El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Monday, April 1, 2019 - 5:30 p.m.
El Camino Hospital | Conference Room A&B
2500 Grant Road, Mountain View, CA 94040

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**5:32 – 5:33**
3.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required** **5:33 – 5:35**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (December 3, 2018) b. Minutes of the Open Session of the Quality Committee Meeting (February 4, 2019) c. Minutes of the Open Session of the Quality Committee Meeting (March 4, 2019 ***Information*** d. Patient Story e. FY19 Pacing Plan f. Progress Against FY19 Quality Committee Goals g. FY20 Committee Meeting Dates h. Hospital Update			
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**Information** **5:35 – 5:40**
5.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 5**	Mark Adams, MD, CMO		**Discussion** **5:40 – 5:50**
6.	**APPOINTMENT OF AD HOC COMMITTEE TO ADDRESS RECRUITMENT OF NEW COMMITTEE MEMBERS** **ATTACHMENT 6**	Julie Kliger, Quality Committee Chair		**Motion Required** **5:50 – 5:55**
7.	**WHAT IS QUALTIY** **ATTACHMENT 7**	Julie Kliger, Quality Committee Chair		**Discussion** **5:55 – 6:25**
8.	**VALUE BASED PURCHASING REPORT** **ATTACHMENT 8**	Mark Adams, MD, CMO		**Discussion** **6:25 – 6:40**
9.	**PT. EXPERIENCE (HCAHPS)** **ATTACHMENT 9**	Cheryl Reinking, RN, CNO		**Discussion** **640 – 6:55**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
10.	**PROPOSED FY20 ORGANIZATIONAL GOALS**	Mark Adams, MD, CMO; Cheryl Reinking, RN, CNO; Jim Griffith, COO		**Motion Required 6:55 – 7:05**
11.	**PROPOSED FY20 COMMITTEE GOALS** **ATTACHMENT 11**	Julie Kliger, Quality Committee Chair		**Motion Required 7:05 – 7:15**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**Information 7:15 – 7:18**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required 7:18 – 7:19**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**7:19 – 7:20**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**Motion Required 7:20 – 7:22**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (December 3, 2018) b. Minutes of the Closed Session of the Quality Committee Meeting (February 4, 2019) c. Minutes of the Open Session of the Quality Committee Meeting (March 4, 2019) ***Information*** d. Quality Council Minutes			
16.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**Discussion 7:22 – 7:27**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required 7:27 – 7:28**
18.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**7:28 – 7:29**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 7:29 – 7:30pm**

Upcoming FY19 Meetings: May 6, 2019 | June 3, 2019 || **Board/Committee Education:** April 24, 2019

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, December 3, 2018
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

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

Members Absent

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. Anderson arrived during Agenda Item 4: Report on Board Actions and Ms. Simon arrived during Agenda Item 5: FY19 Quality Dashboard. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	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: Minutes of the Open Session of the Quality Committee Meeting (November 5, 2018); and for information: Patient Stories; FY19 Pacing Plan; Progress Against FY19 Committee Goals; and Article of Interest. **Movant:** Davis **Second:** Ron **Ayes:** Bauman, Davis, Fung, Kliger, Ron, Reeder **Noes:** None **Abstentions:** None **Absent:** Anderson, Simon **Recused:** None	***Consent Calendar approved***
4. REPORT ON BOARD ACTIONS	In response to questions, Cindy Murphy, Director of Governance Services, explained that the Board approved the revisions to the Quality Committee Charter that the Committee recommended at its August meeting.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the quality metrics on the Committee's FY19 dashboard and Cheryl Reinking, RN, CNO, reviewed the HCAHPS scores. Ms. Reinking noted that the scores improved significantly in October, but the preliminary data for November is not looking quite as good. Dr. Adams explained that some of the Hospital acquired infections can be explained by a failure to document the infections on admission. The Committee members and staff discussed the importance of instilling a culture of safety throughout the organization that includes careful monitoring of others. The Committee also asked staff to bring the data back plotted quarter by quarter as well as on a rolling -12 month basis.	

6. PSI-90 SCORES	Dr. Adams reported on the AHRQ Patient Safety Indicators for Q1 FY19. He noted that ECH performs better than the Premier Composite mean of 0.90 overall for FY18 and Q1 of FY19, but there is still room for improvement. Dr. Davis suggested that this data would be a good candidate for presentation on a rolling 12-month basis.	
7. THROUGHPUT CASE STUDY	Ms. Reinking reported that it is one of ECH's FY19 Organizational Goals to improve (decrease) the amount of time it takes from the time a patient arrives in the ED until they are admitted to an in-patient unit. She explained that the baseline median was 339 minutes and the goal is to get to 280. Ms. Reinking reported that the staff identified 65 barriers to throughput. One barrier was the time it takes to achieve RN to RN handoff once the physician writes the admission order. Staff is piloting making an appointment for the ED RN to give report to the Unit RN, which is already making some improvement.	
8. READMISSIONS	Dr. Adams reported that the organization is very focused on reducing preventable readmission and the effort is organized around teams composed of a mix of various clinicians and administrators. He explained that ECH is trying to focus efforts on those patients most at risk for readmission and that ECH has developed its own predictor tool and validated it. Teams include a Readmissions Review team, a Care Coordination team, a Palliative Care team, and a CV mortality and Readmissions team.	
9. CUTLURE OF SAFETY SURVEY REPORT	Dr. Adams reviewed themes from the culture of safety survey. Some of the Medical Staff members present commented that members of the Medical Staff report feeling as though hospital administration and the Board do not prioritize the needs of physicians, and need to focus on addressing physician burn-out issues. Dr. Davis asked Dr. Adams to take the lead in defining this problem and bring that back to the Committee and the Board. Chair Kliger requested that this be added to the Committee's Pacing Plan as a topic to revisit.	
10. HOW DOES ECH DEFINE QUALITY	Chair Kliger briefly reviewed the results of the Quality Strategy Maturity Model Survey, noting that 12 of 17 requested participants participated in the survey. She requested that the survey be re-administered to the 5 who did not participate and she also asked Dr. Adams to extend the survey to a broader group of participants. The Committee asked that additional information be provided in the responses that provide evidence that justifies or explains the response. Staff was directed to add this back to the Committee's Pacing Plan for the March 2019 meeting.	
11. HOSPITAL UPDATE	Mark Adams, MD, CMO, answered questions from the Committee members about the hospital update.	
12. PUBLIC COMMUNICATION	There were no comments from the public.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:28pm. **Movant:** Anderson **Second:** Reeder **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 7:28pm.***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/	Open session was reconvened at 7:38pm. Agenda Items 14-18 were covered in closed session.	

REPORT OUT	During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (November 5, 2018) a unanimous vote of all members present, (Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon).	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:40pm. **Movant:** Anderson **Second:** Reeder **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:40pm***

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

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Julie Kliger
Chair, Quality Committee

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, February 4, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

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

**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 Hospital (the "Committee") was called to order at 5:30pm by Dr. Fung. A verbal roll call was taken. Ms. Bauman participated via teleconference. Ms. Kliger, Dr. Davis, Ms. Simon and Ms. Anderson were absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	Dr. Fung 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	Dr. Fung asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Due to a lack of quorum, the Committee deferred approval of the meeting minutes to the Committee's March meeting.**	***Approval of the Consent Calendar deferred to the March 4th Meeting***
4. REPORT ON BOARD ACTIONS	There were no questions about the Report on Board Actions.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the quality metrics on the Committee's FY19 dashboard and Cheryl Reinking, RN, CNO, reviewed the HCAHPS scores. Dr. Adams commented that the mortality index is improving and that proper documentation of all patients and proper management of terminally ill patients are both important factors in decreasing this measurement. Ms. Reinking reported that the GIP (general inpatient program provides patients assigned to beds within the acute care setting to receive hospice care. These patients that are on hospice are not included in the mortality index measurement. Dr. Adams reported that readmissions have come down below target and staff is gearing up interventions to improve ED throughput as we move into the end of the fiscal year. Dr. Adams reported that there were zero CAUTIs in December and one CLABSI in the last month. The CLABSI was likely due only to a contaminated blood culture, but it still has to be counted. He also reported ECH needs to improve documentation of patients that have a C. Diff infection on admission so the infection does not get attributed to ECH as hospital-acquired. Dr. Adams also commented that there has been a decreasing trend in sepsis mortality over the last two years, but an increase in the number of terminal cancer patients who developed sepsis. He explained that the GIP program will take those patients out of this category. Dr. Fung and the other Committee members requested staff to consider consolidating the information in the dashboard into fewer pages.	

6. UPDATE ON PATIENT CARE EXPERIENCE	Ms. Reinking reported on initiatives to improve patient experience in the ED in both MV and LG including care team coaches (ED physicians and most staff have received coaching) and improved sound barriers between patient bays and providing iPads in the absence of televisions for distraction in the LG ED.	
7. PHYSICIAN BURNOUT	Dr. Adams reported the national suicide rate of physicians is twice the national rate of the population and explained that physician burnout can impact patient safety and satisfaction and decrease the quality of care. He explained that physician burnout is highest in 45-54 year olds, higher in some specialties than others, and the largest contributing factor is too many bureaucratic tasks. Medical staff members commented that some of the EHR modules are very difficult to use and that physicians being asked to continuously improve efficiency creates burnout as well. The staff and Committee members discussed mitigation measures and it was suggested that the Physician Wellness Committee that is being revitalized by the Medical Staff focus on efforts to prevent burnout, not just addressing it when happens.	
8. JOINT COMMISSION SURVEY RESULTS	Dr. Adams reviewed how the Joint Commission's new SAFER matrix used in the Decembers 2018 triennial survey works. He also reviewed the survey findings, noting that there were 4 moderate level findings and 32 low level findings. One of the moderate level findings (absence of documentation of discharge instructions addressing moderate sedation) was found to be "widespread." Actions plans are in place to address all of the findings.	
9. HOSPITAL UPDATE	There were no questions about the hospital update.	
10. PUBLIC COMMUNICATION	There were no comments from the public.	
11. ADJOURN TO CLOSED SESSION	The meeting was adjourned to closed session at 7:14pm.	***Adjourned to closed session at 7:14pm***
12. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:20pm. Agenda Items 12-16 were covered in closed session. Due to a lack of quorum, the Committee took no actions during the closed session.	
13. AGENDA ITEM 18: ADJOURNMENT	The meeting was adjourned at7:21pm.	***Meeting adjourned at 7:21pm***

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

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Julie Kliger
Chair, Quality Committee

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, March 4, 2019
El Camino Hospital | Conference Rooms E&F
2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Jeffrey Davis, MD	**Katie Anderson**
Peter C. Fung, MD	**Ina Bauman**
Julie Kliger, Chair	**George Ting, MD**
Wendy Ron	
Melora Simon (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 Hospital (the "Committee") was called to order at 5:36 pm by Chair Kliger. A verbal roll call was taken. Ms. Simon participated via teleconference. Committee Members Anderson, Bauman and Ting were absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	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. **Due to a lack of quorum, the Committee deferred approval of the meeting minutes to the Committee's April meeting.**	*Approval of the Consent Calendar deferred to the April 1st Meeting*
4. REPORT ON BOARD ACTIONS	Chair Kliger reviewed action taken by the Board as further detailed in the packet. Dr. Davis provided detail about the recent Board approval regarding the Asset Acquisition Agreement with Verity and Professional Services Agreement with the San Jose Medical Group. He highlighted the alignment with the hospital's strategic plan and noted that the next step is approval of the Asset Acquisition Agreement from the bankruptcy court. Dr. Fung noted that there will be a need to measure quality outcomes for these ambulatory services. The Committee discussed the advantages of acquiring an established medical group including the existing quality infrastructure, data, and capacity to track ambulatory quality metrics. In response to Ms. Kliger's question, Mark Adams, MD, CMO, described the process for establishing mutually acceptable and relevant quality metrics for ambulatory practices such as HEDIS (Healthcare Effectiveness Data and Information Set) measures that payers use to track managed care. Dr. Adams expressed concerns from an operational-management perspective of how to extend quality and clinical effectiveness as well as risk management to SVMD and this new group of physicians. SVMD is a separate entity with its own governing board which will have the primary responsibility to monitor quality and safety within that organization. It is expected that the SVMD board will make periodic reports to the system Board to include quality and safety metrics. Ms. Kliger suggested the Committee leverage Ms. Simon's extensive experience of working with	

Agenda Item	Comments/Discussion	Approvals/ Action
	ambulatory care and quality systems as it relates to this new group.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the quality metrics on the Committee's FY19 Dashboard. Dr. Adams commented on the newly modified dashboard display that shows a rolling twelve month average which dampens the month to month variability and shows trends more clearly. Dr. Adams reviewed metrics of the Quality Dashboard: - Mortality Index in December increased due to an increase in admissions of terminal cancer patients; with an index of .97 indicates steady improvements toward the goal of .95; - Readmission Index was fairly steady and close to target; - Patient Throughput-Median showed reduction and dampening of variability, though still above organizational goal. He commented on expected and unexpected challenges, and remains cautiously optimistic of meeting the organizational targets. In response to questions on throughput work, Dr. Adams explained that the biggest impacts were in physician interactions with the ED physicians and hospitalists. While it is fairly common for hospitalists to approve admitting patients purely on the recommendations of ED physicians, some hospitalists resist the practice. In addition, a cascade of procedural steps are required to admit patients on the nursing side resulting in a fair amount of delay. Meetings are underway with ED physicians and hospitalists to discuss options for more efficiency including, for example, using bridging orders for admissions. Dr. Adams responded to questions regarding the Mortality Index being attributed to severely ill patients and being risk adjusted. He explained that terminal cancer patients don't have all the co-morbidities that help to increase the expected mortality score called Risk of Mortality (ROM). They are admitted with a simple, yet fatal, diagnosis compared to a complex medicine patient. We now have an in-patient hospice with the expectation that more of these patients go to hospice and will not be counted in the mortality index. Cheryl Reinking, RN, CNO, discussed HCAHPS results and described actions in place to improve the scores: - Nursing Communication – hourly, purposeful-rounding or leader rounding as one of the very best documented practices; - Responsiveness – Currently, our biggest struggle. Started a "no pass zone" ensuring that someone finds out what the patient needs; and - Cleanliness – meeting the goal. Successfully eliminated clutter in patient rooms. The committee discussed the value of the report formatted in rolling twelve month averages to show trends. Committee members noted that ECH is clearly on an upward trajectory regarding the hospital environment satisfaction. Ms. Kliger suggested adding descriptive annotation to the report to identify change catalysts. The Committee recommended adding a report to the Pacing Plan showing performance metrics of comparable organizations to ECH.	*Metrics comparison paced for a future meeting*

Agenda Item	Comments/Discussion	Approvals/ Action
6. BEHAVIORAL HEALTH SERVICES QUALITY REPORT	Ms. Kliger introduced the purpose of reviewing BHS' services, performance and future plans. Dr. Adams presented an overview of the Behavioral Health Services (BHS) offered by ECH and the added capacity anticipated with the opening of the new facility. The new facility will expand accommodations from 21 to 36 beds. There are many outpatient services including Maternal Outreach Mood Services (MOMS), Dual Diagnoses, Chemical Dependency Intensive Outpatient Program (CDIOP), Aftercare, Older Adult Transition Services (OATS), Dialectical Behavior Treatment (DBT), Electro Convulsive Treatment (ECT), and several adolescent programs called ASPIRE. On any given day our BHS is caring for 100 patients. BHS tracks and trends many behavioral health metrics including CMS Core Measures. All of the indicators are at or above national benchmarks. This lead to a discussion of responsibility for such measures and accountability of medical directorships. Dr. Adams explained that at least one of the organizational goals is tied to the performance of each medical director. Ms. Kliger posed several questions to be included on what is quality. How to view quality; How broad? What would be valuable data (already being collected at a high level) that would inform the Committee for its work advising the organization? The Committee asked Dr. Adams to present an overview of the process used to evaluate medical directors' performance.	*Staff to present on medical directorships*
7. SAFETY SURVEY – EMPLOYEE RESULTS	Dr. Adams reported that the most recent employee culture of safety survey had a response rate of 87%. The overall score increased compared to 2017 and 2018. The results were highlighted and discussed. The Committee and staff discussed that the results reveal the need to change the culture, such as: • Improve communication and collaboration among peers, and units. • Shift QRR write-ups to focus on systems and not individuals. • Revise the peer review process. The staff discussed the benefits of a former ECH Physician-Liaison program that improved communication, provided training and bridges the communication gap between nurses and physicians. . Dr. Adams presented the good news that the scores for pride & reputation were very good indicating that our employees take pride in the organization. In response to Committee questions, Dr. Adams and Ms. Reinking explained that HR owns the data and is working with consultants to develop a plan of action. **The Committee requested a progress report on the culture of safety plan of action be added to the Pacing Plan for a later date.**	
8. APPOINTMENT OF AD HOC COMMITTEE TO	Ms. Kliger reported that she asked Committee members Ina Bauman, and Wendy Ron to step down when their terms end in June. She explained she would like to open up those two seats to expand the technical	*Topic deferred to the April 1st*

Agenda Item	Comments/Discussion	Approvals/ Action
ADDRESS RECRUITMENT OF NEW COMMITTEE MEMBERS	capabilities of the Committee to bring additional insights and counsel. The Committee discussed recruitment of new members, the composition of the Committee and new ways to continue to have the patient voice on the Committee. Potential means of addressing patient voice are: • Regular reviews from the PFAC; • Feedback from hospital patients; or • Feedback from ambulatory patients. Members of the staff and the Committee expressed their concerns and advocated for keeping the patient voice on the Committee. **Due to a lack of quorum, the Committee deferred appointing an Ad Hoc Committee to the Committee's April meeting.**	*Meeting*
9. WHAT IS QUALITY	Due to time constraints, the Committee deferred discussion of this item to its April 1st meeting.	*Topic deferred to the April 1st Meeting*
10. PROPOSED FY20 ORGANIZATIONAL GOALS	Due to time constraints, the Committee deferred discussion of this item to the Committee's April meeting.	*Topic deferred to the April 1st Meeting*
11. PROPOSED FY20 COMMITTEE GOALS	Due to time constraints, the Committee deferred discussion of this item to the Committee's April meeting.	*Topic deferred to the April 1st Meeting*
12. PUBLIC COMMUNICATION	There were no comments from the public.	
13. ADJOURN TO CLOSED SESSION	Ms. Simon discontinued participation in the meeting at 7:34pm. **Motion:** To adjourn to closed session at 7:36 pm. **Movant:** Davis **Second:** Ron **Ayes:**, Fung, Kliger, Davis, Ron **Noes:** None **Abstentions:** None **Absent:** Anderson, Bauman, Simon, Ting **Recused:** None	***Adjourned to closed session at 7:36pm.***
14. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:43pm. Due to lack of quorum the committee took no action during the closed session.	
15. AGENDA ITEM 19: ADJOURNMENT	The meeting was adjourned at 7:44pm.	***Meeting adjourned at 7:44pm***

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

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Julie Kliger
Chair, Quality Committee

[redacted]
Mountain View, California

Mr. Dan Woods
Chief Executive Officer
El Camino Hospital

Dr. Mark Adams
Chief Medical Officer
El Camino Hospital

March 15, 2019

Dear Mr. Woods and Dr. Adams,

Recently, I completed a three-month cardiac rehabilitation program at El Camino Hospital's Cardiac and Pulmonary Wellness Center. My objectives with the program were to become comfortable with exercise, establish a regular exercise routine, and learn about heart healthy factors (nutrition, medications, exercise, labs, stress, etc.). The program was superb, exceeded my expectations, and allowed me to meet all of my objectives and more.

The team delivering the program was wonderful: Tena, Ace, Joanne, Terence, Julie, Craig, Julee, Molly, Andrea, Nanette, Karen, and Eunissa. They are knowledgeable, engaging, and compassionate with seemingly limitless amounts of positive comments and actions. The program runs in a structured, well-organized manner with plenty of individualized attention and care. It was clear that the team was quite expert at delivering the same high quality care for the diverse population of individuals who participate in the program. No question went unanswered and issues were addressed thoroughly and quickly.

I want to thank the entire cardiac rehabilitation team and El Camino Hospital for providing such an outstanding and meaningful program. As I continue to progress in my heart healthy efforts, the El Camino Hospital cardiac rehabilitation program has been a critical foundation for those activities.

With deep appreciation,

[redacted]

[redacted]

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

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

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

FY2019 Q3		
JANUARY 2019	**FEBRUARY 4, 2019**	**MARCH 4, 2019**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 7. Q2 FY19 Quality and Safety Review (Q2 Reportable events if any) 8. Physician Burnout 9. Joint Commission Survey Results 10. Update on Patient Care Experience (ED Patient Satisfaction)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Proposed FY20 Committee Goals 2. Proposed FY20 Organizational Goals 3. Behavioral Health Services Quality Report 4. Committee Recruitment 5. What is Quality? (Maturity Model)
FY2019 Q4		
APRIL 1, 2019	**MAY 6, 2019**	**JUNE 3, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Committee Recruitment 2. What is Quality? (Maturity Model) 3. ~~Leapfrog Survey~~ (Move to June) 4. Value Based Purchasing Report 5. Pt. Experience (HCAHPS) 6. ~~ED Pt. Satisfaction (Press Ganey)~~ (Done 2/4) 7. Approve FY20 Committee Goals 8. Proposed FY20 Committee Meeting Dates 9. Proposed FY20 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Approve FY20 Committee Goals (if needed) 4. Proposed FY20 Organizational Goals 5. Proposed FY20 Pacing Plan 6. Q3 FY19 Quality and Safety Review ~~6.~~7. Medical Director Goal Process and Accountability	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Approve FY20 Pacing Plan ~~5.~~6. Leapfrog Survey

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

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

SUBMITTED BY:

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

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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Mountain View, CA 94040-4378
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Quality Committee Meetings
Proposed FY20 Dates

RECOMMENDED QC DATE	CORRESPONDING HOSPITAL BOARD DATE
Monday, August 5, 2019	Wednesday, August 14, 2019
Wednesday, September 4, 2020 or Monday , September 9, 2019	Wednesday, September 11, 2019
Monday, October 7, 2020	Wednesday, October 16, 2019
Monday, November 4, 2019	Wednesday, November 13, 2019
Monday, December 2, 2019	Wednesday, January 8, 2020
Monday, February 3, 2020	Wednesday, February 12, 2020
Monday, March 2, 2020	Wednesday, March 11, 2020
Wednesday, April 1, 2020 or Monday, April 6, 2020 *(week of Spring Break)*	Wednesday, April 15, 2020
Monday, May 4, 2020	Tuesday, May 13, 2020
Monday, June 1, 2020	Wednesday, June 10, 2020

El Camino Hospital®
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Hospital Update
April 1, 2019
Mark Adams, MD, CMO

Quality and Safety

To enhance the physician's efficiency within the EHR and meet The Joint Commission requirements related to the safe control of prescription pads, all controlled substance prescriptions now default to electronic prescribing. In addition, physicians can now use a single sign on solution to access the Cures Website to check on patients prior controlled substance prescriptions which is a new requirement to address the current opioid crisis.

Patient Experience

Clinicians can now customize Discharge Instructions or the After Visit Summary (AVS) in 8 additional languages (Arabic, Danish Dutch, French, German, Russian, Spanish, and Vietnamese). The AVS will be partially translated in these languages and the patient desiring a preferred language will receive two AVSs (one in the preferred language and one in English).

Financial Services

Global Healthcare Exchange ("GHX"), a company whose mission is to enable better patient care and billions in savings for the healthcare community by maximizing automation, efficiency and accuracy of business processes, honored ECH as one of the "Best 50" Healthcare Providers for Supply Chain Excellence. ECH ranked fifth overall at the GHX Best 50 Healthcare Providers for Supply Chain Excellence in 2018. To select the Best 50, GHX looked at the performance of more than 4,100 hospitals in the U.S. and Canada connected to the GHX electronic trading exchange. GHX identified the 50 healthcare organizations that scored highest in areas such as maximizing document automation, exchange utilization, and trading partner connections during the 2018 calendar year.

Information Services

Our March 3rd upgrade to Epic's current version (2018) provides improved efficiency and use of the system for physicians and nurses. Future upgrades will occur on a quarterly versus annual basis to provide more immediate access to the newest features and functionality.

Corporate and Community Health

Community Benefit Staff received 118 applications (64 Hospital and 54 District) for our FY20 grant program. Staff had the opportunity to participate in the Santa Clara County Public Health Department's chronic disease prevention strategic planning effort.

Government and Community Relations

Dr. Punit Sarna spoke to a Campbell Chamber of Commerce luncheon on heart disease prevention. Chamber CEO Ken Johnson offered their business members a 30% discount on Automated External Defibrillators (AEDs), part of a collaboration with the nonprofit Racing Hearts. This event continues the extensive work ECH has done to equip the community with easily accessible AEDs.

Dan Woods attended a luncheon with Governor Gavin Newsom and a small group of Silicon Valley CEOs. Brenda Taussig met with California Senate President Pro Tem Toni Atkins. It is already proving to be a very active year in state health and hospital legislation. Updates will be provided to the Board as developments evolve in Sacramento.

Marketing and Communications

To further employee engagement, leadership and staff participated in six town hall presentations across campuses during which we shared information about awards, our successful Joint Commission survey, Silicon Valley Medical Development, our LEAN transformation and plans for the year ahead. 250 Community members registered to attend the Heart and Vascular Institute's annual Heart Forum on March 2nd. Physicians representing the specialties of interventional cardiology, cardiothoracic surgery, electrophysiology, lifestyle medicine and women's heart health participated in this education program for the community.

Philanthropy

As of January 31, 2018, El Camino Hospital Foundation had secured $13,472,695, more than double the $6,175,000 FY19 fundraising goal.

Auxiliary

Our very dedicated Auxiliary contributed 6,299 volunteer hours in February 2019.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee
From: Cindy Murphy, Director of Governance Services
Date: April 1, 2019
Subject: Report on Board Actions

Purpose:

To keep the Committee informed with regards to actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

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

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

3. Background: Since the last Quality Committee Meeting the Hospital Board has met once and the District Board has met once. In addition, the Board has delegated certain authority to the Finance Committee and the Executive Compensation Committee. Going forward, those approvals will also be noted in this report.

A. ECH Board Actions

March 13, 2019

- Approved in concept increasing ECH Board to a maximum of 11 members and reserving a seat for the CEO. A bylaws revision implementing the changes will be brought forward to the Board from the Governance Committee for the May ECH Board meeting. This will ultimately require approval of the El Camino Healthcare District Board also.
- Approved structure and guidance for enterprise risk management as recommended by the Compliance and Audit Committee.
- Approved Compensation for Nurse Practitioner for ASPIRE Program.
- Approved Revised ECH Director Compensation and Reimbursement Policy and Procedure.
- Approved Revised Hospital Board Officers Nomination and Selection Procedures Updating Dates for Submission of Statements of Interest.
- Approved Revised Surplus Cash Investment policy.
- Approved Sponsorship of SVMD as Risk Bearing Organization with Department of Managed Healthcare.

B. ECHD Board Actions

March 19, 2019

- Approved Resolution 2019 -02 Recognizing Community Benefit Partner Magical Bridge

- Approved Revised ECHD Board Director Compensation Policy and Compensation Reimbursement Procedure.

C. Finance Committee Actions – None Since Last Report

D. Executive Compensation Committee Actions None Since Last Report

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, Sr. Director, Quality Improvement and Patient Safety
Date: April 1, 2019
Subject: FY19 Quality Dashboard

Purpose:

To provide updated metrics for current Organization Goals, FY18 Organizational Goals, and additional quality metrics of interest.

Summary:

1. Situation: This report monitors progress toward FY19 Organizational Goals, and sustaining of FY18 Organizational Goals, and metrics monitoring sepsis.

2. Authority: The Quality Committee is responsible for oversight of quality and safety.

3. Background: These twelve metrics were selected for monthly review by this Committee as they reflect the Hospital's FY19 quality, efficiency, and service goals. Annotation is provided to explain actions taken affecting each metric. Committee request to add a rolling 12-month average for each metric included.

4. Assessment:
- **a.** Mortality Index while less than the March report, has increased over target, due to high number of deaths in January with many on comfort care and/or DNR status
- **b.** Readmission Index remains below target level for FYTD.
- **c.** Hospital-acquired Infections: Zero CLABSI and CAUTI for Feb.. 2019.
- **d.** ALOS/GMLOS increased in January to above target level.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

FY19 Quality Dashboard (January data unless otherwise specified - final results)

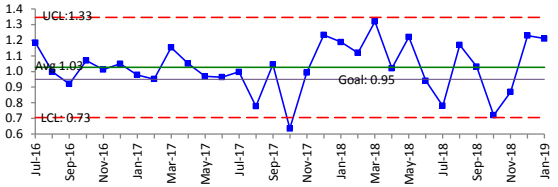
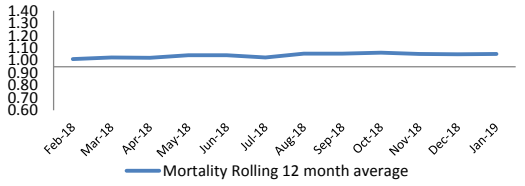
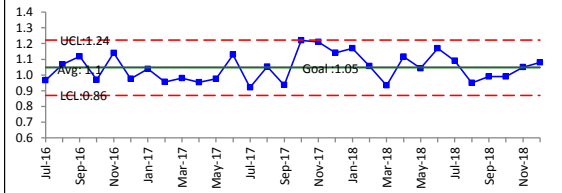
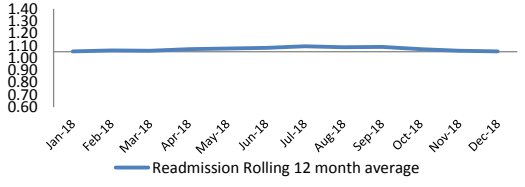
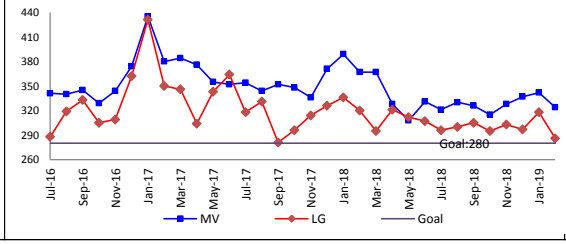
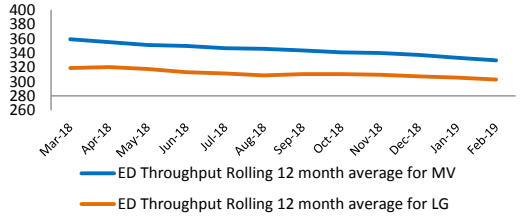
Suggested Committee Discussion Questions: None

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

February 2019 (Unless otherwise specified)

Month to Board Quality Committee: April, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
Quality		Month	FYTD				
1	*** Organizational Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: January 2019*	1.21 (2.20%/1.81%)	1.01 (1.53%/1.51%)	1.05	0.95		
2	***Organizational Goal** **Readmission Index (All Patient, All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: December 2018*	1.08 (7.81%/7.23%)	1.03 (7.19%/7.00%)	1.08	1.05		
3	*** Organizational Goal** **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: February 2019*	MV: 324 mins LG: 286 mins	MV: 327 mins LG: 301 mins	MV: 350 mins LG: 314 mins	280 mins		

Definitions and Additional Information

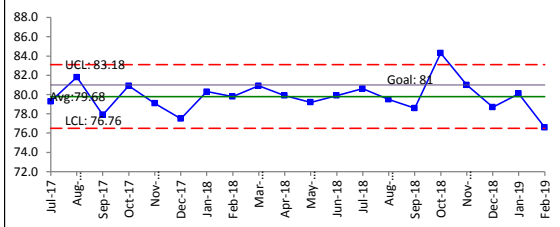
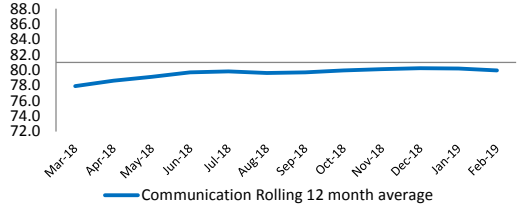
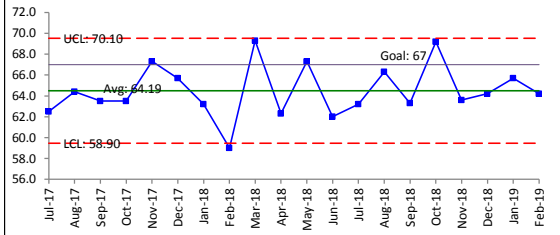
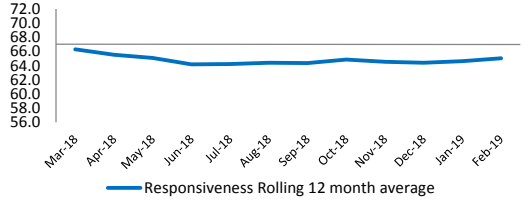
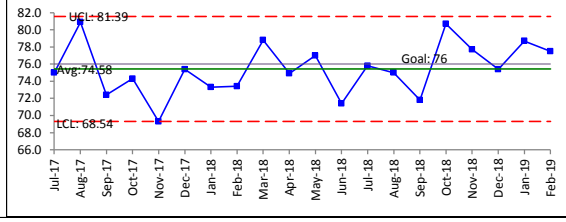
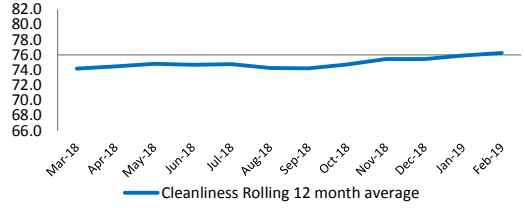
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	All deaths reviewed against mortality algorithm, with information on each patient's risk of mortality (ROM) and severity of illness(SOI) (levels 1-4 for each) Cases then reviewed wth Assist. CMO & Quality Med. Director for opportunites, and preventable deaths, some sent to Peer Review. No deaths with less than 3 ROM or 3 SOi.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Readmission Index (All Patient, All Cause Readmit) Observed/Expected	December Readmission detail report screened for cases to be considered for Peer Review if not already reviewed and sent to HVI and Chronic Respiratory Teams for review if not previously identified. Most frequent readmission reasons this month were Sepsis, Renal Failure (dialysis), and post op complications/issues.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	The nursing units are continuing to follow the standard work for RN-RN handoff, which, when there is a bed available, is helping the last interval of order to floor. In addition, complex continues to be used to help with anticipating bed needs and confirming plans for the moving of patients. The ED leadership and hospitalist leadership for both PAMF and TeamHealth participated in a workgroup to confirm process for bridge orders, and they will be focusing on clear admit, stable patients in an effort to reduce the time from arrival to floor.	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**iCare Report: ECH ED Arrival to Floor**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

February 2019 (Unless otherwise specified)

Month to Board Quality Committee: April, 2019

	Service	FY19 Performance Month	FY19 Performance FYTD	HCAHPS Baseline Q4 2017 - Q3 2018	FY19 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: February 2019*	76.6 (235/307)	79.9 (1675/2097)	80.0	81.0		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: February 2019*	64.2 (183/285)	65 (1290/1985)	65.1	67.0		
6	* Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: February 2019*	77.5 (234/302)	76.6 (1588/2073)	74.5	76.0		

Definitions and Additional Information

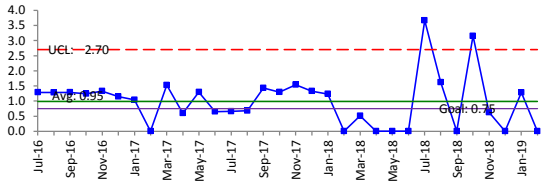
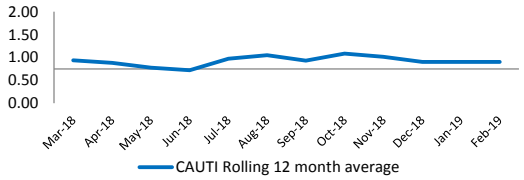
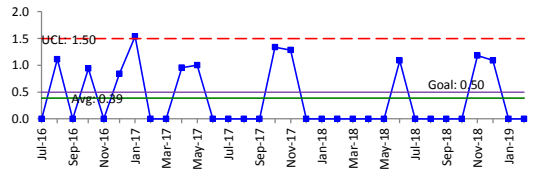
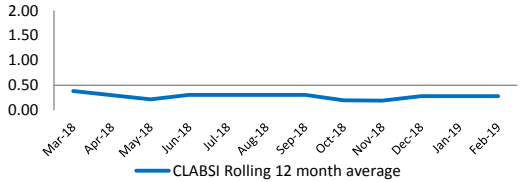
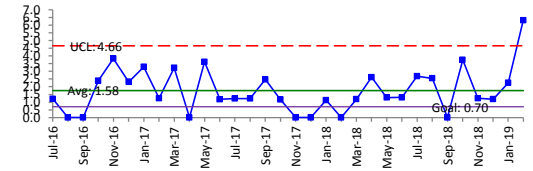
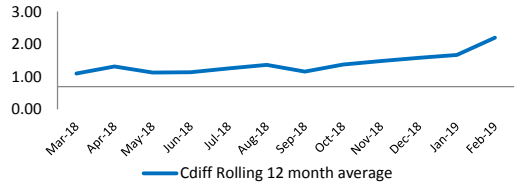
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include; Leader Rounding, Enhanced Interactions: Bedside Handoff/PPEPP (Pain, Potty, Environment, Position, Pumps/Golden Hour), and Care Team Coaching.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include: Leader Rounding, Standardized Call Light Answer Process and Escalation Process, and Enhanced Interactions.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	The ongoing projects to address this HCAHPS domain include: Leader Rounding, Smile/Scan/Listen/Act which is Patient rounding for non-clinical staff, and Monthly Cleanliness Challenges.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

February 2019 (Unless otherwise specified)

Month to Board Quality Committee: April, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	
Quality		Month	FYTD				
7	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: February 2019*	0.00 (0/1234)	1.23 (13/10534)	0.77	SIR Goal: <= 0.75		
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: February 2019*	0.00 (0/970)	0.27 (2/7357)	0.28	SIR Goal: <= 0.50		
9	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: February 2019*	6.31 (5/7919)	2.49 (16/64176)	1.13	SIR Goal: <= 0.70		

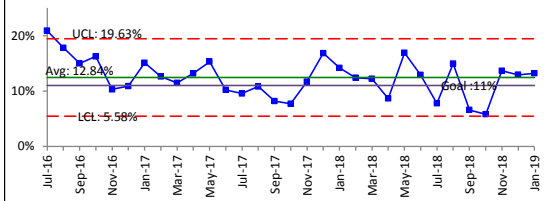
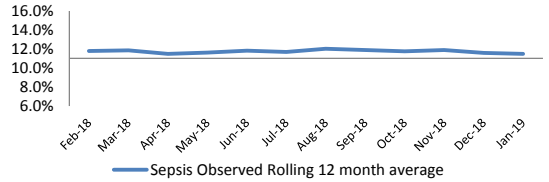
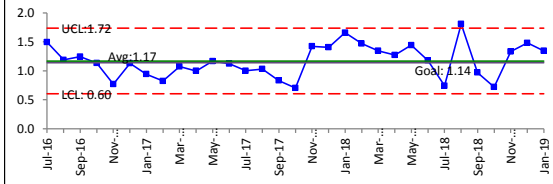
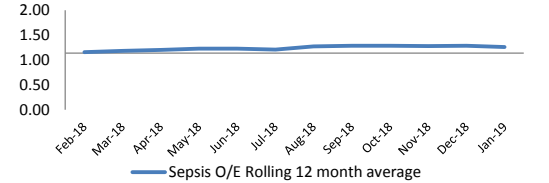
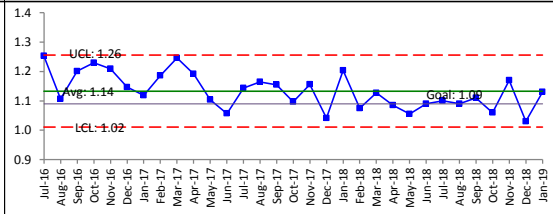
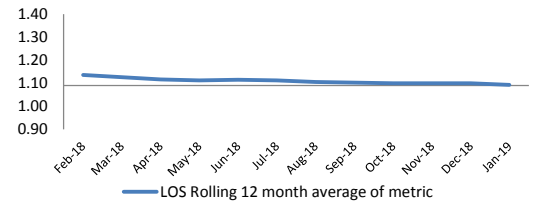
Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Zero CAUTIs for February 2019.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Zero CLABSI for February 2019.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	5 Hospital-acquired C. Difficle infections in February; 3 at MV, 2 at LG: MV: 2 cases developed infeciton after antibiotic usage; 3 ABX for each pt.. 3rd case not hospital-inset, but counted as hospital-acquired because stool culture not collected until 4th hospital day, when ordered on 3rd hospital day. LG: Pt to surgery for femoral fracture and developed C.Diff infection w/diarrhea5 days post op. Only antibiotic use was for prophylaxis, 3 doses total. 2nd pt. in Acute Rehab and during acute hospitalization had severe C.Diff infection requiring a fecal transplant.	Catherine Carson/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_

FY19 Organizational Goal and Quality Dashboard Update

February 2019 (Unless otherwise specified)

Month to Board Quality Committee: April, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
		Month	FYTD				
10	**Sepsis Mortality Observed Rate Enterprise, based on ICD-10 codes** *Date Period: January 2019*	13.21%	10.91%	11.72%	11.00%		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: January 2019*	1.35 (13.21%/9.81%)	1.22	1.22	1.14		
Efficiency							
12	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: January 2019*	1.13	1.10	1.12	1.09		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Observed Rate Enterprise, based on ICD 10 codes	138 Sepsis pts seen in January with a higher % (4%) with DNR/Comfort care orders than 3 prior months. Fiscal YTD mortality rate is below goal.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	The 4% incidence of death with DNR/comfort care in Sepsis patients is reflected in the lower expected mortality of 8.73% (patients are not receiving aggressive treatments).	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Arithmetic Observed LOS Average over Geometric LOS Expected (Medicare definition, MS-CC, Inpatient)	LOS Index over goal in January, overal trend since March 2018 at of below goal.	Cheryl Reinking Catherine Carson (Cornel Delogramatic)		The Observed LOS over the Expected LOS Ratio is determined by calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient's MD-DRG.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: April 1, 2019
Subject: Appointment of Ad Hoc Committee to Address Recruitment of new Members

Recommendation(s): To appoint Committee members _____ and _____ to an Ad hoc Committee to address the recruitment of new members.

Summary:

1. Situation: Pursuant to its Charter, in addition to Board members "the Quality Committee may also include no more than nine (9) external (non-Hospital Board member) members with expertise in in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient." Over the last year or so, several subject matter experts have resigned from membership on the Committee, leaving at least some of these competencies unrepresented.

2. Authority: In accordance with the attached Hospital Board Advisory Committee Nomination and Selection Policy and Hospital Board Advisory Committee Nomination and Selection Procedures, the Committee has the authority to appoint and Ad hoc Committee to begin the recruitment process.

3. Background: This item was briefly discussed at the April 1st meeting but action on the appointment of an Ad Hoc Committee was deferred due to the lack of a quorum.

4. Assessment: N/A

5. Other Reviews: Committee Chair Julie Kliger, RN, and Executive Sponsor Mark Adams, MD, CMO, have expressed a desire to add additional members to the Committee.

6. Outcomes: N/A

List of Attachments:

1. Hospital Board Advisory Committee Nomination and Selection Policy & Procedures
2. Draft Committee Member Competencies
3. PFAC Charter
4. PFAC Agendas (February and March 2019)

Suggested Committee Discussion Questions:

1. Which members of the Committee shall be appointed to the Ad hoc Committee?
2. What are the most important competencies missing from the Committee at this time?

Agenda Item Name Here
October 10, 2018 [Meeting Date]

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION POLICY

XX.XX HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION POLICY

A. Coverage:

El Camino Hospital Board Advisory Committees

B. Adopted:

June 12, 2013;

C. Policy:

It is the policy of ECH that appointment of Hospital Board Advisory Committee Members to vacant or newly created positions follow the procedure set forth in the attached Document entitled:

Hospital Board Advisory Committee Member Nomination and Selection Procedure

1. Length of Service and Term Limits for Committee Members

As provided in the Committee Charters, Committee Members will serve a term of one (1) year, renewable annually.

D. Reviewed:

Governance Committee March 31, 2015
ECH Board Approved April 8, 2015

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION PROCEDURES
Adopted February 12, 2014
Revised (Approved) April 8, 2015

01.07 HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION PROCEDURES

A. Coverage:

El Camino Hospital Board Advisory Committees

B. Adopted:

2/12/2014

C. Procedure Summary:

The nomination and selection of each Hospital Board Advisory Committee (Advisory Committee) member (Member) shall follow the procedures below.

D. Procedure for Nominating and Appointing an Advisory Committee Member:

1. Eligibility and Qualifications

Each Advisory Committee shall determine minimum qualifications and competencies for its Members. In addition, the Governance Committee will periodically conduct a strategic assessment of the respective Advisory Committee's membership needs and ensure that it evolves with the Hospital's strategy.

2. Nomination and Declaration

a. Nominations for Advisory Committee membership may be received from any source.
b. The Board Liaison will notify the Board, the Advisory Committee members, the Executive Leadership Team and the public of all vacancies for which new Advisory Committee Members are being recruited.
c. A candidate shall submit an application to the Board Liaison that includes reason(s) the candidate wishes to serve, the candidate's relevant experience and qualifications,

potential conflicts of interest including any personal or professional connections to ECH, a release to permit ECH Human Resources to conduct a background check, and specifies which Advisory Committees that the candidate wishes to be considered for.

d. If the interested candidate is currently serving on another Advisory Committee at ECH, the candidate shall notify the Chair(s) of the Advisory Committee with a vacancy and the Advisory Committee on which they are serving. The interested candidate shall also notify the Board Liaison, provide all application materials, and be subject to all other requirements of this procedure.
e. All candidates will be considered in the candidate due diligence process.
f. In the event that no qualified candidates can be found through the routine recruitment procedures of the Hospital, the Board may, in its discretion, obtain the services of a recruiting firm to identify qualified candidates.

3. **Review of Candidates and Selection of New Members.**

a. The Board Liaison will forward the names and resumes of all applicants to the Chair of the Advisory Committee with any vacancy or, if appointed by the Committee, to the members of an Ad hoc Committee for review.
b. At the request of the Chair of the Advisory Committee, current Advisory Committee Members, and the Advisory Committee Chair shall select and interview the final slate of candidates and will recommend the top finalist(s) to the Board.
c. The Board shall appoint the Advisory Committee Member in accordance with the Hospital Bylaws.

4. **Obtaining Approval to Increase the number of Members of an Advisory Committee**

a. If an Advisory Committee Chair proposes to increase the number of Members of such Chair's Advisory Committee, then the Advisory Committee Chair must submit a brief description of the need (e.g., gap in skill-set) for an increase in membership to the Governance Committee.
b. Upon review of the request, the Governance Committee shall make a recommendation to the Board whether the membership of such Advisory Committee should be increased.

.

Proposed Draft Competencies for New Quality Committee Members – For Discussion 4/1/19

Submitted by Julie Kliger, RN, Committee Chair and Mark Adams, MD, CMO

1. Expertise in High Reliability Organizations
2. Data/Technology Background
3. Clinical Informatics
4. Patient Engagement
5. Customer Experience (could be someone outside healthcare but in an industry that excels at this)
6. Innovation Track Record
7. Continuum of Care or Managed Care Expertise

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

El Camino Hospital Patient & Family Advisory Council (PFAC) Charter

September 29, 2015

This charter outlines the structure, function and process for organizing the El Camino Hospital PFAC.

The Patient and Family Advisory Council for El Camino Hospital provides insight and advice to the strategies and initiatives of the organization. Engaging and partnering with patients and families in meaningful ways to provide their firsthand perspectives and experience enables El Camino Hospital to reflect the voice of the diverse services and community we serve in continuous performance improvement. The knowledge of what is important to both those receiving care and those who support the patient is incorporated into the structure, processes, and culture of care provided within the hospital and in community partnerships. Patient and Family Advisors inspire and co-design an enhanced patient and family centered eco-system

I. **PFAC Objectives** – The PFAC will provide relevant recommendations to El Camino Hospital Operations Council, Patient Experience Committee, and Board Quality Committee including, but not limited to:
   - Consultative feedback on various aspects of the care continuum: prevention and wellness, chronic illness management, acute and critical care, end-of-life and/or survivorship care as designated by El Camino Hospital.
   - Review clinical program quality indicators and measures selected by El Camino Hospital to evaluate impact on patient experience.
   - Review and evaluate patient education materials for El Camino Hospital.

II. Assumptions

This charter makes the following key assumptions concerning the purpose and structure of the PFAC.

- A trained facilitator will lead the Patient & Family Advisory Council meetings. Hospital personnel will be present to answer questions and engage in meaningful dialogue, listening first to the opinions of the group.
- El Camino Hospital encompasses all health care services across the continuum of care, from screening and prevention through end-of-life and survivorship.
- El Camino Hospital should be patient-centered and thoughtfully designed to meet patient needs.
- The PFAC represents the voice of the patient and therefore provides a key vehicle for assessing patient needs.
- The PFAC's primary role is to provide feedback and guidance regarding the development of service at El Camino Hospital and ensure patient-centered care.
- The PFAC's role is consultative, but the PFAC does not hold organizational decision rights.
- The PFAC's primary connection to organization leadership is via El Camino Hospital Board Quality Committee and Operations Council.

- El Camino Hospital will provide regular feedback on how the PFAC's recommendations are being utilized.
- The El Camino Hospital will work in close coordination with the PFAC to consistently bring the voice of the patient to decision making.
- This proposal will be reviewed by El Camino Hospital leadership for approval.

III. Council structure and organization.

This section includes a discussion of the composition and function of the PFAC, how PFAC members will be selected and recruited, and the relationship between the PFAC and other El Camino Hospital groups.

A. Council Role and Authority

- **Statement of Purpose** – The PFAC represents the voice of the patient and will provide relevant recommendations to the El Camino Hospital PaCT Steering Committee. The PFAC will help guide clinical program development by providing guidance concerning patient-centered care and share insights so that El Camino Hospital is thoughtfully designed to meet patient needs.
    - Current and former patients and their families guide El Camino Hospital (ECH) to ensure that the care, communication, and education provided meets their individual needs.
    - Patients and their families help develop the relevant and timely information needed before, during and after the care they receive from us.
    - Patients and their families help direct ECH to improve patient and community health status through active engagement and compliance in care.
    - Patients and their families prioritize and identify key aspects of the care experience that are most valued.
    - Patients and their families voice the community perspective and provide input into elements that influence and bolster ECH's reputation.

- **Logistics** -
    - The first meeting for the PFAC is anticipated for September, 2015.
    - The Council will meet every other month, between 5:30 - 7:30 p.m. with dinner provided.
    - Council meetings will rotate between both campuses of ECH and will be conducted in person.

B. PFAC Membership

- **Selection -** Selected PFAC members will have the opportunity to voluntarily apply or may be nominated to apply by an employee of El Camino Hospital.
    - Members will represent patients and families of both Mountain View and Los Gatos Hospitals.
    - In order to serve on the PFAC, members must have had a patient or family

member experience at ECH within the last year.
  - Recognizing that the family perspective is very important, this group will be inclusive of both patients and family member advisors.
  - All interested candidates shall complete a phone screening as well as a written application. Additional interviews may be required.
  - Those candidates most suitable to meet the needs and demands of the PFAC will be asked to join the council.
  - Ideal members are able to provide balance and constructive feedback and able to commit to attending bi-monthly meetings.

- **Compensation -** Members will not be compensated for their time, however meals & parking will be provided.

- **Confidentiality -** Each candidate who is offered a position on the PFAC will sign a confidentiality statement.

- **Number of Members -** The PFAC will consist of 8 - 12 members to allow for a variety of opinions and feedback while remaining small enough to allow everyone to actively participate in the discussion.

- **Membership Term -** Council members will serve a two-year initial term, evolving to a rotating term structure over time to help infuse new perspectives on a more regular basis.

C. **Relationship**
  - **Consultation -** The PFAC may be utilized by other clinical and non-clinical El Camino functioning committees to provide consultative ad hoc feedback on patient experience related topics at El Camino Hospital.

Resources & *References:*

- Linda Frommer, MPH, Veteran and Family Centered Care Coordinator, VA Palo Alto Health Care System, (650) 493-5000 ext. 64258, linda.frommer@va.gov

- Dr. Karen Wayman, Endowed Director of Family Centered Care, Lucile Packard Children's Hospital, 650-498-6410: KWayman@LPCH.org

- The Patient Experience Toolkit, The Advisory Board Company, Nursing Executive Center, 2012
  - Available: http://www.advisory.com/nec Publication #24820

- Developing a Community-Based Patient Safety Advisory Council, AHRQ, 2008
  - Available:https://www.ahrq.gov/research/findings/final-reports/advisorycouncil/index.html

- Patient and Family Advisory CouncilGetting Started Tool Kit, Beryl Institute, 2009
  - Available: https://cdn.ymaws.com/www.theberylinstitute.org/resource/resmgr/webinar_pdf/pfac_toolkit_shared_version.pdf
- Patient and Family Advisory Council 2011 Annual Report, Dana Farber Cancer Institute, 2011
  - Available: https://www.dana-farber.org/for-patients-and-families/becoming-a-patient/patient-safety-and-advocacy/patient-and-family-advisory-councils/adult-patient-and-family-advisory-council/
- Creating Patient and Family Advisory Councils, Institute for Patient and Family Centered Care, 2002
  - Available: http://www.ipfcc.org/resources/Advisory_Councils.pdf
- Advancing PCC Across the Continuum, Planetree, August 2012
  - Available: https://www.rti.org/publication/advancing-pcc-across-continuum-care

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

PFAC Agenda
February 19, 2019

1. Welcome and Introductions of new PFAC members
2. Presentation from Foundation on the Circle of Caring Program
    a. Perception of the community on program
    b. Ways to promote it in a mindful way
    c. Seeking recommendations on the marketing/brochure
3. Presentation from Marketing on the new branding
    a. Seeking feedback and discussion of new website and other materials with the new branding
4. Internal PFAC goal setting for 2019
5. Adjourn

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PFAC Agenda
March 19, 2019

1. Welcome and Introductions of new PFAC members
2. Review of patient satisfaction surveys
    a. Ideas to increase response rate
    b. Focus areas for ECH currently
    c. Process improvement recommendations for Nursing Communication, Cleanliness and Responsiveness.
3. Presentation from iCare team and discussion on ED patient/caregiver secure messaging
4. Continued discussion of internal PFAC goals for 2019
5. Adjourn

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: April 1, 2019
Subject: What is Quality?

Purpose:

To continue the discussion we began at our November 5, 2018 and December 3, 2018 meetings regarding how to define quality.

Summary:

1. Situation: At the Committee's November 5th meeting, we introduced this topic and indicated it was something we would continue to discuss during upcoming meetings. It was deferred from the March 4th meeting due to time constraints.

2. Authority: N/A

3. Background: At a previous meeting, we distributed a "Healthcare Quality Strategy Maturity Model" and asked the Committee members, as well as staff and members of the Medical Staff who regularly attend the Committee meeting to participate in a related survey. Initially, we received responses from 12 of 17 requested participants and asked those who had not responded to please respond. Since that time we also asked the other Members of the Board Directors to respond to the survey. In total, we received eight additional responses.

4. Assessment: For each domain in the survey there was a fairly wide range of responses (2 -4 with one outlier of 5 and 3 outliers of 1). The range of averages for all domains was 2.64 – 3.28 and the average of the averages was 2.99. As noted in the attachment, a response of 3 ("Defined") means activities/behaviors are formally defined and moderately managed (activities/behaviors followed 70-80% of the time). There was no discernable trend based on the type of survey respondent (physician, leader, Committee member, Board member), at least in part because the number of survey participants was low. One Committee member commented that in many instances his/her rating based on a sense of what is happening or bits and pieces that is learned at Committee meetings. Or, there were some qualities, but not all, as defined on the grid, he/she knew about for a certain rating. This Committee member noted that it would be helpful to see evidence to justify the ratings.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Healthcare Quality Strategy Maturity Model
2. Survey Data

Suggested Committee Discussion Questions:

1. What do the survey results tell us about the maturity of ECH's quality strategy?
2. Is it possible the results tell us more about perceptions than actual maturity?

Alvarez & Marsal's Healthcare Quality Strategy Maturity Model

Dimension	Description	INITIAL [1]	MANAGED [2]	DEFINED [3]	QUANTITATIVELY MANAGED [4]	OPTIMIZED [5]
		Activities/behaviors are not defined	**Activities/behaviors are commonly performed but in an adhoc and reactive manner with large variation**	**Activities/behaviors are formally defined and moderately managed (activities/behaviors followed 70-80% of the time)**	**Activities/behaviors are proactively managed and measured according to defined standards (activities/behaviors followed 80%+ of time)**	**A consistent process exists where activities and behaviors are reviewed and improved upon. Innovation occurs to establish new frontiers**
Leadership and Culture	• Role(s) of Leader(s) is/are clear to others. • Leader has set clear objectives to align the organization to its vision, mission, strategy and core values in quality **Key Themes:** • Vision/Mission/Strategy/Core values • Communication of quality goals • Priority of creating a quality plan • Quality defined	• No organizational vision, mission, strategy and core values related to quality • Quality is not a top priority • Leadership communication on quality performance does not exist • No common definition of quality exists	• Inconsistent organizational vision, mission, strategy and core values related to quality • Quality is only a priority when there are problems with reputation, funding, accreditation, or resource requests (single item issues and not strategic items) • Leadership communication on quality performance is inconsistent/adhoc • Varying views exist of what quality means in the organization	• Vision, mission, strategy and core values on quality are established and the organization is aware • Quality is a priority but no plan exists for an organization-wide quality program • Leadership communication on quality is delivered on a need basis • Organization is in alignment with the definition of quality	• Vision, mission, strategy and core values on quality are routinely communicated and goals are established related to the vision • Quality is a leadership priority, a plan is in place, and measurements are being used to determine efficacy of quality • Leadership communication on quality is consistently delivered and measured for effectiveness (surveys, open rates, adoption rates, etc...) •Organization understands the drivers of quality improvement and leaders hold the organization accountable to quality	• Vision, mission, strategy, and core values on quality are revisited on a predetermined time horizon • Results from measuring quality plan are used to identify improvements • Communication is altered to adapt to staff preferences and changing needs • Definition of quality is revisited to ensure it is relevant to the organization's vision, mission, strategy, and core values
Organizational Integration	• Shared governance of clinical activities across all Physicians, Nurses and other Service Lines • Vertical and horizontal accountability • Physician Alignment with organization's goals **Key Themes:** • Collaboration/ shared goals around quality measures • Transparency and accountability • Decision making (linked and aligned work streams)	• Collaboration is not encouraged and staff do not engage others in decision making or sharing best practices in delivering quality • No forum for collaboration exists at a department/unit/service line or organization/system-wide level	• Ad hoc collaboration takes place (hallway conversations), but drive minimal improvements • Discussions exist across services lines but with no defined follow-through • Department/unit/service line discussions on quality exists inconsistently and only on a need basis	• Pockets of collaboration exists (e.g., some clinical pathways, high performing units) • Just developing organization-wide view of shared responsibilities and sharing of best practices exist in achieving positive outcomes. • Formal department/unit/service line meetings are established and consistently held to drive improvements in quality	• Formal collaboration meetings are held department/unit/service line- wide, as well as organization-wide and yielding measurable improvements in quality	• Leadership reviews output from collaboration meetings and makes needed changes to improve quality across all lines of service • Leadership uses collaboration meetings to spur new ideas and innovation
Performance Improvement Methodology	• Common view (mental model) and operational model for executing change across organization. • Process of creating a ongoing practice of improving quality across the organization **Key Themes:** • Methodology for ongoing improvements	• Performance improvement methodologies do not exist • Staff make no efforts at improvements and performance improvement has a negative connotation	• Performance improvement methodologies are not widely known or understood • Improvement efforts are made ad hoc based on immediate needs • Some unit-based improvement efforts exist but are not consistently enforced or followed	• Leadership committed to an organization-wide approach and has set organization-wide goals • Performance methodologies are defined, deployed and managed across the organization	• Performance methodologies adoption and effectiveness are tracked • Feedback and best practice sharing is encouraged on performance improvement methodology • Policy and protocol deviation evaluated • Feedback about performance and continuing education	• Consistent review process for performance improvement methodologies are in place and changes are made where necessary or new methodologies are incorporated in the practice • Metrics are used to help improve the practice
Policy and Procedure Management	• A defined, executed and measured series of actions to deliver clinical quality through the management of clinical policies and protocols **Key Themes:** • Define, create accountability and measure for clinical quality policy and procedures	• There is no standardization or automation of processes (e.g., clinical pathways) • No policies and procedures exist or they exist and no knows where to find them, or not followed • Staff is left to determine their own method • No accountability for use or non-use of P&P	• There are some standardization and automation of processes but there is an adhoc approach to execution or adoption • Policies and procedures exist but poor adoption • Little accountability for staff to follow policies and procedures • Individuals who are held responsible lack the appropriate authority	• Processes are generally standardized and adhered to • Policies and procedures are well defined documented and followed throughout the organization • People are held accountable to policies and procedures • The appropriate people are held responsible and have appropriate authority	• Breaks in standards or possible deviations from standards are tracked and evaluated for revision root cause analysis and possible policy revision • Policies and procedures are routinely reviewed and evaluated for alignment with best practice • Process automation exists throughout the organization	• Based on best practices, lessons learned and outcomes, processes are revised and improved upon • A formal process is in place for process revision, ownership, testing and execution • All deviations evaluated with positive deviance deeply understood
Training and Learning	• Necessary training and learning opportunities delivered to aid in effective delivery of quality **Key Themes:** • Formal education/training/learning	• No training and learning opportunities exist	• Training and learning opportunities exist but quality varies and inconsistently used or organization does not provide the time for staff to take training	• Training and learning opportunities are available and valued as a skill development resource • Training is delivered to the appropriate service lines • Training supports strong adoption of quality performance drivers • Reinforcement training provided on a continual basis • Tools (guides, aids, etc…) are provided to support the training	• Continuous learning and education are in place to ensure most current evidence based practices are occurring • Training participation and achievements are tracked • Surveys or assessments are created for staff to gauge the effectiveness of training and learning opportunities • Follow-up and reinforcement training provided on a consistent basis	• Metrics are tracked and used on a regular basis to improve overall training and yield innovative approaches and improvements to quality • Materials and learning opportunities are reviewed, updated and continuously improved upon
Data Measures and Management	• Collecting, tracking and use of metrics to drive improvements • Managing data to advance quality **Key Themes:** • Data Timing • Data Type • Data Use • Data Stakeholders • Data Integrity	• Little to no data are used to inform or drive improvements • Data that are used are not defined or relevant in driving strategic goals or improvements in quality and lacking insight (i.e., lagging indicators) • Front-line staff or physicians are not informed of important stats/metrics (e.g., LWBS, sepsis rates) • Poor quality/integrity to the data. data are not believed ("my patients are sicker" mindset) • Industry performance benchmarks are not being met	• Data are generated on demand and are used for regulatory purposes only (external) • Data delivery method has an inconsistent format providing an incomplete picture • Appropriate stakeholders are not always updated on the metrics • Industry performance benchmarks are being inconsistently met for some elements	• Data generation is managed and aligns to the strategy • Data have a consistent format and delivery schedule • Stakeholders are regularly provided metrics • Industry performance benchmarks are being mostly met and showing continuous improvements in multiple benchmarks	• Data generate relevant information that is easily tailored to interest areas of stakeholders • Data are insightful with leading indicators to help in decision making or a course of action • Data are used to drive improvements • Industry performance benchmarks are being met in all categories	• Process is in place to review data to ensure it is relevant with any changes in the industry, and modifications are made if necessary '• Input and feedback is continuously obtained from stakeholders to ensure that reporting meets stakeholder needs. • Industry performance benchmarks are consistently being met in all categories year over year

Definition of Quality:
IOM- Lowering Mortality • Effectiveness • Safety • Equity • Efficiency • Patient Centered
Triple Aim- Patient Centered • Population Health • Lower Cost
Rate of Improvement- Improving Externally Reporting Metrics • Innovative • Reputation/ Name Recognition

Responses to Quality Maturity Model Survey

20 of 24 Requested Participants

Mix of Board Members, Committee Members, Physicians and ECH Leadership Responded

Rating	1	1.25	1.5	1.75	2	2.25	2.5	2.75	3	3.25	3.5	3.75	4	4.25	4.5	4.75	5	Average
Domain																		
Leadership and Culture	1				2		1		7		2	1	6					3.16
Organizational Integration	1				2		2		12		2		1					2.70
Performance Improvement Methodology					3			1	7		2		6				1	3.27
Policy and Procedure Management					6		1	1	6		1		5					2.94
Training and Learning	1				5	1	2		5		1		4					2.64
Data Measures and Management					1	1	1		8		2	1	6					3.28

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: April 1, 2019
Subject: Value Based Purchasing Report

Purpose:

Review the contributing components of the Value Based Purchasing Program

Review the El Camino scores for FY 2019 and financial impact

Review the El Camino projected scores for FY 2020 and financial impact

Summary:

1. Situation: N/A

2. Authority: N/A

3. Background: Value Based Purchasing is a CMS program designed to improve hospital quality performance. It allows for an up to a 2% penalty or up to a 2% gain in Medicare payments. Based on an historical baseline period which is then compared to a performance period, the future Federal Fiscal Year payments are adjusted accordingly.

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

Value-Based Purchasing Report Powerpoint

Suggested Committee Discussion Questions:

1. Where are we doing well and what are the areas of opportunity?

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Value-Based Purchasing Report

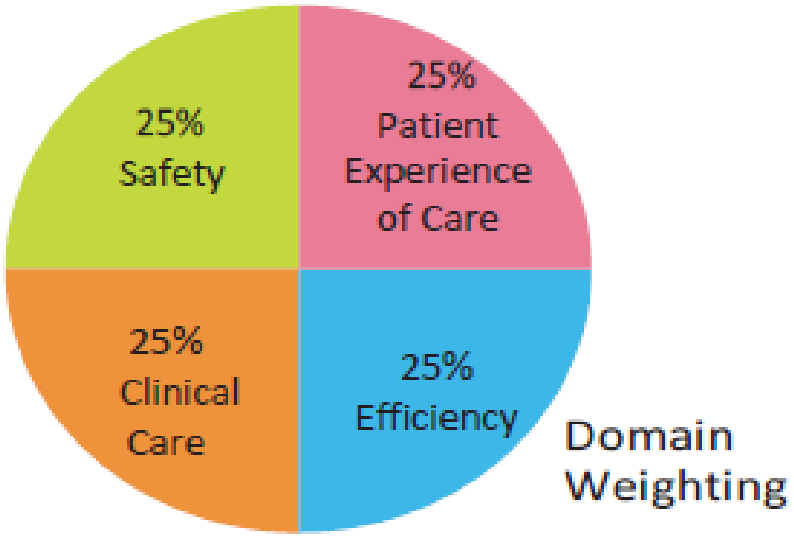
Quality Committee

Mark Adams, MD, Chief Medical Officer

April 1st, 2019

FY 2019 Hospital Value-Based Purchasing
FFY 2019 (October 1, 2018)

Base Operating DRG Payments	Withhold Amount/ % of revenue -2.00%	Bonus Amount/ +1.71%	Net Impact / -0.30%	Estimated Total Score
$79,240,876	$1,584,818	$1,351,057	-233,761	28.2



Safety

Safety (25% of Total Performance Score) **Domain Score = 36.67**			
Baseline period		Performance period	
PSI-90: 7/2010–6/2012 All others: CY 2015		PSI-90: 7/2014–9/2015 All others: CY 2017	
Description	Threshold	Performance vs Threshold	Benchmark
Catheter-Associated UrinaryTract Infection	0.464	0.939	0.000
Central Line-Associated Blood Stream Infection	0.427	0.387	0.000
Clostridium difficile Infection	0.816	0.679	0.013
Methicillin-Resistant *Staphylococcus aureus* Bacteremia : HO LabID	0.823	0.860	0.000
Surgical Site Infection Colon Abdominal Hysterectomy	0.832 0.698	0.446 0.732	0.000 0.000
Complication/patient safety for selected indicators (composite)	0.840335	0.541799	0.589462
Elective Delivery Prior to 39 Completed Weeks Gestation	0.010038	0.000	0.000

Infections are SIRs. PSI-90 is a score and PC-01 is a rate. Lower is better for all measures.
**Threshold values will be modified when re-baseline data is released.*

Patient Experience of Care

Patient Experience of Care (25% of Total Score) Domain Score = 37.00			
Baseline period		Performance period	
CY 2015		CY 2017	
Description	Performance (%)	Threshold (%)	Benchmark (%)
Communication with Nurses	79%	78.69	86.97
Communication with Doctors	82%	80.32	88.62
Responsiveness of Hospital Staff	64%	65.16	80.15
Pain Management	76%	70.01	78.53
Communication about Medicines	66%	63.26	73.53
Hospital Cleanliness and Quietness	67%	65.58	79.06
Discharge Information	86%	87.05	91.87
Care Transitions	54%	51.42	62.77
Overall Rating of Hospital	77%	70.85	84.83

Higher is better for all scores.

Clinical Care

Clinical Care (25% of Total Performance Score) **Domain Score = 40.00**				
Baseline period			Performance period	
Mort - 10/2009–6/2012			7/2014–6/2017	
THA/TKA Complications - 7/1/2010–6/2013			1/2015–6/2017	
Measure ID	Description –Survival Rate	Threshold %	Performance vs Threshold	Benchmark %
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate	85.0671	87.7	87.3263
MORT-30-HF	Heart Failure (HF) 30-day mortality rate	88.3472	88.6	90.8094
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	88.2334	83.3	90.7906
THA/TKA	PrimaryTHA/TKA complication rate	3.2229	2.8	2.3178

Measures expressed as survival rates (higher is better).

Efficiency

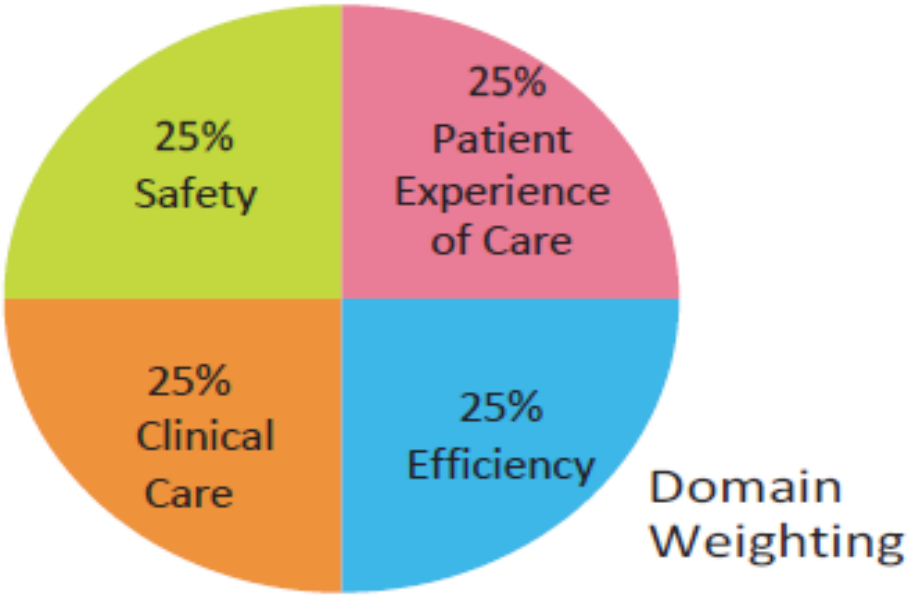
Efficiency (25% of Total Performance Score) **Domain Score = 0.00**				
Baseline period			Performance period	
CY 2015			CY 2017	
Measure ID	Description	Threshold	Performance	Benchmark
MSPB-1	Medicare Spending per Beneficiary	Median MSPB ratio hospitals during performance period 0.99	1.00	Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.844

Lower is better for all scores.

Adapted by Qualis Health from materials provided by Stratis Health and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the U.S. Department of Health and Human Services.

FY 2020 Hospital Value-Based Purchasing
FFY2020 (10/1/2019)

Base Operating DRG Payments	Withhold Amount/ % of revenue -2.00%	Bonus Amount/ +1.71%	Net Impact / -0.34%	Estimated Total Score
$91,362,923	$1,827,258	$1,514,340	312,918	27.63



Safety

Safety (25% of Total Performance Score) **Domain Score = 15**			
Baseline period		Performance period	
HAI: CY 2016		HAI: CY 2018	
Description	Threshold	Performance vs Threshold	Benchmark
Catheter-Associated UrinaryTract Infection	0.83	1.30	0.000
Central Line-Associated Blood Stream Infection	0.78	0.59	0.000
Clostridium difficile Infection	0.85	0.77	0.09
Methicillin-Resistant *Staphylococcus aureus* Bacteremia : HO LabID	0.82	0.73	0.000
Surgical Site Infection Colon Abdominal Hysterectomy	0.78 0.72	0.55 1.12	0.000 0.000
Surgical Site Infection Composite	N/A	N/A	N/A
PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation	0.010038	2.0	0.000

Infections are SIRs. Lower is better for all measures.
**Threshold values will be modified when re-baseline data is released.*

Patient Experience of Care

Patient Experience of Care (25% of Total Score) **Domain Score = 38.00**			
Baseline period		Performance period	
CY 2016		CY 2018	
Description	Performance (%)	Threshold (%)	Benchmark (%)
Communication with Nurses	80%	79.08	87.12
Communication with Doctors	82%	80.41	88.44
Responsiveness of Hospital Staff	65%	65.07	80.14
Communication about Medicines	66%	63.30	73.86
Hospital Cleanliness and Quietness	67%	65.72	80.14
Discharge Information	87%	87.44	92.11
Care Transitions	54%	51.14	62.50
Overall Rating of Hospital	78%	71.59	85.12

Higher is better for all scores.

Clinical Care

Clinical Care (25% of Total Performance Score) **Domain Score = 57.5**				
Baseline period			Performance period	
Mort - 7/2010–6/2013			7/2015–6/2018	
THA/TKA Complications - 1/1/2011–6/2014			1/2016–6/2018	
Measure ID	Description - Mortality Rate	Threshold %	Performance vs Threshold	Benchmark %
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate	0.15	0.11	0.12
MORT-30-HF	Heart Failure (HF) 30-day mortality rate	0.12	0.11	0.09
MORT-30-PN	Pneumonia (PN) 30-day mortality rate	0.12	0.15	0.09
THA/TKA	PrimaryTHA/TKA complication rate	0.03	0.02	0.02

Efficiency

Efficiency (25% of Total Performance Score) Domain Score = 0.00				
Baseline period			Performance period	
CY 2016			CY 2018	
Measure ID	Description	Threshold	Performance	Benchmark
MSPB-1	Medicare Spending per Beneficiary	Median MSPB ratio hospitals during performance period 0.99	1.02	Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.84

Lower is better for all scores.

Adapted by Qualis Health from materials provided by Stratis Health and prepared under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the U.S. Department of Health and Human Services.

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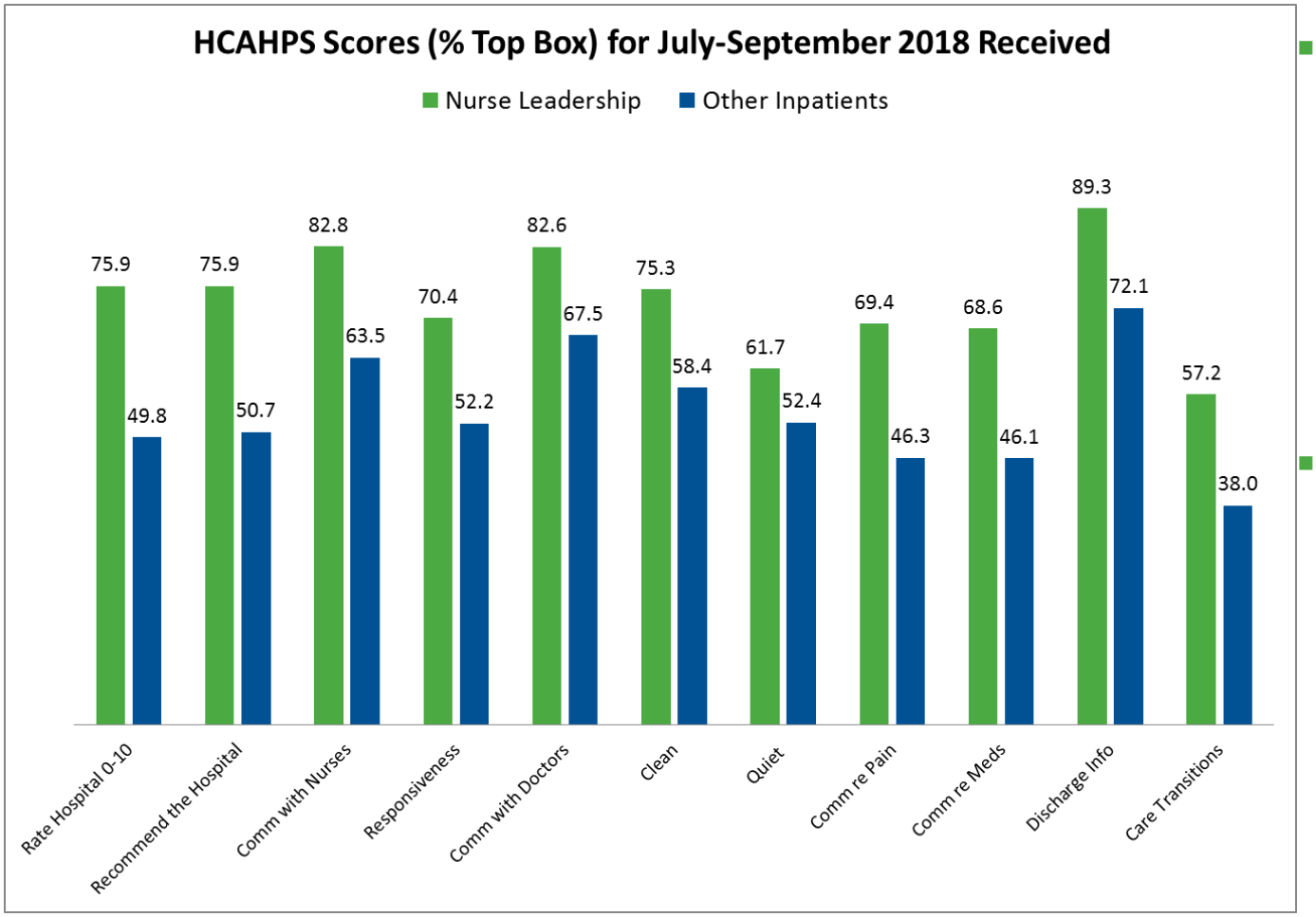
Patient Experience
April 2019

Leader Rounding—Purpose

Rounding on patients helps ensure good outcomes, learn what we are doing right and what could be improved upon. Rounding on staff helps us learn how to support them better.

Impact of Nurse Leader Rounding on HCAHPS Domains

National Database – Q3 2018



- When patients are Visited by Nursing Leadership, hospitals' Top Box scores are higher across all HCAHPS domains.
- Nationally, for Q3 2018, Visited by Nursing Leadership had the greatest impact on "Rate Hospital 0-10" and "Recommend the Hospital."

Top Box by Received Date, n=155,841

It Takes a Village…

- We've heard from many managers that they feel like a one person band responsible for everything but the kitchen sink! (And it's leaking…)
- Our goal is to support you:
  - Establish rounding teams to create an "adopt a unit" model
  - Ensure that 80% of our patients have at least one round documented before discharge (currently at 5%)

Team Rounds

- Process
  - Each team will round daily - meet at the VIS Board
    - Review rounds completed yesterday & update VIS Board, discuss any open issues, get assignments off of the patient list
    - Rounding priorities:
      - New patients
      - Patients soon to be discharged
      - Those needing service recovery or special needs
      - Those not yet rounded on or not rounded on yesterday
- Time allotment – Protected time from 11 am-12:30 pm daily
  - Rounding will take approximately 60-75 minutes
    - Goal will be to interact with at least 4-5 patients and 1-2 staff members daily
  - Follow-up should take approximately 15 minutes

Questions & Approach – Patients, Family & Staff

- Conversations vs. interviews/surveys
- Focus on open-ended responses vs. yes/no answers
- Tell me more about that…
- Trying to get a "take away"
  - Something to follow up on
  - A kudo to share with a staff/WOW
  - A constructive piece of feedback

If the Patient is Unavailable…

Leadership Rounding

As leaders of this hospital, we visit all of our patients to ensure they are receiving exceptional care during their stay with us.

Our goal is to provide our patients and families with an extraordinary, personalized experience and ensure their needs are being met. I would welcome your comments or any concerns you would like to share with us. Please feel free to contact me. You can also share some comments on the back of this card and give it to your nurse to share with me.

Leader: _____

Phone: _____

Thank you for trusting us with your care.

**If you have an immediate concern, please let your charge nurse know.*

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Notes/Questions:

Data From First 3 Days

- Rounded upon in week prior to rounding plan implementation:

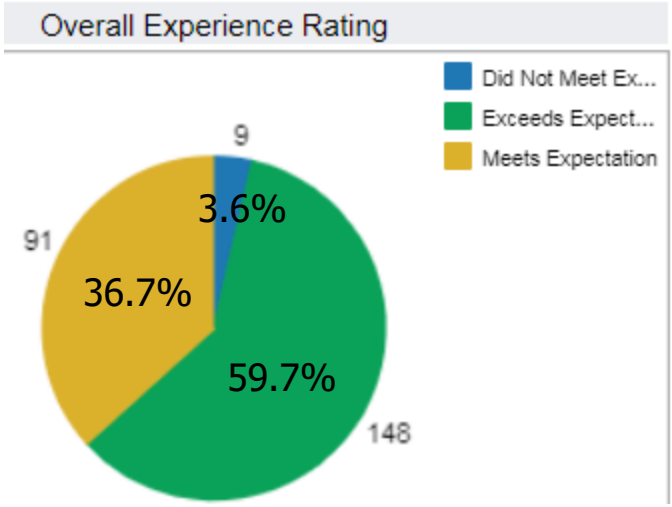
Date Selection	Start Date	End Date	Facility Name	Group Name	Unit Name	Round Type
Custom	3/11/2019	3/13/2019	(All)	Other	(Multiple values)	Leader Round

- Rounded upon in week of rounding plan implementation:

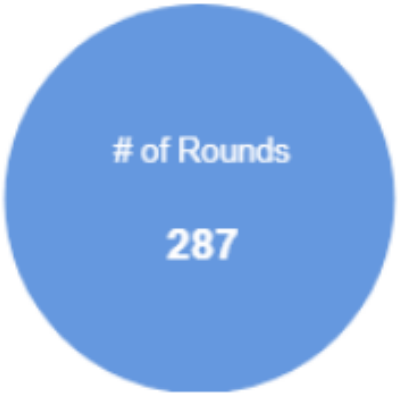
Date Selection	Start Date	End Date	Facility Name	Group Name	Unit Name	Round Type
Custom	3/18/2019	3/20/2019	(All)	Other	(Multiple values)	Leader Round

Percentage of Discharged Patients Who Were Rounded Upon 3/18-3/20

- Average Percentage of Discharged Patients from 3/1-3/17 = **7.93%**
- Average Percentage of Discharged Patients from 3/18-3/20 = **31.97%**



Date Selection	Start Date	End Date	Facility Name	Group Name	Unit Name	Round Type
Custom	3/18/2019	3/20/2019	(All)	Other	(Multiple values)	Leader Round



Comments From Patient Rounds 3/18-3/20

- "ECH is a phenomenal hospital"
- Patient upgraded expectation rating from yesterday as she feels the staff are truly caring about her and addressing her concerns. She states she is internally struggling with the changes in her medications and health care plan.
- "Better experience this time, great service and follow up on my concerns"
- "The entire team that cared for me was excellent. They picked up that our daughter was in trouble and acted quickly."
- Sometimes not clear on what CNA do versus what nurses do. If she knew from the beginning who is responsible for what then she could ask the right person

Patient Family Advisory Council (PFAC)

- Past patients and family members
- Meets throughout the year
- Currently 10 members from various backgrounds and experiences
- Purpose is to:
  - Shape change throughout the hospitals
  - Improve the patient experience
  - Participate in forming policies and standards
  - Review forms and educational materials

FY 2019 PFAC Accomplishments

- Review of the El Camino Hospital Mobile App
  - Changes made based on feedback from PFAC
- Input into LifeLink project and EPIC texting in the Emergency Department
- Help with ideas generated from the organizational goal sub-committees
- Feedback on online bill estimator
- Review of the "Hello/Goodbye" folder
- Sit on various hospital committees:
  - Pharmacy and Therapeutics
  - ED Steering
  - Patient Experience Steering

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Proposed FY20 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

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

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

GOALS	TIMELINE	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY19 Achievement and Metrics for FY20 (Q1 FY20) - FY21 Goals (Q3 – Q4)	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline –
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management –
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals

SUBMITTED BY:

Chair: Julie Kliger, RN
Executive Sponsor: Mark Adams, MD, CMO