Minutes of the Open Session of the Quality, Patient Care and Patient Experience Committee of the El Camino Hospital Board of Directors

Monday, February 3, 2020
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

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

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. A silent roll call was taken. Ms. Simon arrived at 6:05 pm during the discussion about the consent calendar. Terrigal Burn, MD was absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: For information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 QC Goals; and Hospital Update. **Movant:** Sharma **Second:** Falwell **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Consent Calendar approved***
4. REPORT ON BOARD ACTIONS	Chair Kliger asked if any Committee members had any questions about the Report on Board Actions. No questions were reported.	
5. PATIENT STORY	Cheryl Reinking, RN, CNO, introduced the Daisy Award that ECH started in December 2019. The Daisy Award was created by a family in honor of their son, Patrick, who died in 1999 of an auto immune disease. The family was so moved by the care their son received by the nursing staff, the family created the Daisy Foundation. The Daisy Awards are written by patients/families. In January, Debra Anderson, RN, won this award for going beyond what is expected and doing what is needed. Ms. Reinking stated that this award will be given every month.	
6. PATIENT EXPERIENCE	In response to a previous request by the Quality Committee to report on areas where we can improve, Ms. Reinking presented data pulled from	

	comments from patients. She presented complaints from patients where there were complaints of being unprofessionalism, unresponsive, rude, and carelessness. Ms. Reinking presented metrics in improving communication since communication is the most important factor that influences patients to likely recommend this organization. Our goal is 84.2. Fiscal year to date is currently 83.3 so we are 0.9 below target for likelihood to recommend. As shown in the materials, courtesy and respect received the highest score. On the other hand, the physician communication is at 84.6 for the fiscal year to date, which is essentially the same trend as the nurses. Both graphs show that listening and explaining could use some work. Ms. Reinking explained that we have Care Team Coaching to improve care practices in developing relationships with patients. We've also been doing Commit to Sit to create an eye level communication to actually sit down for at least two minutes for each patient. Ms. Reinking also stated that Leader Rounding where leaders check in on the patients also makes a big difference and shows in the data presented. In response to Committee Members' questions, Ms. Reinking stated there is a very narrow difference in comparison to the national percentile ranking. The percentile ranking is constantly changing. Dr. Adams commented that nurses are always changing from shift to shift so the patients see more different nurses versus the physicians where there is a constant relationship with the same person. Nurses also can only give so much information and cannot make or communicate diagnoses. Ms. Reinking stated that usually in the winter months, there is a decline in scores. November was a very good month. There is really no explanation of variability of why the scores fluctuate. The leaders are trying to motivate behavior through sharing the data with staff.. Dr. Sharma suggested that the Commit to Sit for the managers should be on the radar for them to do productivity tracking. Also, for the behaviors, there should be accounting for differences in diversity, culture, age, etc. for both the employee and patient.	
7. PATIENT SAFETY INDICATORS 4, 18, 19	Dr. Adams presented Patient Safety Indicator (PSI) scores for 4, 18, and 19. <u>PSI 4:</u> Dr. Adams suggested the Committee should not spend a lot of time on this metric because it's a controversial patient safety index and our safety index composite is very good. That is one of the reasons we were issued a 5 star rating. The definition of PSI 4 is the death rate among surgical patients with serious treatable complications AND any surgery performed within two days of admission. This means that in many cases it is really a failure to rescue because patients can come in for a procedure while already having the condition being treated. About half of the patients already have the condition before coming into the hospital to be treated.	

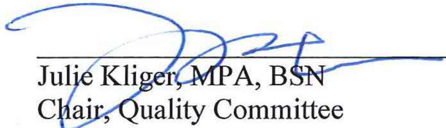
	Dr. Adams presented four cases that accounted for all of the PSI-04 deaths last month to illustrate why this definition is problematic: Case #1 – Patient who comes in with massive severe cirrhosis, GI bleed, Schizophrenia, Hep C, and is severely bleeding from esophageal varices. The patient was treated with transjugular intrahepatic portosystemic shunt (TIPS), but the patient died of the underlying disease. Had that TIPS procedure not taken place, the patient would've died anyway and would not have counted for the PSI 4. Case #2 – Patient was admitted with a strangulated hernia, bowel perforation, peritonitis and septic shock. She subsequently developed respiratory deterioration and collapse that was caused by sepsis; it would be classified as a PSI-4. The surgery was not the reason for the death and in fact was the last measure to try save the patient. Case #3 – Patient was admitted with necrotizing fasciitis, which carries a high death rate. The patient had a host of intraabdominal catastrophes as well. From the underlying disease with some surgeries in the process, the patient could not be saved/rescued. Case #4 – Patient was found in cardiac arrest, CPR was initiated, and the patient was brought to the ED with cryptococcal meningitis which is a fatal disease. There was an attempt to relieve pressure on the brain and because of that procedure, it becomes a PSI 4 even though the procedure did not affect or influence the course or the patient. In response to Committee Members' questions, Dr. Adams stated that none of the cases presented went to Peer Review because it was felt that these were not issues of clinical care but rather underlying diseases of the patients. Had the physicians not acted to try to save the patients from these underlying diseases, our score would be much lower. Dr. Adams stated that this comes from CMS and we have no say in this. Dr. Mallur stated that every mortality is reviewed by Mortality Review team which is different from the Peer Review team. If there is found to be a care problem, then it is sent to Peer Review. Dr. Po also agreed that part of the role is to see if the process isn't working. It is up to the Mortality Committee to make that judgement. If we don't trust that process, then we can re-evaluate, but right now, the process should be trusted. Chair Kliger requested for future meetings of a higher level of understanding what goes to peer review, mortality committee, etc. She also requested that when there is grouped data, it would be helpful to understand the committee ultimately responsible for the review. <u>PSI 18 & 19:</u> Dr. Adams stated that PSI 18 & 19 relate to trauma in vaginal birth with or	

	without instrumentation. There was a taskforce implemented to do the OB Trauma Report presented. Dr. Adams stated that the ethnicity of our patient population poses a much higher risk for this injury. El Camino has a higher rate, aside from Santa Clara County, related to 3rd and 4th degree laceration associated with vaginal deliveries. The Asian ethnicity makes up 62% of the child bearing population in Mountain View, which contributes to a higher risk based on national published data. This correlates statistically in the data underlying PSI 18 & 19. Another factor is induction with the reason being that it is more stressful. Nonetheless, there are things we can do to mitigate the risk factors such as decreasing the use of instrumentation. The committee suggested to getting rates from Asian, specifically South Korea, and compare those rates. In addition, Chair Kliger suggested statistical data and to revisit this topic in July.	
8. BOARD QUALITY DASH REPORT	Dr. Adams stated that the CMS Star rating has been released and El Camino Hospital has received a 5-Star rating. In additional, California started the "Patient Safety Honor Roll" this year to which El Camino Hospital proudly made the list. Dr. Adams presented the STEEEP report. The PSI 90 for composite score is very good. If you see an E, that means Enterprise metric, H is hospital specific, and A is ambulatory specific. We don't always have baseline data for SVMD, but they should be included going forward. Dr. Adams stated that OP-8 and OP-10 are important when CMS looks at efficiency and value of care, which the hospital is in red at the moment. This relates to people who have back pain. This should be lower. In response to Committee members' questions, Dr. Adams stated unmet requests for translation services is not at a 0 because some of the languages requested were not in the list of languages on the iPad translator and it could also be related to dialects being too specific. Chair Kliger stated this should be presented quarterly to help guide the conversation for the board to understand how we're doing and a plan of correction. In addition, the report being presented to the Quality Committee should be reviewed and discussed with internal management committees beforehand. Members of the Committee agree that any suggestions for changes to the proposed Dashboard be sent to Ms. Murphy via email.	
9. DRAFT REVISED COMMITTEE CHARTER	Dr. Adams stated that the Chiefs of the Medical Staff regularly attend the Quality Committee meetings and believe that they should serve as voting members; one from Los Gatos and one from Mountain View. Dr. Fung suggested for the Chiefs to vote and Vice Chiefs to vote in their absence. **Motion:** To recommend that the board approve include the two (2) Chiefs of	

	the Medical Staff as voting members and for the Vice Chiefs to vote in their absence. **Movant:** Po **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Nayes:** None **Abstentions:** None **Absent:** Burn **Recused:** None Dr. Adams also suggested the Committee members be able to review the Medical Executive Committee's monthly credentialing and privileging reports to make recommendations to the Board. **Motion:** For the Committee to review the Medical Executive Committee's monthly credentialing and privileging reports to make recommendations to the Board. **Movant:** Po **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	
10. SVMD REPORTING TO QUALITY COMMITTEE	Dr. Adams stated that there is no report other than what is current being worked on. SVMD is under construction and a SVMD dashboard will be forthcoming. The first report would be at the end of first quarter. To answer the Committee members' questions, Dr. Adams stated that there is no definite person who will be reporting on behalf of SVMD. They currently don't have a CQO. They have a chair of their Quality Committee and that will most likely be who will be presenting.	
11. PUBLIC COMMUNICATION	There was no public communication.	
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:45pm. **Movant:** Po **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Adjourned to closed session at 7:45pm***
13. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:59pm. Agenda items 13-17 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (12/2/2019); and for information: Medical Staff Quality Council Minutes.	
14. AGENDA ITEM 19: CLOSING WRAP UP	None noted.	

15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 8:00pm. **Movant:** Fung **Second:** Simon **Ayes:** Ting, Currie, Falwell, Fung, Kliger, Po, Simon, & Sharma **Noes:** None **Abstentions:** None **Absent:** Burn **Recused:** None	***Meeting adjourned at 8:00pm***

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



Julie Kliger, MPA, BSN
Chair, Quality Committee