care and Patient Experience 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: There are no new revisions for FY 2023 by CMS or the Joint Commission (TJC) to the core measures. Some metrics are measured as eCQM (electronic Clinical Quality Measure) reporting in accordance with CMS "Meaningful Use" program. Sepsis (SEP-1) Core Measure is reported as its own dashboard. These measures only reflect Inpatient Quality Reporting (IQR) and some Outpatient Quality Reporting (OQR) Program Measures.

3. Assessment: CMS has two sets of Core Measures relevant to El Camino Health acute care: one covers acute hospitals (Non-HBIPS) 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 (**Non**-** Hospital-based Inpatient Psychiatric Services**)**

      i. **PC01- Elective Delivery (EED)** Prior to 39 weeks gestation- Percent of mothers with elective vaginal deliveries or elective cesarean births at >=37 and < 39 weeks gestation completed. Maternal Child Health (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. FY23 ECH Target = 1.5%, vs TJC <=2%. FY 2023 Performance: 0.6% (2/330).

Hospital Compare reporting period Q42021-Q32022 PC-01 - ECH 1%; national 2% and state 2%.

ii. **PC02- Cesarean Birth**- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; FY 2023 Performance is 27% (595/2207). Of note, Leapfrog is following Healthy People 2020 NTSV cesarean birth rate target of 23.9% and 23.6% or less by 2030. 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, ECH OB Task Force is working to identify where we can make system improvements to reduce unnecessary NTSV. MCH leadership team has worked with independent OBs and OB groups to identify practice patterns and opportunities for improvement. Currently each provider gets their personal score card quarterly (used to be twice a year) so they can see how they are doing along with their peers. NTSV taskforce meets bi-weekly to work on improvements. Education for nurses and physicians has been completed. A new process is being trialed in which the CMQCC NTSV Checklist is being utilized by the care team prior to making the decision to proceed with a cesarean section.

iii. **PC05- Exclusive Breast Milk Feeding**- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; FY 2023 Performance: 61.7% (514/833) which is below target, but above TJC's rate of 50%. Currently renewing our Baby Friendly certification for LG and have started implementing measures to achieve Baby Friendly designation in MV by January 2025. Implemented banked breastmilk in June 2023 for well newborns who need supplementation, which is having a significant positive impact on our rate (ENT rate was 62.9% in July 2023).

iv. **PC06- Unexpected Complications in Term Newborns**- this measure is intended to track moderate-to-severe adverse outcomes of healthy infants without preexisting conditions. Target goal is <3%; FY 2023 Performance: 2.2% (91/4062) compared to TJC's 3%. This measure is not publicly reported.

v. **OP18b- Median Time from ED Arrival to ED Departure for Discharged ED Patients**-Median time (in minutes) patients spent in the emergency department before leaving from the visit. Target goal is 180 minutes or less; FY 2023 rate is ENT:182 minutes. Latest Hospital Compare - ECH 184 minutes, California 197 minutes, and National average-207 minutes with reporting period 4Q2021 to 3Q2022.

vi. **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%; FY 2023 performance is 86% (6/7) which has improved from FY2022 which was at 60%.

B. **HBIPS Core Measures (**Hospital-based Inpatient Psychiatric Services)

i. **IMM-2 Influenza Immunization** - Patients assessed and given influenza vaccination. Target goal is 100%; FY 2023 rate is 95.5%. IMM-2 Influenza California rate 78%; National 77% reporting period 1Q2021-1Q2022.

ii. **HBIPS-5 Patients Discharged on multiple antipsychotic medications with appropriate justification**. Target goal is 80% FY 2023 rate is 47.4%. Fallouts sent to MHAS team for further review and education to providers. This measure is part of OPPE. This measure will be retired as the clinical guidelines which form the basis for this measure have been updated and the measure no longer algins with the current clinical guidelines.

iii. **PC-TOB Perfect Care - Tobacco Use**-Target goal is 80% FY 2023 rate is 43%. Daily concurrent review of this measure shows there are less and less patients using tobacco products (denominator is 4-5 cases/month). Variances sent to MHAS team for further review and education to providers. iCare modified tobacco order set to increase compliance. New Social workers were educated on tobacco counseling referral process. Quitline process is still efficient versus California Smoker's Helpline. Daily concurrent review of this measure includes participation of MHAS team – director, Manager, ACM/house supervisors, frontline staff and social workers.

iv. **PC-SUB Perfect Care - Substance Abuse**- Target goal is 80% FY 2023 rate is 87%.

v. **TR-1 Transition Record with Specified Elements Received by Discharged Patients.** Target goal is 75% FY 2023 rate is 95%.

vi. **MET-1 Screening for Metabolic Disorders** - Comprehensive screening currently defined to include: Body mass index, A1C or glucose test, Blood pressure, Lipid panel, Total cholesterol Low density lipoprotein, High density lipoprotein, Triglycerides. Target goal is 75%; FY 2023 rate is 93%.

vii. **HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours)** lower is better. Target goal is 0.0004; FY 2023 rate is 0.0002.

viii. **HBIPS-3 Hours of Seclusion Use (per 1000 patient hours**) lower is better Target goal is 0.0003; FY 2023 rate is 0.0002. Unusual high number of patients in restraint (8) and seclusion (8) in November 2022.

List of Attachments:

1. Attachment 1: CY2022 Core Measure Report Non-HBIPS for GB
2. Attachment 2: CY2022 Core Measure Report HBIPS for GB

El Camino Health

Core Measures Dashboard (non-HBIPS) - FY 2023 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2023 Performance	FY 2022 Baseline	Target	Trend Graph
PERINATAL CARE MOTHER					
PC-01 Elective Delivery Prior to 39 weeks gestation (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: June 2023	ENT: 0.0% (0/24) MV: 0.0% (0/22) LG: 0.0% (0/2)	ENT: 0.6% (2/330) MV: 0.8% (2/260) LG: 0% (0/70)	ENT: 1.1% (4/356) MV: 0.4% (1/271) LG: 3.5% (3/82)	< 2% (Joint Commission Benchmark)	
PC-02 Cesarean Birth (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: June 2023	ENT: 32.0% (56/175) MV: 32.7% (49/150) LG: 28.0% (7/25)	ENT: 27.0% (595/2207) MV: 28.1% (530/1884) LG: 20.1% (65/323)	ENT: 25.8% (586/2274) MV: 27.1% (503/1857) LG: 19.9% (83/417)	< 25% (Joint Commission Benchmark)	
PERINATAL CARE BABIES					
PC-05 Exclusive Breast Milk Feeding **FINALIZED** Data Source : Merative Latest Data Month: June 2023	ENT: 71.4% (45/63) MV: 73.2% 41/56) LG: 57.1% (4/7)	ENT: 61.7% (514/833) MV: 61.1% (436/714) LG: 65.5% (78/119)	ENT: 58.0% (507/869) MV: 56.3% (404/178) LG: 68.2% (103/151)	> 50% (Joint Commission Benchmark)	
PC-06 Unexpected Complications in Term Newborns (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: June 2023	ENT: 2.2% (7/317) MV: 2.5% (7/279) LG: 0.0% (0/38)	ENT: 2.2% (91/4062) MV: 2.1% (73/3410) LG: 2.8% (18/652)	ENT: 2.1% (92/4361) MV: 2.0% (71/3541) LG: 2.6% (21/1820)	< 3% (Joint Commission Benchmark)	
ED THROUGHPUT					
OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients (lower = better) **FINALIZED** Data Source : Merative Latest Data Month: June 2023	ENT: 158 Minutes	ENT: 182 Minutes	ENT: 180 Minutes	< 98 mins (CMS Standard of Excellence - Top 10% of Hospitals)	

OUTPATIENT MEASURES

Comments	FY 2023 Definition	Definition Owner	Work Group	Source
PC01- Elective Delivery Prior to 39 weeks gestation- Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary. Also known as Early Elective Delivery (EED) ECH Target goal is 1.5 %; FY 2023 Performance: 0.6% Statistically topped out national 2% and state 2% and was recently removed from Value Based Purchasing Program. MCH has an EED tracking system and reach out to providers to reschedule as needed. EED is tracked and closely monitored to avoid unindicated cases.	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed	**TJC**	**Quarterly meeting/ emails with L&D nursing leadership; failure summary cases referred to peer review coordinator**	**IBM CareDiscovery Quality Measures**
PC02- Cesarean Birth- Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. Target goal of 23.9%; FY 2023 Performance is 27% The providers get their score card generally every quarter so they can see how they are doing along with their peers;OB Task Force has been evaluating where they can make system improvements to reduce unnecessary NTSV.	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	**TJC**	**Quarterly meeting/ emails with L&D nursing leadership; failure summary cases referred to per review coordinator**	**IBM CareDiscovery Quality Measures**
PC05- Exclusive Breast Milk Feeding- Newborns that were fed breast milk only since birth during the entire hospitalization. Target goal is 70%; FY 2023 Performance: 61.7% Our target compliance rate of 70%- this gives us 30% allowance for cases with maternal /infant indIcators to supplement with formula feeding. Medical reasons are not given credits or exempted e.g. Jaundice with TsB @ high risk or requiring phototherapy, hypoglycemia, weight loss >7% and dehydration. • 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	Numerator Statement: Newborns that were fed breast milk only since birth Denominator Statement: Single term newborns discharged alive from the hospital	**TJC**	**Quarterly meeting/ emails with L&D nursing leadership**	**IBM CareDiscovery Quality Measures**
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 1.82%; FY 2023 Performance: 2.2% This measure is intended to track moderate to severe adverse outcomes of healthy infants without pre-existing conditions. Failed cases are referred to peer review coordinators/ nurses for further investigation.	Numerator Statement: Newborns with severe complications and moderate complications Denominator Statement: Liveborn single term newborns 2500 gm or over in birth weight. This measure simply asks: of babies without preexisting conditions (no preemies, multiple gestations, birth defects or other fetal conditions) and who are normally grown and were not exposed to maternal drug use, how many had severe or moderate neonatal complications?	**TJC**	**Quarterly meeting/ emails with L&D nursing leadership; failure summary cases referred to per review coordinator**	**IBM CareDiscovery Quality Measures**
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 2023 rate is ENT:182 mins	"Numerator -Time (in minutes) from ED arrival to ED departure for patients discharged from the ED - Reporting Measure Denominator -Any ED Patient from the facility's emergency department, not expired Included Populations: Any ED patient from the facility's emergency department Excluded Populations: Patients who expired in the emergency department"	**Hospital OQR Specifications Manual**		**IBM CareDiscovery Quality Measures**

El Camino Health

Core Measures Dashboard (non-HBIPS) - FY 2023 Performance - Enterprise (unless otherwise specified)

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2023 Performance	FY 2022 Baseline	Target	Trend Graph
OP-23 Head CT or MRI Scan Results fro Acute Ischemic Stroke or Hemorrhagic Stroke **FINALIZED** Data Source : Merative Latest Data Month: June 2023	ENT: 0.0% No Cases MV: 0.0% No Cases LG: 0.0% No Cases	ENT: 85.7% (6/7) MV: 100% (5/5) LG: 50.0% (1/2)	ENT: 60.0% (6/10) MV: 71.4% (5/7) LG: 33.3% (1/3)	100% (CMS Standard of Excellence - Top 10% of Hospitals)	

Comments	FY 2023 Definition	Definition Owner	Work Group	Source
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%; FY 2023 is 85.7% The metric only includes patients who arrive within 2 hours of last known well explaining the low denominator . Currently, we are a Thrombectomy-capable Stroke Center in MV and Primary Stroke Center in LG so 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.)	Numerator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT scan is within 45 minutes of arrival Denominator -ED Acute Ischemic or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the time last known well with an order for a head CT or MRI scan	**Hospital OQR Specifications Manual**	**Shared with Christine Kilkenny (monthly) /Stroke Committee (quarterly prn)**	**IBM CareDiscovery Quality Measures**

El Camino Health

FY 2023 Performance - Core Measures (HBIPS) - Enterprise

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2023 Performance	FY 2022 Baseline	All Core Measures Hospitals FY 2023 Benchmark	Trend Graph
HOSPITAL BASED INPATIENT PSYCHIATRIC SERVICES (HBIPS)					
IMM-2 Influenza Immunization **FINALIZED** *Data Source : Merative* *Latest Data Month: March* ***Data only capture for Jan-Mar, Oct - Dec months**	94.5% (69/73)	95.5% (429/449)	95.3% (367/385)	87.4%	
HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification **FINALIZED** *Data Source : Merative* *Latest Data Month: June 2023*	23.1% (3/13)	47.4% (65/137)	70.7% 94/133)	62.7%	
PC-TOB Perfect Care - Tobacco Use **FINALIZED** *Data Source : Merative* *Latest Data Month: June 2023*	0% (0/5)	22.6% (14/62)	43.2% (19/44)	19.4%	
PC-SUB Perfect Care - Substance Abuse **FINALIZED** *Data Source : Merative* *Latest Data Month: June 2023*	55.6% (10/18)	86.8% (112/129)	92.1% (82/89)	64.8%	

Comments	FY 2023 Definition	Definition Owner	Work Group	Source
IMM-2 Influenza Immunization Patients assessed and given influenza vaccination. Target goal is 100%; FY 2023 rate is 95.5%	Numerator: Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated. Denominator: Acute care hospitalized inpatients age 6 months and older discharged during October through March. Excludes patients less than 6 months of age, patients who expire prior to hospital discharge, patients with an organ transplant during the current hospitalization, patients with hospital discharges Oct 1 through March 31 when the provider's vaccine supply is on order but has not yet been received, patients who are transferred or discharged to another hospital, or patients who leave AMA. Definition: Documentation of the patient's vaccination status during this influenza season. If found to be a candidate for the influenza vaccine, documentation that the influenza vaccine was given during this hospitalization.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**
Patients Discharged on multiple antipsychotic medications with appropriate justification. Target goal is 80%; FY 2023 rate is 47.4% Reports were created and shared monthly to BHS leadership to identify patients discharged on two or more antipsychotic medications without appropriate supporting documentation. Education efforts targeted to remind providers that even if they prescribed antipsychotic (e.g. Abilify) to treat depression, it's still counted as antipsychotic. Also not to bypass or work-around the hardwired discharge documentation of reason for 2 or more antipsychotics by answering NO. **retiring in 2024**	Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification Denominator Statement: Psychiatric inpatient discharges	**TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**
PC-TOB Perfect Care - Tobacco Use-Target goal is 80% FY 2023 rate is 22.6% Each element has to be met to pass the measure. Current improvement work related to these measures includes Social Worker's Quitline referral, prescribing of FDA approved tobacco cessation drugs while inpatient and upon discharge. . Daily monitoring to identify current tobacco users to ensure proper interventions are implemented- quality collaborating with MHAS asst. clinical managers and hospital supervisors.	No tob 1 , same Tob 2 and 3	**TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**
PC-SUB Perfect Care - Substance Abuse- Target goal is 80% FY 2023 rate is 86.8%	No Sub 1, same SUB 2 and 3	**TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**

El Camino Health

FY 2023 Performance - Core Measures (HBIPS) - Enterprise

KEY PERFORMANCE INDICATORS & METRICS	Latest Month Performance	FY 2023 Performance	FY 2022 Baseline	All Core Measures Hospitals FY 2023 Benchmark	Trend Graph
TR-1 Transition Record with Specified Elements Received by Discharged Patients FINALIZED Data Source : Merative Latest Data Month: June 2023	94.9% (75/79)	87.0% (760/874)	86.2% 726/842)	44.3%	
MET-1 Screening for Metabolic Disorders FINALIZED Data Source : Merative Latest Data Month: June 2023	89.8% (53/59)	93.3% (558/598)	95.0% (569/599)	88.1%	
RESTRAINTS AND SECLUSIONS					
HBIPS-2* Hours of Physical Restraint Use (per 1000 patient hours) (lower = better) FINALIZED Data Source : Merative Latest Data Month: June 2023 *Event measures are calculated by event occurrence date	0.0000 (0/35080)	0.0021 (42.55/261096)	0.0027 (56.1333/273024)	0.0001	
HBIPS-3* Hours of Seclusion Use (per 1000 patient hours) (lower = better) FINALIZED Data Source : Merative Latest Data Month: June 2023 *Event measures are calculated by event occurrence date	0.0002 (4.7667/19944)	0.0002 (29.4666/167448)	0.0005 (131.1335/269784)	0.0003	

Comments	FY 2023 Definition	Definition Owner	Work Group	Source
TR-1 Transition Record with Specified Elements Received by Discharged Patients Target goal is 75% FY 2023 rate is 87.0%	Numerator: Psychiatric inpatients or their caregiver(s) who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all 11 required elements. Denominator: Psychiatric inpatients, regardless of age, discharged from the IPF to home/self-care or any other site of care.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**
MET-1 Screening for Metabolic Disorders - Comprehensive screening currently defined to include: Body mass index A1C or glucose test Blood pressure Lipid panel Total cholesterol Low density lipoprotein High density lipoprotein Triglycerides. Target goal is 75%; FY 2023 rate is 93.3%	The numerator is the total number of patients who received a metabolic screening either prior to, or during, the index IPF stay. The screening must contain four tests: (1) body mass index (BMI); (2) blood pressure; (3) glucose or HbA1c; and (4) a lipid panel. The screening must have been completed at least once in the 12 months prior to the patient's date of discharge. Screenings can be conducted either at the reporting facility or at another facility for which records are available to the reporting facility. The denominator includes IPF patients discharged with one or more routinely scheduled antipsychotic medications during the measurement period. The measure excludes patients for whom a screening could not be completed within the stay due to the patient's enduring unstable medical or psychological condition and patients with a length of stay equal to or greater than 365 days or equal to or less than 3 days. Screening for Metabolic Disorders Studies show that antipsychotics increase the risk of metabolic syndrome.1 Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes.	**CMS/TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**
HBIPS-2 Hours of Physical Restraint Use (per 1000 patient hours) Target goal is 0.0004; FY 2023 rate is 0.0021	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**
HBIPS-3 Hours of Seclusion Use (per 1000 patient hours) Target goal is 0.0003; FY 2023 rate is 0.0002	Rationale: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint or seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).	**TJC**	**quarterly meeting/email to BHS team**	**Merative CareDiscovery Quality Measures**

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, DipACLM
Date: November 6, 2023
Subject: Voice of the Patient/Family Feedback

Purpose: To provide the Committee with written patient feedback that is received by the hospital from patients and/or families who received care at ECH.

Summary:

1. Situation: This was a hand-written note from a patient's mother.

2. Authority: To provide insight into the impact that our care and treatment of an organ donor patient had on a family experiencing the traumatic loss of their loved one.

3. Background: The note describes the care the patient received as she was emergently brought to ECH via EMS after collapsing on the football field where her son was playing. The family was very pleased with the care throughout their loved one's stay at ECH. Even though she did not survive her condition, the family was complimentary as the staff made a great effort to work closely with The Donor Network to coordinate the patient's care at the end of life. Most memorable for the family was the honor walk. ECH instituted the honor walks a few years ago. The honor walk is a ceremonial event to commemorate a patient whose organs are donated. The event takes place as the patient is transported to the operating room. The honor walk for this patient was very special with an abundance of staff lining the halls to honor and commemorate this patient's choice. It was a moving and memorable moment for all involved.

4. Assessment: This note validates that even though the patient did not survive, a dignified and caring end-of-life ritual leaves a positive lasting impression on all the family members and loved ones of the patient.

5. Other Reviews: None

6. Outcomes: El Camino plans to continue the honor walks to commemorate and honor those who make the gift of life.

7. List of Attachments: See patient comments.

Suggested Committee Discussion Questions:

1. What is the relationship ECH has with the Donor Network?

2. How do we honor patient wishes who choose to donate organs?

Patient Story

“On [***redacted***] our daughter [***redacted***] was rushed and admitted to room [***redacted***] with having no brain activity after collapsing on the football field at [***redacted***], after suffering a seizure or stroke. We want to thank all the medical staff for the excellent care given to our daughter. She gained her Angel wings on [***redacted***]. The medical staff were all her Angels who took such loving care of her since the minute she entered the hospital. These Angels were the paramedics, doctors, nurses, and all medical staff who made our daughter so comfortable with their tender, loving care. They made her look so beautiful and so at peace. Thank you all for snacks provided and the clergy staff for providing us with words of comfort and love, for accepting the will of God. Although our hearts are shattered, we find solace in knowing the best medical care was given to her. We feel so blessed that God gave us a beautiful daughter who was so giving until her last breath. May the lives she saved be blessed like we were sooo blessed to have her in our lives. Thank you, thank you to everyone for the super comforting care and loving care given to her. With deep regards and appreciation. The Walk of Honor was the most beautiful experience of our lives.”

El Camino Health

EL CAMINO HOSPITAL
QUALITY COMMITTEE MEETING COVER MEMO

To: El Camino Hospital Quality Committee
From: Ken King, CAO
Date: November 6, 2023
Subject: FY-23 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 for FY-23.

Summary:

1. Situation: The management of the environment of care, the safety program with all its elements and the emergency management plan produced solid results in FY-23. Highlights include:

a) **Employee Safety:** The rate of OSHA Recordable Injuries decreased 15% from the previous year and the lost work time rate decreased 50% from the previous year.

b) **Security:** The number of OSHA reportable Workplace Violence incidents decreased 6% from the prior year. The decrease in incidents is attributed to enhanced Nonviolent

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

d) **Fire Safety:** There were no Fire Incidents at any El Camino Health facilities in FY-23.

e) **Medical Equipment:** The planned maintenance for high-risk medical equipment was maintained at 99.23% completion rates, a slight improvement over the prior year.

f) **Utilities:** There were nine PG&E electrical power outages during FY-23, three in Los Gatos and six in Mountain View. All emergency power systems functioned as designed and there were no negative outcomes.

g) **Emergency Management:** There were three incidents during FY-23 that prompted the activation of the Command Center and activation of the HICS (Hospital Incident Command System) protocols. These actual events were in addition to various table top drills that we conducted throughout the organization.

Additionally we conducted extensive active shooter drills and training events with outside experts that was available to all staff. The training modules have been updated and risk assessments in all high risk areas have been completed.

Overall, a positive outcome for the year.

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

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

3. 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.

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

5. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-23.

List of Attachments:

1. Full Report – FY-23 Evaluation of the Environment of Care & Emergency Management

Fiscal Year 2023 Evaluation of the Environment of Care And Emergency Management

Prepared by:

Matt Scannell
Director, Safety and Security

Bryan Plett
Manager, Environmental Health and Safety

Created: 08/22/2023

Table of Contents

Program Overview **1**

Executive Summary **2**

EC 1.0 – Safety Management **9**

EC 2.0 – Security Management **17**

EC 3.0 – Hazardous Materials and Waste Management **23**

EC 4.0 – Fire Safety Management **25**

EC 5.0 – Medical Equipment Management **26**

EC 6.0 – Utilities Management **28**

EM – Emergency Management **29**

Program Overview

The Joint Commission 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. 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 the 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 2023. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

Executive Summary

Safety Management

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-23. This includes data from both the Mountain View and Los Gatos campuses.

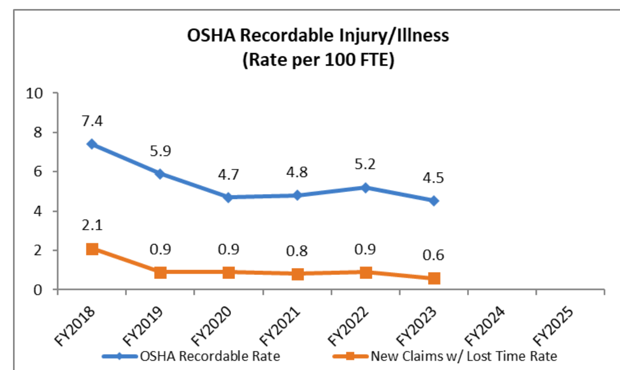
[See Attachment 1 for a definition of terms and formulas used to calculate in this report.]

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE slightly decreased in FY-23 to 4.5 as compared to 5.2 in FY-22.

The total number of recordable incidents decreased to 132 compared to 145 in FY-22.

The rate of lost workdays for all open claims (per 100 FTEs) decreased to 0.6 in FY-23 compared to 0.9 in FY-22.



Analysis

- In FY-23, the rate of OSHA recordable injuries decreased 15% compared to FY-22 and the loss time rate decreased by 50% compared to FY-22.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were Musculoskeletal Disorders (MSD)-not related to patient handling at 26%, blood and bodily fluid exposures at 21%, and slips/trips/falls at 13%.
- In FY-23 blood borne pathogen exposures due to needle sticks remained consistent at 22 injuries compared to 21 injuries in FY-22. An increase in sharp injuries was noted. Improvement strategies will be explained in the blood borne pathogens exposures section below.

Effectiveness

Key indicators were identified to establish goals for FY-23 with opportunities to improve Safety Management within the Environment of Care.

FY 23 Goals

1) Reduce employee musculoskeletal disease injuries

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce MSD (musculoskeletal disorder) OSHA recordable employee injuries **NOT** related to patient handling by 15% over FY22	EWHS /EH&S	15% reduction over FY 22

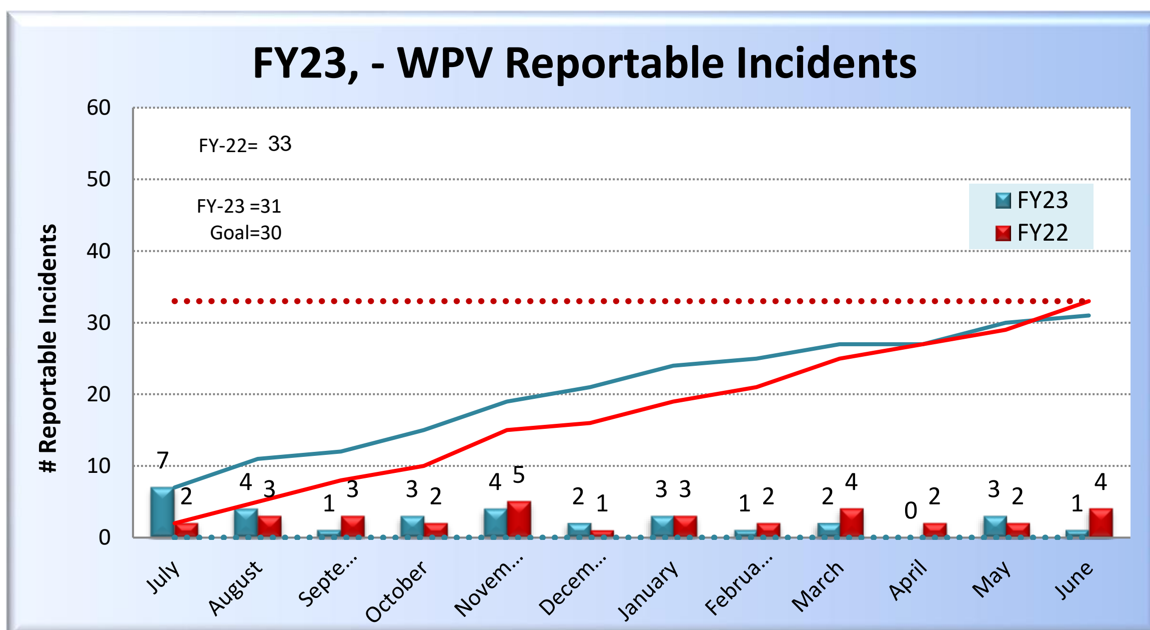
- **Measurement of success**: The goal was not accomplished. In FY22, there were 35 MSD OSHA recordable employee injuries not related to patient handling. The goal was a 15% reduction. In FY-23 there were 33 MSD OSHA recordable injuries not related to patient handling. Although the goal was not met, there was a net decrease.

Security Management

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 FY23. The data includes activity from both campuses.

There were a total of 522 reported security incidents for FY23 requiring a security response. This is a slight increase from the FY22 of 510.

Review of the FY23 WPV incidents showed:



- There were 31 Workplace Violence (WPV) incidents reported to CA-OSHA in FY 23. This is a 6% decrease from FY22. 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 behavioral health or substance abuse patients in FY23.
  - More proactive use of the combative patient flagging tool in Epic.
  - Daily communication between the clinical staff and the security staff on patients that have the potential to be combative.
  - The pilot of the "CALM Team" (Collaborative Aid through Listening and Motivation) to proactively engage with a patient who might have the potential for a workplace violence event

Note - The number of events decreased slightly but the events increased in their combative or violent nature.

Effectiveness

Key performance indicators were identified in FY23 to improve Security Management within the Environment of Care.

FY23 Goals

1) 10% reduction in number of reportable workplace violence incidents- In FY23 there was a 6% decrease in the number of Workplace Violence reports submitted to CAL-OSHA in FY 23.
   a) **This goal was not met.**
2) Security Officer (non- recordable) injury rate of **<5% per 100 employees for FY 23.** Reduce the number of non- recordable security officer injuries compared to FY 22.
   a) **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

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve hazardous materials & waste management.

FY-23 Goals:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
    - **Measurement of success** :> 95%. **This goal was accomplished.**
2. Staff can describe the process for accessing a safety data sheet.
    - Measurement of Success: >95%. This goal was accomplished.

Fire Safety Management

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 FY23.

Fire Incidents:

There were no fire incidents in Mountain View or Los Gatos in FY23.

Effectiveness:

Based on opportunities for improvement identified in FY22 annual EOC evaluation the FY23 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY24 due to staff performance in FY23.

Medical Equipment

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-23.

A. Reports to the FDA –

There were 8 reports through the Medwatch[2] system in FY-23. 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-23. A 13% improvement from FY-22. The year-end completion rate is 91.26%, a 4% increase from FY-22. The team averaged 95% since the beginning of the calendar year. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 96%.
- All high risk, life safety equipment was maintained at 99.23% completion rate. A 1.2% improvement from FY-22. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.84%.

FY23 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

1. Raise the asset confidence level currently at 96.8% to 98%. This will confirm that 98% of all medical devices received a completed maintenance.

   Goal was not met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 97.28%

2. Network visibility through the ORDR tool of all networked medical devices. Current visibility is 86.5%, the goal would be 100%.

   Goal not met. We were able to raise the ORDR visibility to 91.6%. We continue to strive for 100%. Most of those assets not seen by ORDR are on a separate segmented network and therefore protected from main network vulnerabilities and issues.

---

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

Utility Systems

A. Utility Reportable Incidents

There were nine reportable incidents in FY-23. All were electrical outages or voltage fluctuations.

- Los Gatos had 3 reportable incidents. On January 10, 2023, Los Gatos had loss of electrical utility (PG&E) campus wide for 2 ½ hours that started up the Emergency Generators. On March 14 and June 5, 2023, there were momentary power fluctuations of the electric utility (PG&E) that started up the Emergency Generators.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates, emergency generators ran and functioned as designed: 10/24/22, 1/5/23, 2/21/23, 3/14/23, 3/15/23, 3/17/23.

Effectiveness

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**88% Goal was not met**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**93%- Goal was met**

Note: Data is collected through fire drills and environment of care rounds.

Emergency Management

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant, events are presented to the Central Safety Committee for their review. The following Emergency Management indicators were reported in FY23.

A. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY23 requiring activation of HICS and opening of the Hospital Command Center (HCC).

1. The Mountain View campus experienced a power fluctuation on October 24, 2022 that resulted in the activation of the Hospital Command Center from 12:38 to 14:00.

2. The Mountain View campus experienced a weather related power outage on January 4th from 17:38 to 19:31 that resulted in the partial activation of the Hospital Command Center.
3. Both the Los Gatos and Mountain View campuses experienced a complete network outage on April 11th 2023 from 09:20 to 17:50 that shut off all internal phone lines and computer/network connectivity for approximately nine hours.

FY23 Goals

1. Expand the use of mass notification system (Everbridge) to all employees (continued from FY22)
   - 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 including active shooter tabletops and drills.
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: ***Michael Rea***

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-23. This includes data from both the Mountain View and Los Gatos campuses.

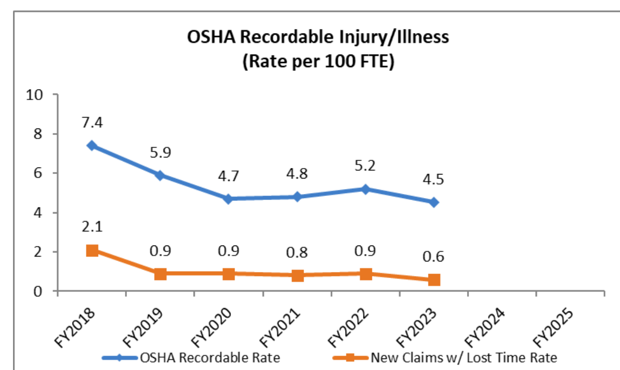
[See Attachment 1 for a definition of terms and formulas used to calculate in this report.]

B. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 FTE slightly decreased in FY-23 to 4.5 as compared to 5.2 in FY-22.

The total number of recordable incidents decreased to 132 compared to 145 in FY-22.

The rate of lost workdays for all open claims (per 100 FTEs) decreased to 0.6 in FY-23 compared to 0.9 in FY-22.

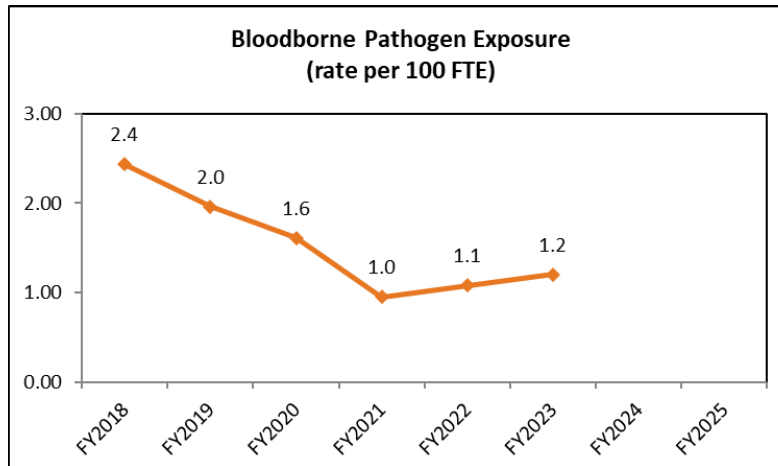


Analysis

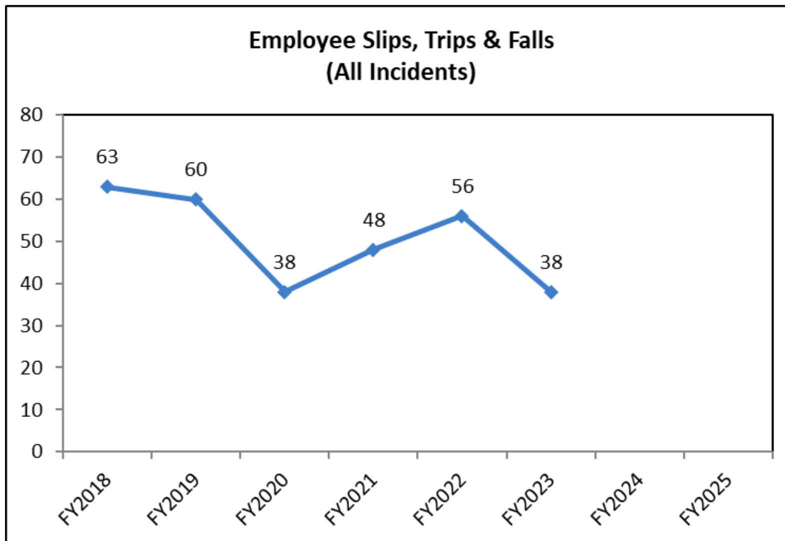
- In FY-23, the rate of OSHA recordable injuries decreased 15% compared to FY-22 and the loss time rate decreased by 50% compared to FY-22.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were Musculoskeletal Disorders (MSD)-not related to patient handling at 26%, blood and bodily fluid exposures at 21%, and slips/trips/falls at 13%.
- In FY-23 blood borne pathogen exposures due to needle sticks remained consistent at 22 injuries compared to 21 injuries in FY-22. An increase in sharp injuries was noted. Improvement strategies will be explained in the blood borne pathogens exposures section below.

Improvement Strategies:

The OSHA recordable rate of blood borne pathogen exposures is slightly increasing. More information is contained in the blood borne pathogen exposure section below.

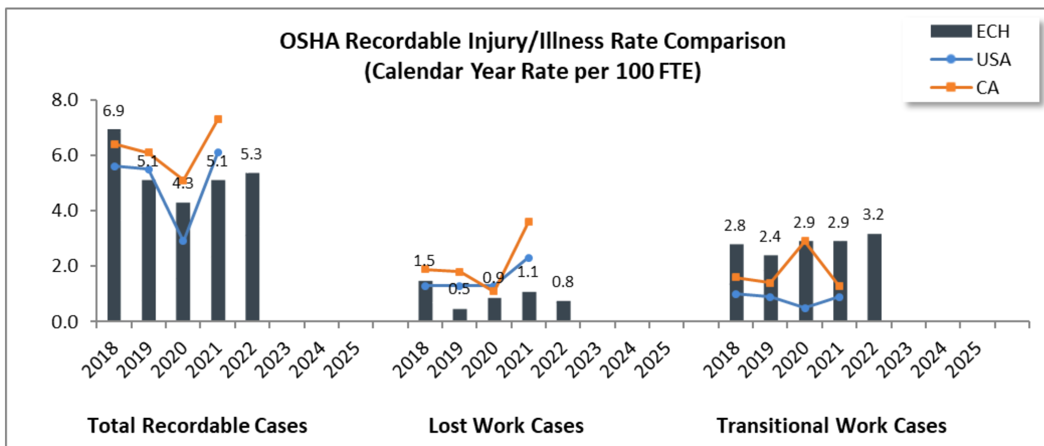


Slips, trips, and falls among employees decreased after a three year trend of increasing OSHA recordable injuries. More information is contained in the Slips, trips, and falls section below.



C. 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[3].



The ECH injury/illness rate in ***calendar year 2022*** was 5.3, which is comparable to the California state and national averages in 2021 (7.3 and 5.1, respectively where 2021 is the most recent year available from the BLS). The ECH lost work cases rate was 0.8, which is below both state and national average. The lower rate in lost time incidents is

[3]The BLS data is calculated by calendar year. 2021 is the most recent calendar year of injury and illness data available as of September 08, 2023.

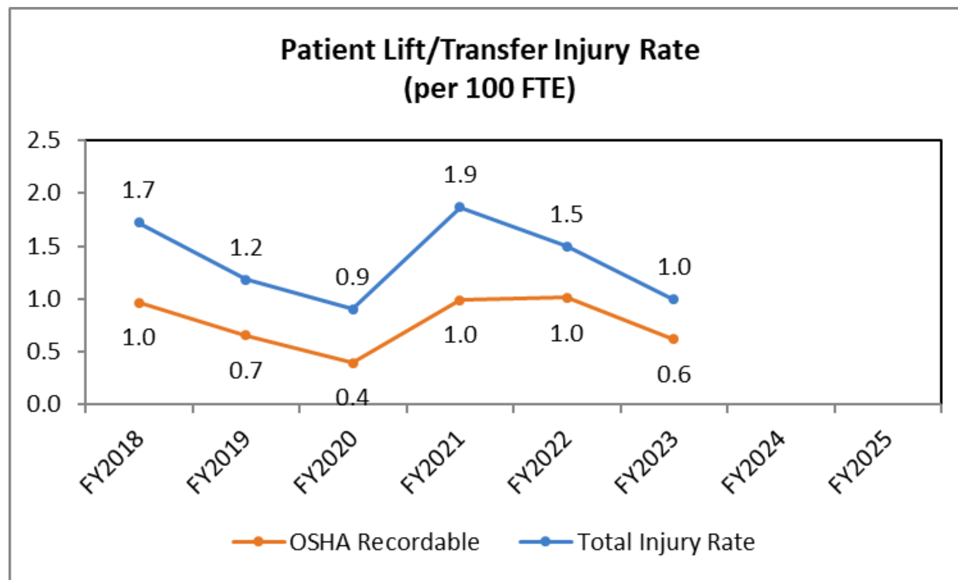
due to prevention efforts in worksite evaluations and outreach to departments along with the Safe Patient Handling & Mobility (SPHM) program.

El Camino Health's robust Transitional Work Assignment Program shows a commitment to keeping employees safely working and engaged through an injury or illness. This innovative program accounts for the nearly three-fold increase in transitional work cases (3.2) relative to the state and national rates of Cases with job transfer or restriction (1.3 and 0.9, respectively).

D. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **decreased in FY-23, from 1.0 in FY-22 to 0.6 in FY-23.**
- **Total Injuries**: The overall number of SPHM injuries (29) and those persistent downward trend in both the total number of SPHM injuries and those that are OSHA-recordable (18) returned to pre-COVID-19 norms as observed in fiscal years 2018, 2019, and 2020.



SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 18-21)

SPHM Injuries	2017	2018	2019	2020	2021	2022	2023
Total Reported	44	41	29	23	50	37	29
OSHA-recordable	29	23	16	10	26	28	18
% OSHA	66%	56%	55%	43%	52%	76%	62%

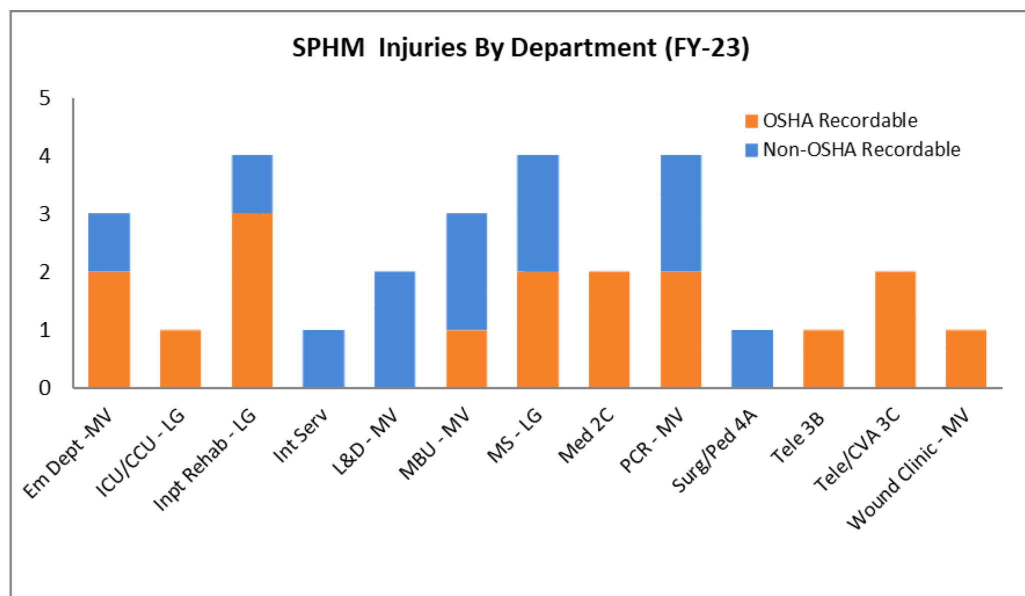
- **Lost/Restricted Days due to SPHM Injuries:** Of the 18 OSHA-recordable injuries, one resulted in lost days.

SPHM Injuries by Type, Fiscal Years 17 – 23

Activity	2017	2018	2019	2020	2021	2022	2023
Combined Transfer	6	5	5	2	3	1	4
Cumulative Pt Handling	5	4	0	1	2	5	1
Lateral Transfer	8	1	5	3	9	4	3
Patient fall/prevention	5	9	8	8	10	3	9
Car extraction	0	0	0	1	2	1	0
Pt Holding	2	3	2	1	5	0	1
Turning/Pulling	12	16	5	6	17	11	9
Vertical Transfer	5	3	4	1	2	3	1

- Preventing/assisting patient falls and turning/pulling persist as the top categories of SPHM injuries.

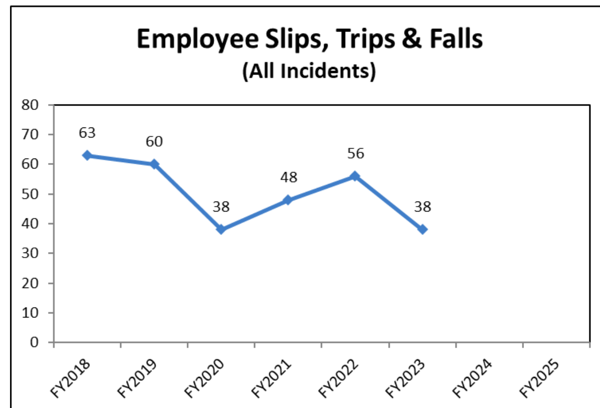
- **Injuries by Department**



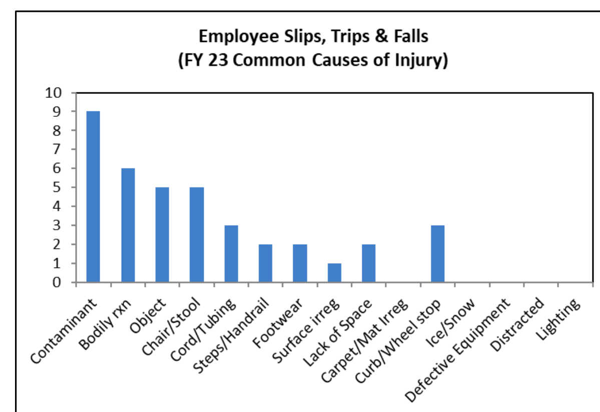
E. Slips, Trips, Falls Injuries

Analysis:

- **Injury Incidence**: Targeted interventions to reduce Slip, Trip, and Fall (STF) injuries were initiated in FY-17 due to the consistently rising incidence. There was a decline in incidents in FY-23 following several years of increase returning to pre-COVID-19 pandemic levels.



- The number of OSHA-recordable STFs was 14.
- **Injury Types:**
    - Contaminants/slippery floor continues to be a leading cause most significant cause of STFs (n=9) but reduced from a high of 20 in FY-22.
    - Bodily reaction, or "I just fell" (n=6) was the second most common cause.

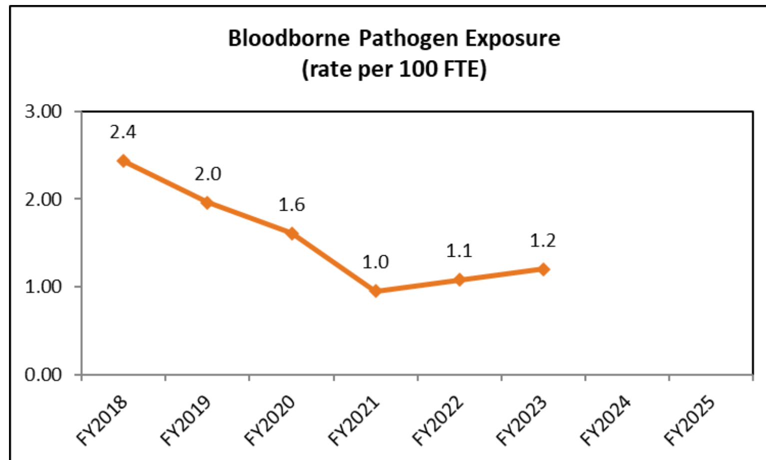


Improvement Strategies:

- Task force attendance continues to be robust, with reviews of injuries and collaboration of improvement strategies among managers.
- Partnership with Facilities and annual outside stair maintenance continues to contribute to a reduction in STFs on stairs, down to 2 from a high of 8 in FY-19.
- New landscaping and signage has effectively reduced falls outside. This is the first FY that no falls were reported due to falls in dirt pathways and shortcuts.
- Two falls were attributed to scrub pants dragging under heels. After review of available and feasible options, reusable leg bands are being trialed.
- The introduction of Safety First and HRO training: focusing on the task by using STAR to raise awareness and reduce distractions are targeted techniques to reduce falls due bodily reaction, falls from chairs and on wet or slippery floors.
- *Test Your Tread* was a marketing slogan and process introduced this fiscal year as an additional strategy to maintain shoe traction to prevent falls on wet or slippery conditions.

F. Blood-borne Pathogen (BBP) Exposures

The rate of blood-borne pathogen exposures per 100 FTE **increased to 1.2 in FY-23 compared to 1.1 in FY-22.** The total number of exposures for both campuses increased to 35 exposures in FY-23 compared to 30 in FY-22. Of these, 29 were percutaneous exposures and six were body fluid exposures due to splashes.



Analysis:

- The number of sharp injuries increased in FY-23 to 7 compared to two in FY-22:

	FY 22	FY 23
Needlestick	21	22
Blood	4	3
Body Fluids	1	2
Urine	2	0
Saliva	0	1
Scissors	2	5
Scalpel	0	1
Instrument	0	1
TOTAL	**30**	**35**

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.
- Continue to analyze potential patterns of injuries for further investigation and action. Specifically, the increase in sharp injuries in FY-23 led to a product change.
- EWHS continues to collaborate with Clinical Education to explore ways to increase awareness and possible education among our nursing new graduates.

G. TB Conversions

There were no known occupational exposure conversions during FY-23.

H. 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--23 are:

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

Effectiveness

Key indicators were identified to establish goals for FY-23 with opportunities to improve Safety Management within the Environment of Care.

FY 23 Goals

2) Reduce employee musculoskeletal disease injuries

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Reduce MSD (musculoskeletal disorder) OSHA recordable employee injuries **NOT** related to patient handling by 15% over FY22	EWHS /EH&S	15% reduction over FY 22- **Goal not met**

- **Measurement of success**: The goal was not accomplished. In FY22, there were 35 MSD OSHA recordable employee injuries not related to patient handling. The goal was a 15% reduction. In FY-23 there were 33 MSD OSHA recordable injuries not related to patient handling. Although the goal was not met, there was a net decrease.

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
     - Charge Nurses/Clinical Managers
     - Assistant Hospital Managers (Hospital Supervisors)
     - Security
     - Course is also available as an option to all staff.

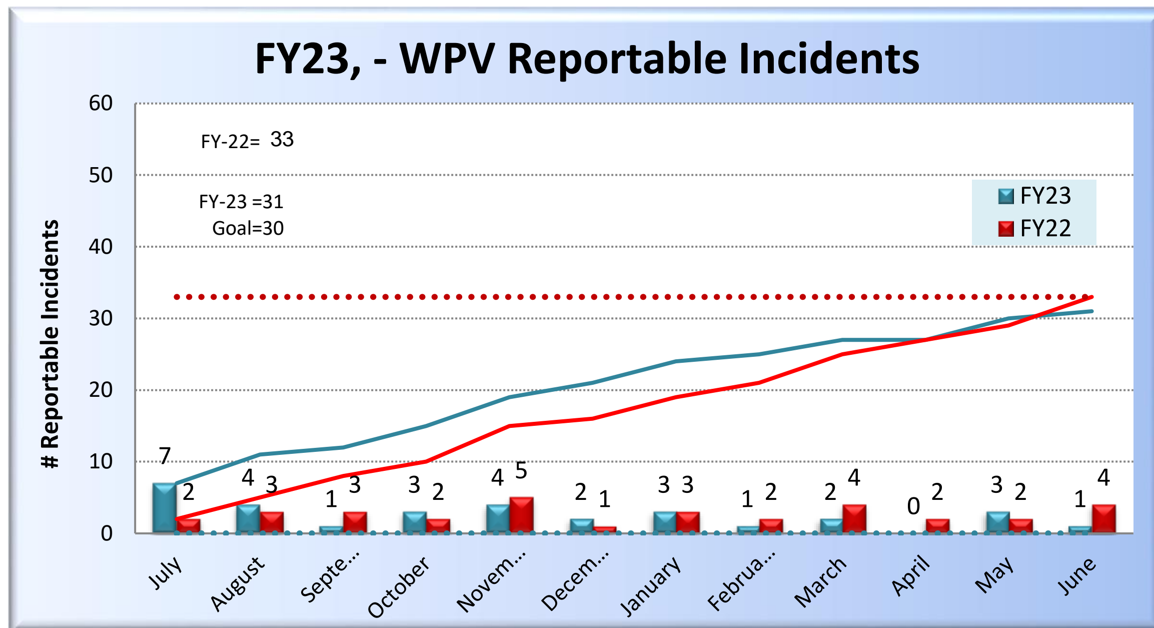
     Note- The hands on portion of the class was restarted in February of 2023. This training was revised to include a three-hour mental health component.
4. Reporting: An ongoing WPV reporting team ensures reporting is completed as required.
   - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
   - In FY23, 31 incidents reported to CAL-OSHA WPV website. 65% of the incidents resulted in no injury and 35% of the incidents had bruises or abrasions. There were no major injuries reported to the CAL-OSHA district office.

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 FY23. The data includes activity from both campuses.

There were a total of 522 reported security incidents for FY23 requiring a security response. This is a slight increase from the FY22 of 510.

Review of the FY23 WPV incidents showed:

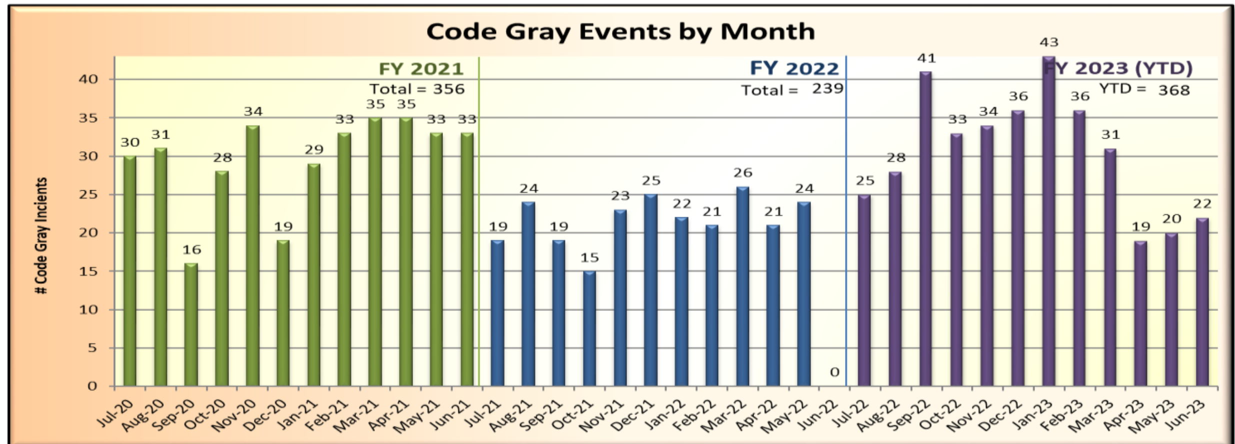


- There were 31 Workplace Violence (WPV) incidents reported to CA-OSHA in FY 23. This is a 6% decrease from FY22. Contributing factors to this decrease in reportable CAL-OSHA workplace violence incidents can be attributed to the following:
  - More focus on the root causes of workplace violence events 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 behavioral health or substance abuse patients in FY23.
  - More proactive use of the combative patient flagging tool in Epic.
  - Daily communication between the clinical staff and the security staff on patients that have the potential to be combative.
  - The pilot of the “CALM Team” (Collaborative Aid through Listening and Motivation) to proactively engage with a patient who might have the potential for a workplace violence event

Note - The number of events decreased slightly but the events increased in their combative or violent nature.

A. Code Gray Responses

Code Gray responses increased in both MV and LG. The total number of incidents in FY23 was 368 compared to 255 in FY22. The increase in code greys is largely due to an increase in patients and difficult discharges out of the emergency room in the winter months. Additionally, in FY 23 more visitors were on campus after removing all COVID 19 restrictions.



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) – 57%
- Medical Unit (3B)- 15%
- MV Medical Unit (2C) – 12%
- Medical Unit (4A)- 12%

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

In FY 23 a new program was launched called the “CALM Team” (Collaborative Aid through Listening and Motivation) to proactively engage with a patient who might have the potential for a code grey or a workplace violence event. The pilot was launched in June of 2023 on 2 C and 3C.

B. Bulletins, Alerts & Presentations

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

C. Patient Belongings

Security Officers performed 6,165 chain-of-custody transactions involving patient’s belongings.

D. Patient Escorts, Watches, Standbys & Restraints

Security Officers performed 2,565 patient watches, standbys and restraints. This was an increase over FY22 (2565). Hospital Supervisors or Nurse Managers 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 104 fire drills and 8 fire watches were performed in FY23.

F. General Assistance

Security Officers performed 44,323 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 Badging Services issued 2,591 El Camino Health badges in FY 23, which was an increase of 659 Photo ID Badges. This provides access and barcoding technology to staff, physicians, auxiliary, contractors, and students. Additionally, in FY 23 1,365 temporary badges were issued to staff who forgot or temporality lost their badges.

H. Investigations & Audits

Security Services performed 109 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 473 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

J. Inspections

Security Services performed a total of 84,423 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 411 incidents involving problematic individuals who required extra time and assistance leaving hospital property. This was an increase of 79 loitering or trespassing responses. 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 107 vehicle-related services including jump-starts, door unlocks and tows. 904 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

M. Police Activity

Law enforcement agencies were on-site 185 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

N. Statistics –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:[4]	2.11	0.35
Previous Year	2.33	0.48
Property:[5]	26.29	15.53
Previous Year	24.46	18.98

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

Effectiveness

Key performance indicators were identified in FY23 to improve Security Management within the Environment of Care.

FY23 Goals

3) 10% reduction in number of reportable workplace violence incidents- In FY23 there was a 6% decrease in the number of Workplace Violence reports submitted to CAL-OSHA in FY 23.
    a) **This goal was not met.**
4) Security Officer (non- recordable) injury rate of **<5% per 100 employees for FY 23.** Reduce the number of non- recordable security officer injuries compared to FY 22.
    a) **This goal was met.**

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:
    1) Oxytocin 5ml spill - MV Mother Baby Unit – roller clamp user error. MBU Nursing Education reviewed roller clamp procedure and safety. Cleanup was handled safely.
    2) Chemotherapy Taxol 150ml spill – MV Unit 4B Room 4220 – CTSD (Closed System Transfer Device) not secured, loosened due to. Gap identified with incomplete Code Orange Response Team present lack of frontline staff knowledge. Nursing Educator present –Reviewed/Educated staff. Cleanup was handled safely.
    3) Buffered 10% Formalin 16 oz. spill – LG 2nd Floor OR Pathology Room – contents spilled when RN transferred Buffered 10% Formalin from 5-gallon container spigot into a small container. Gap identified lack of frontline staff knowledge. Reviewed/Educated procedures for Formalin storage/handling and switched to

prefilled containers and 1 gallon container only as needed. Cleanup was handled safely.

4) Buffered 10% Formalin 5ml spill- Imaging Nurses station – contents spilled when container failed during collection of a biopsy. Spill contained in secondary container. Gap identified with incomplete Code Orange Response Team present. Reviewed/Educated procedures for Formalin storage/handling with Imaging Staff. Reviewed procedures for Formalin storage/handling. Cleanup was handled safely.
5) Fentanyl 250cc spill – MV Labor and Delivery room 9 - contents spilled when RN transferring bag slipped and fell to floor. Gap identified in incomplete Code Orange Response Team present & lack of frontline staff knowledge. Reviewed/Educated safe handling procedures for Fentanyl storage/handling with staff. Cleanup was handled safely.
6) Chemotherapy Methotrexate Spill <1ml spill – MV ED Fast Track. Contents spilled when new RN attempted to draw up methotrexate with the transfer device but was unsure how to use. Gap identified in incomplete Code Orange Response Team present & lack of frontline staff knowledge. ED Educator Reviewed/Educated procedures on transfer device and location of spill kits. Cleanup was handled safely.

- Reportable Hazardous Material Incidents – There were no reportable spills in FY 23.

B. Waste Water Discharge Violations:

- There were no wastewater discharge violations in FY 23.

C. Monitoring and Inspections

- Hazardous Waste Inspections – There were no hazardous materials and or waste inspections in FY 23.
- Santa Clara County Annual Medical Waste Inspections – There were no medical waste inspections in FY 23.
  - **In FY 23 the organization focused on the following monitoring and education of staff to ensure medical and hazardous 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 at the Central Safety Committee. .

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-23. The following goals presented opportunities to improve hazardous materials & waste management.

FY-23 Goals:

3. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
    - Measurement of success :> 95%. **This goal was accomplished.**
4. Staff can describe the process for accessing a safety data sheet.
    - Measurement of Success: >95%. 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 FY23.

A. Fire Incidents

There were no fire incidents in Mountain View or Los Gatos in FY23.

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 incidents are evaluated for potential opportunities for improvement.

The total number of events in FY23 (49) was slightly higher than FY22 (45). There were 45 events in Mountain View and 4 in Los Gatos. This was accomplished despite heavy construction activity at both hospitals during FY23.

C. Fire Drills Completed / Scheduled

[6] HAZWOPER: Hazardous Waste Operations and Emergency Response

All required fire drills were completed in FY23. For all drills, there are 24 required actions by staff. All issues corrected either on the spot or with further education by the dept. Manager.

D. Effectiveness

Based on opportunities for improvement identified in FY22 annual EOC evaluation the FY23 Performance Improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY24 due to staff performance in FY23.

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-23.

C. Reports to the FDA –

There were 8 reports through the Medwatch[7] system in FY-23. There were no patient deaths associated with any of the reports.

D. 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-23. A 13% improvement from FY-22. The year-end completion rate is 91.26%, a 4% increase from FY-22. The team averaged 95% since the beginning of the calendar year. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 96%.
- All high risk, life safety equipment was maintained at 99.23% completion rate. A 1.2% improvement from FY-22. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.84%.

E. Product Recalls Percentage Closed / Received

For FY-23, there were 73 recorded equipment recalls; 10 still open.

Effectiveness

FY23 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

3. Raise the asset confidence level currently at 96.8% to 98%. This will confirm that 98% of all medical devices received a completed maintenance.
   Goal was not met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 97.28%
4. Network visibility through the ORDR tool of all networked medical devices. Current visibility is 86.5%, the goal would be 100%.
   Goal not met. We were able to raise the ORDR visibility to 91.6%. We continue to strive for 100%. Most of those assets not seen by ORDR are on a separate segmented network and therefore protected from main network vulnerabilities and issues.

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

EC 6.0 - Utilities Management

Work Group Chair: John Thompson

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-23.

B. Utility Reportable Incidents

There were nine reportable incidents in FY-23. All were electrical outages or voltage fluctuations.

- Los Gatos had 3 reportable incidents. On January 10, 2023, Los Gatos had loss of electrical utility (PG&E) campus wide for 2 ½ hours that started up the Emergency Generators. On March 14 and June 5, 2023, there were momentary power fluctuations of the electric utility (PG&E) that started up the Emergency Generators.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates, emergency generators ran and functioned as designed: 10/24/22, 1/5/23, 2/21/23, 3/14/23, 3/15/23, 3/17/23.

C. 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.

D. Generator Test % completed/scheduled

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

Effectiveness

Key indicators were targeted to establish goals for FY-23. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**88% Goal was not met**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**93%- Goal was met**

Note: Data is collected through fire drills and environment of care rounds.

EM – Emergency Management

Committee Chair: Matt Scannell/Bryan Plett

Scope

El Camino Hospital's Emergency Operations Plan addresses all non-fire related internal and external emergencies affecting 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 to the Emergency Management and Central Safety Committees. Significant, events are presented to the Central Safety Committee for their review. The following Emergency Management indicators were reported in FY23.

B. Activation of Hospital Incident Command System (HICS)

There were three recorded events and/or emergencies during FY23 requiring activation of HICS and opening of the Hospital Command Center (HCC).

4. The Mountain View campus experienced a power fluctuation on October 24, 2022 that resulted in the activation of the Hospital Command Center from 12:38 to 14:00.
5. The Mountain View campus experienced a weather related power outage on January 4th from 17:38 to 19:31 that resulted in the partial activation of the Hospital Command Center.

6. **Both the Los Gatos and Mountain View campuses experienced a complete network outage on April 11th 2023 from 09:20 to 17:50 that shut off all internal phone lines and computer/network connectivity for approximately nine hours.**

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 FY23, 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. Active Shooter tabletop drills were held in Los Gatos on February 10th 2023 and in Mountain View on February 17th 2023. In total approximately 560 staff members' participated either in person or on zoom.

b. During the months of March and April, department specific active shooter drills were held in both Mountain View and Los Gatos. A total 365 staff members' participated in those department specific active shooter drills.

D. Emergency Management Training

- New hire and new manager emergency management training was presented to the new staff members.
- Safety coordinator 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 held in Anaheim and was well attended by El Camino Health.

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.

The Hospital conducts an annual 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 no changes to the top five HVAs at both campuses in FY23 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	(1) Earthquake
(2) Pandemic	(2) Pandemic
(3) Infectious Disease Outbreak	(3) Infectious Disease Outbreak
(4) Patient Surge	(4) Patient Surge
(5) Cyberattack	(5) Power Outage

F. Effectiveness

Key indicators were targeted to establish goals for FY23. The following goals presented opportunities to improve emergency management.

FY23 Goals

4. Expand the use of mass notification system (Everbridge) to all employees (continued from FY22)
   - 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.
5. 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 including active shooter tabletops and drills.
6. 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.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Ute Burness, RN, VP of Quality and Shahab Dadjou, President, ECHMN
Date: October 25, 2023
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 two key areas of focus for ECHMN with respect to quality and service:

   A. Clinical Excellence, Dependable and Convenient Care
   B. Patient Experience (Likelihood to Recommend (LTR)

   ECHMN has established true north pillars, one of which is quality and service. Starting June 1, 2023, ECHMN changed its quality reporting methodology. The methodology measures the performance of PCP attributed patients on eight (8) clinical indicators based on their calendar year performance These measures were selected because they are important measures of health and consistent with the priorities of our health plan partners and with Centers for Medicare and Medical (CMS). ECHMN tracks the performance to targets. We are currently meeting target for four (4) of eight (8) clinical measures. Four (4) of the measures we are very close to being at target.

   For the dependable and convenient domain, third next available (3NA) remains unfavorable for primary care and specialty care. The clinical response to patient messages also did not meet target. The attached slide deck, describes the corrective action plan that is in place.

   Likelihood to Recommend (LTR) is ion target for Primary Care and Specialty LTR. For urgent care LTR, we are not on target for Q1, but above the FY 23 baseline. The attached slide deck, describes the action plan that is in place.

   List of Attachments:

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

El Camino Health Medical Network Report
November 6, 2023

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?

El Camino Health

ECH Quality Committee Meeting
ECHMN Quality Update

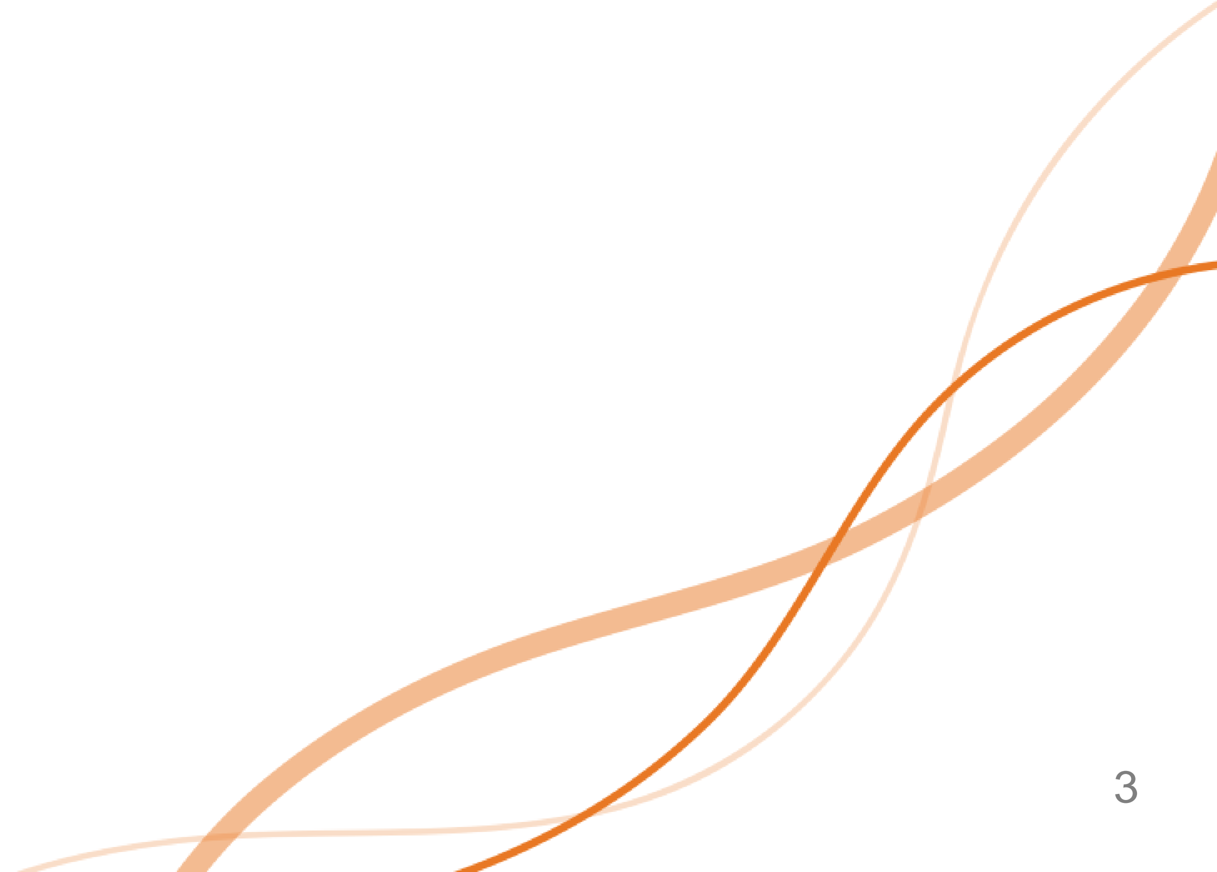
November 6, 2023

Ute Burness, RN, Vice President of Quality ECHMN
Shahab Dadjou, President ECHMN

Agenda

- **Clinical Domain**
  - Calendar Year 2023 YTD Results
- **Dependable and Convenient Domain**
  - FY 2024 1st Quarter Results
- **Patient Experience Domain**
  - FY 2024 1st Quarter Results

Clinical Domain



Calendar Year 2023 Core Quality Measures Results as of 10/2/23

Core Measures	CY 2023 Goal		Current Results		Trend from Previous Month
	Percentage	CMS Decile*	Percentage	CMS Decile*	
	7 of 8		4 of 8		
CMS 112 Breast Cancer Screening	78%	9th	77%	9th	↑
CMS 122 Diabetes: Hemoglobin A1c poor control>9% *(lower number is better)*	17%	10th	19%	9th	↑
CMS 130 Colorectal Cancer Screening	68%	8th	65%	7th	↑
CMS 138 Tobacco – Screening and Cessation Intervention Plan	85%	8th	96%	9th	↓
CMS 139 Fall Risk Screening	98%	9th	98%	9th	↑
CMS 165 Controlling High Blood Pressure	72%	8th	72%	8th	↑
CMS 347 Statin Therapy for ACSVD Patients	86%	10th	84%	9th	≈
CMS 68 Reconciliation of Current Medications	98%	7th	98%	7th	≈

*CMS publishes quality measure deciles based on national performance. A decile rank arranges the data in order from lowest to highest and is done on a scale of one to 10 where each successive number corresponds to an increase of 10 percentage points. The percentage performance in a decile is different for each quality measure. For 5 out of the 8 measures, ECHMN is performing in the top 20%.

Met Target
Missed Target by < 5%
Missed Target by > 5%

El Camino Health

Quality Improvements Activities to Achieve Targets

- Monthly discussion with all providers to discuss open care gaps, performance status, and opportunities for improvement.
- A new “EPIC Quick Start Guide” which guides providers to reconcile and document the quality measures.
- A campaign to provide “Cologuard” at all sites to capture appropriate outlier patients that need colorectal cancer screening.
- Continuous EPIC enhancements to ensure data integrity.
- Retraining of MA staff for assessing fall risk, secondary check of blood pressure, and automated reports for timely audits.
- Periodic MyChart message campaign for patients to capture any outstanding measures.

Dependable and Convenient Care Results

Dependable, Convenient and Experience Domain – FY 2024

Results as of 9/30/2023

Domain	Measure	Baseline FY23	FY24 Target	FYTD 24
Dependable and Convenient	Access 3na for Primary Care by Department (in days) (Access Third Next Available – Lower is better)	7.5	7.0	7.7
	Access 3na for Specialty Care by Provider (in days) (Access Third Next Available – Lower is better)	23.6	22	37.2
	Clinician Response to Patient Messages < 48 hours (in days)	1.6	1.2	1.5
Experience	Primary Care and Specialty LTR (Likelihood to Recommend)	82.7	81.3	81.4
	Urgent Care LTR (Likelihood to Recommend)	76.1	78	76.5

Dependable, Convenient Domain – Corrective Action Plan

Measure	Results	Contributing Factors	Action Plan
Primary Care 3rd Next Available (3NA)	7.7 Days	• Concentrated time off in July, August due to summer vacation • Unexpected time off due to illness in early September	• Ten new primary care providers have been hired with start dates from August-March; access is expected to be improved by the end of this calendar year
Specialty Care 3rd Next Available (3NA)	37.2 Days	• The exclusion criteria was narrowed from 120 days to 365 days, pulling in providers with worse access than before; GI and Rheumatology significantly skew 3NA • Multi-site, part-time, and surgical providers have higher averages	• Nine specialists have been hired for both ambulatory and inpatient service with start dates from September-April • Overall 3NA is not expected to improve unless more specialists are hired/aligned • Currently exploring "lag time" which represents "time to consult" rather than 3NA – a better representation of access for specialty access • Exploring "specialty-wide 3NA" to pool providers of the same specialty in different locations
Clinician Response Time for Messages	1.5 Days	• The Refill Request response time has a high response rate due to automated Epic background functions • Patient Advice Request and User Message categories response times are averaging 0.9-1.1 days consistently	• Email to all providers and clinic leaders about Epic workflow to avoid the automated timestamp was sent 10/7/2023 • Epic technical support employees are still looking into resolving the automatic timestamp process

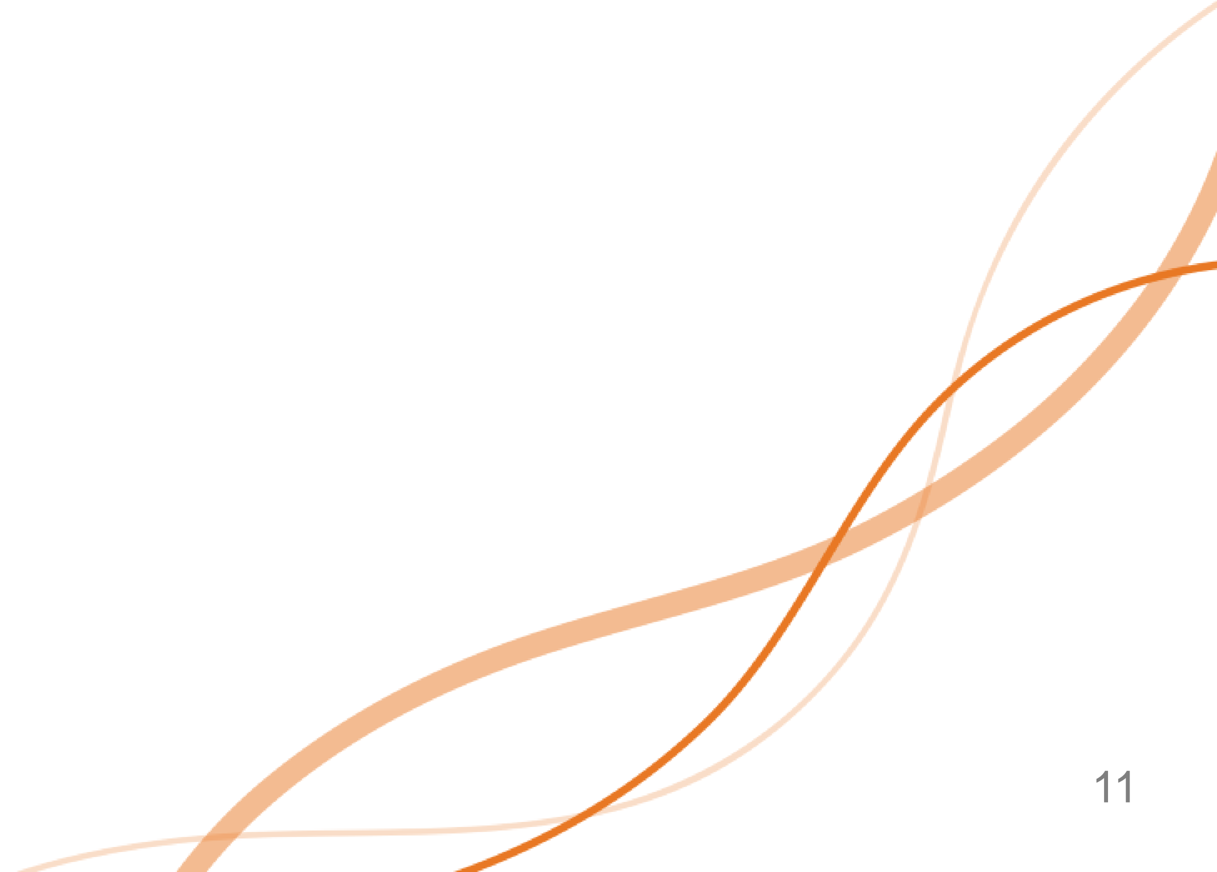
Patient Experience – Corrective Action Plan

Measure	FY24 YTD Results	Contributing Factors	Action Plan
Urgent Care LTR	**76.3 (29%ile)**	• Not on target for Q1 but above FY23 baseline – making improvements • Willow Glen Urgent Care accounts for over 50% of volume	• Alignment with Vituity Patient Experience Department • 100% activation and completion of program for 6 core Vituity providers for Practicing Excellence

El Camino Health

Questions?

Appendix



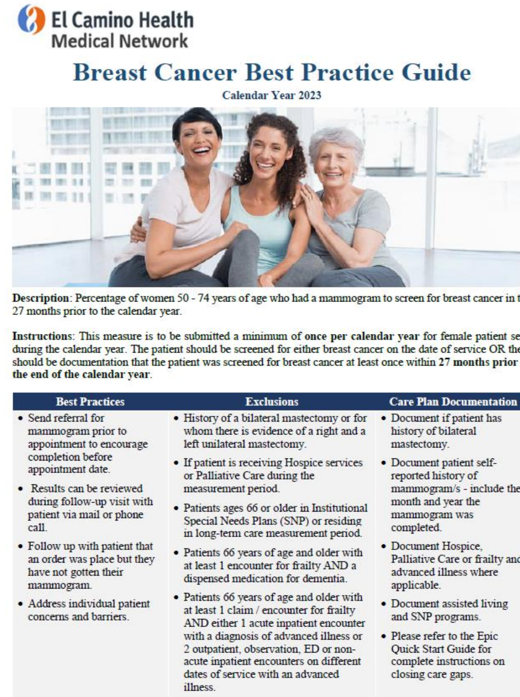
Additional Quality Initiatives – Best Practice Guides

- “*Best Practice Guides*” for all core and radar measures were created and distributed to Physicians, APPS and Support Staff

- The guides provide the reader with:
  - *The CMS description*
  - *The CMS instruction on who is included*
  - *Best Practices to achieve the measure*
  - *Patient exclusions*
  - *Care plan documentation tips*

- “*Epic Quick Start Guides*” for all core and radar measures were created and shared with the Physicians, APPS and support staff.

- The guides provide the step by step instructions to properly capture the needed steps in Epic for both the staff and the physicians.



El Camino Health
Medical Network

Breast Cancer Best Practice Guide
Calendar Year 2023

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 calendar year.

Instructions: This measure is to be submitted a minimum of **once per calendar year** for female patient seen during the calendar year. The patient should be screened for either breast cancer on the date of service OR there should be documentation that the patient was screened for breast cancer at least once within **27 months prior to the end of the calendar year.**

Best Practices	Exclusions	Care Plan Documentation
• Send referral for mammogram prior to appointment to encourage completion before appointment date. • Results can be reviewed during follow-up visit with patient via mail or phone call. • Follow up with patient that an order was place but they have not gotten their mammogram. • Address individual patient concerns and barriers.	• History of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy. • If patient is receiving Hospice services or Palliative Care during the measurement period. • Patients ages 66 or older in Institutional Special Needs Plans (SNP) or residing in long-term care measurement period. • Patients 66 years of age and older with at least 1 encounter for frailty AND a dispensed medication for dementia. • Patients 66 years of age and older with at least 1 claim / encounter for frailty AND either 1 acute inpatient encounter with a diagnosis of advanced illness or 2 outpatient, observation, ED or non-acute inpatient encounters on different dates of service with an advanced illness.	• Document if patient has history of bilateral mastectomy. • Document patient self-reported history of mammogram/s - include the month and year the mammogram was completed. • Document Hospice, Palliative Care or frailty and advanced illness where applicable. • Document assisted living and SNP programs. • Please refer to the Epic Quick Start Guide for complete instructions on closing care gaps.

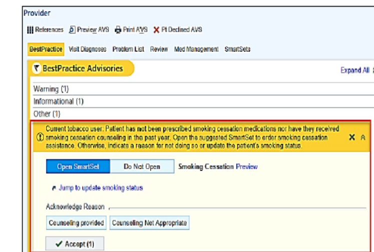
* For Internal Use Only *

Provider Workflows to Address Measures

CMS138v11: Tobacco - Screening & Cessation Intervention

This is an ECHMN core measure assessing the percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the current calendar year **AND** who received tobacco cessation intervention if identified as a tobacco user.

1. If it was documented that a patient is a current tobacco user during the clinical support staff's intake assessment with the patient documented in the Rooming activity, then the provider seeing the patient in this encounter will see a BPA alert in the Best Practice Advisories section of the Provider activity.



2. Selecting **Open SmartSet** and the **Accept** option will add Tobacco Use Disorder [Z72.0] to the patients Visit Diagnosis list and present provider with the available smoking cessation prescriptions to select from to order for the patient.

8/24/2023 EpicCare Ambulatory- ECHMN 2023 Quality Measures *Quick Start Guide* 4

El Camino Health

Additional Quality Initiatives – QAPI Meeting

- Implemented monthly Quality Assurance Performance Improvement (QAPI) meeting with the Quality team and the Operations leaders.
- On a monthly basis, we will review the following:
  - *Quality measures*
    - *Action Items*
    - *Barriers*
  - *Incidents*
  - *Complaints*
  - *Grievances*

El Camino Health Medical Network

QAPI Committee Meeting Minutes

Meeting Date: 9/7/23

Review Period: August 2023 ☐ quarter ☒ month ☐ special

Meeting

Title	Signatures
☐ Clinical Manager	
☐ Regional Director	
☐ Administrative	

Title	Signatures
☐	
☐	
☐	

☐ **Previous QAPI Committee Meeting Minutes reviewed.**

Topic	Comments

Status of Active QAPI Projects

Title	Comments

☐ **Quality Management Reviewed**

Action Item	Comments / Plan of Corrections
Controlling Blood Pressure	ECHMN is at 71% not meeting goal of 72%; Action items 1) Remind Clinic Staff to complete second blood pressure and to use the red heart 2) Working on a report in Epic to help audit the second check and identify those patients leaving with Hypertension 3) We will a my chart campaign in December Identified Barriers • Staff not completely second check Provider Outliers =/> 5% from Target •
A1C	ECHMN is at 21% not meeting goal of </= 17% Action Items 1) Clinics are reaching out to outlier patients

El Camino Health