El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

Quality, Patient Care and Patient Experience Committee Meeting of the El Camino Hospital Board

Monday, June 5th, 2017, **5:30 p.m.**
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Melora Simon will be participating via teleconference from 107 Crescent Ave, Portola Valley, CA 94028

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**	Jeffrey Davis, MD, Quality Committee Member		**5:30 – 5:31pm**
2.	**ROLL CALL**	Jeffrey Davis, MD, Quality Committee Member		**5:31 – 5:32**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Jeffrey Davis, MD, Quality Committee Member		**5:32 – 5:33**
4.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Jeffrey Davis, MD, Quality Committee Member	*public comment*	**Motion Required 5:33 – 5:36**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (May 1, 2017) ***Information*** b. Research Article c. Patient Story d. FY17 Pacing Plan			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Jeffrey Davis, MD, Quality Committee Member		**Discussion 5:36 – 5:39**
6.	**QUALITY PROGRAM UPDATE: NICU** **ATTACHMENT 6**	Dharsi Sivakumar, MD, Medical Director, NICU		**Discussion 5:39 – 5:59**
7.	**FY17 QUALITY DASHBOARD** **ATTACHMENT 7**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 5:59 – 6:14**
8.	**PATIENT AND FAMILY ADVISORY COUNCIL UPDATE** **ATTACHMENT 8**	Cheryl Reinking, RN, Chief Nursing Officer; Michelle Gabriel, Director, Performance Improvement		**Discussion 6:14 – 6:24**
9.	**PROPOSED FY18 PACING PLAN** **ATTACHMENT 9**	Jeffrey Davis, MD, Quality Committee Member	*public comment*	**Possible Motion 6:24 – 6:29**
10.	**UPDATE ON FY18 COMMITTEE GOALS** **ATTACHMENT 10**	William Faber, MD, Chief Medical Officer		**Discussion 6:29 – 6:39**

A copy of the agenda for the Regular Committee 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
11.	**DRAFT FY18 ORGANIZATIONAL GOALS** **ATTACHMENT 11**	Mick Zdeblick, Chief Operating Officer	*public comment*	**Possible Motion** **6:39 – 6:49**
12.	**PUBLIC COMMUNICATION**	Jeffrey Davis, MD, Quality Committee Member		**Information** **6:49 – 6:52**
13.	**ADJOURN TO CLOSED SESSION**	Jeffrey Davis, MD, Quality Committee Member		**Motion Required** **6:52 – 6:53**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Jeffrey Davis, MD, Quality Committee Member		**6:53 – 6:54**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.* ***Approval*** *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (May 1, 2017) ***Information*** b. Quality Council Minutes (April 5, 2017)	Jeffrey Davis, MD, Quality Committee Member		**Motion Required** **6:54 – 6:57**
16.	*Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - CMO Report	William Faber, MD, Chief Medical Officer		**Discussion** **6:57 – 7:02**
17.	*Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - Review Draft Management of Serious Safety Events and Red Alert Patient Safety Events Policy	Shreyas Mallur, MD, Associate Chief Medical Officer; William Faber, MD, Chief Medical Officer		**Discussion** **7:02 – 7:12**
18.	*Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - Red/Orange Alert and RCA Updates	William Faber, MD, Chief Medical Officer		**Discussion** **7:12 – 7:22**
19.	**ADJOURN TO OPEN SESSION**	Jeffrey Davis, MD, Quality Committee Member		**Motion Required** **7:22 – 7:23**
20.	**RECONVENE OPEN SESSION/REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Jeffrey Davis, MD, Quality Committee Member		**7:23 – 7:24**
21.	**ADJOURNMENT**	Jeffrey Davis, MD, Quality Committee Member		**Motion Required** **7:24 – 7:25pm**

Upcoming FY 18 Meetings (*tentative upon Board approval)*

- August 7, 2017
- August 28, 2017
- October 2, 2017
- October 30, 2017
- December 4, 2017
- February 5, 2018
- March 5, 2018
- April 2, 2018
- April 30, 2018
- June 4, 2018

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, May 1, 2017
El Camino Hospital, Conference Rooms E&F
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder; Peter Fung, MD; Jeffrey Davis, MD; Diana Russell, RN; Nancy Carragee, Mikele Bunce, Wendy Ron, Katie Anderson, and Melora Simon.	Alex Tsao Robert Pinsker, MD	None

**Melora Simon joined the meeting at 5:41pm*
**Wendy Ron joined the meeting at 5:43pm*
**Mikele Bunce left the meeting at 6:55pm*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 1st of May, 2017 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Committee Chair Dave Reeder at 5:36 p.m.	
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Mick Zdeblick, Chief Operating Officer, introduced Michelle Gabriel, Director of Performance Improvement	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member may have a conflict of interest with any of the items on the agenda. No conflict of interest was reported.	
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (April 3, 2017). **Movant:** Davis **Second:** Anderson **Ayes:** Anderson, Bunce, Carragee, Davis, Fung, Reeder, Russell **Noes:** None **Abstentions:** None **Absent:** Pinsker, Ron, Simon,Tsao **Excused:** None	***Consent Calendar approved***

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Agenda Item	Comments/Discussion	Approvals/Action
	Recused: None	
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and highlighted the Board's current priorities to include: • The Board and Leadership Team are revising the Strategic Plan with the help of a consultant. • CEO interviews will be occurring this week for anticipated permanent CEO selection. • The District Board will consider revising the Hospital Board structure and adding additional subject matter experts at a Special Meeting on May 15th. Public comment is encouraged.	
6. QUALITY PROGRAM UPDATE: VASCULAR SURGERY	Tej Singh, MD, Medical Director, Vascular Surgery, updated the Committee on the accomplishments of the Vascular Surgery program. Dr. Singh reported that El Camino Hospital provides an excellent facility and nursing care to the community. He highlighted that the program's safety on aortic and cost control of AAA (Abdominal Aortic Aneurysm) surgery is recognized nationally as pioneering. He explained our newly expanding Wound Care Services program as an important community resource. Dr. Singh asked for feedback and questions from the Committee and a brief discussion ensued.	
7. FY17 QUALITY DASHBOARD	Catherine Carson, RN, Sr. Director of Quality Improvement and Patient Safety reviewed the newly annotated FY17 quality dashboard with the committee. Ms. Carson discussed the ongoing challenge of falls prevention and highlighted a new initiative to provide patients with pajamas that have cuffs to prevent tripping. Cheryl Reinking, RN, CNO, explained that nursing staff is receiving ongoing education around remaining with patients at high risk for falls while toileting. Ms. Carson reported that pain reassessment scores are improving and an enterprise-wide pain management pharmacist will be added to the staff this summer. Other Metrics: med errors are well under baseline; length of stay is below benchmark and has stayed under control for the last 3-4 months; the readmission rate is the lowest in the community; we are above goal for the sepsis metric due to operationalization of a new ED protocol. The Committee had a lengthy discussion about surgical site infections and asked the team to bring back comparator groups to provide some context for developing a reasonable goal. Ms. Carson also reported that HCHAPS scores are better for February (communication with nurses = 80.9; staff responsiveness = 73.6; pain management = 79.2; and	

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Agenda Item	Comments/Discussion	Approvals/Action
	communication about medication = 77.1) than the January scores reflected in the version of the dashboard presented. Dr. Faber advised the committee he plans to start looking at longer trend lines in an effort to evaluate the long-term sustainability of corrective initiatives.	
8. PROPOSED FY18 QUALITY COMMITTEE DATES	The Committee discussed the proposed FY18 Committee Dates including the new dates of August 7, 2017, October 30, 2017, and April 30, 2018. Chair Reeder explained the changes are due to the time frame with the corresponding Hospital Board Meetings. **Motion:** To recommend that the Board approve the FY18 Quality Committee Meeting Dates. **Movant:** Fung **Second:** Simon **Ayes:** Anderson, Bunce, Carragee, Davis, Fung, Simon, Reeder, Ron, Russell **Noes:** None **Abstentions:** None **Absent:** Tsao, Pinsker **Excused:** None **Recused:** None	***Proposed FY18 Quality Committee Dates approved***
9. DRAFT FY18 ORGANIZATIONAL GOALS	Mick Zdeblick, COO, reviewed the Proposed FY18 Organizational Goals to include: 1. Arithmetic Observed LOS Average/Geometric LOS expected for Medicare population (ALOS / GMLOS) 2. HCAHPS Service metric: Rate the Hospital 3. Culture of Safety: Percent improvement in staff perception of culture of safety Mr. Zdeblick reviewed the proposed FY18 organizational goals which follow ECH's standard format - the first is performance to budget, the next three are modeled on the Triple Aim. For affordability/cost effectiveness, a new goal of improving inpatient utilization for Medicare patients of average length of stay over predicted length of stay (GMLOS) was proposed. This goal captures improvements in both length of stay and accuracy of clinical documentation and received the committee's support. The proposed patient service goal is improvement of HCAHPS performance on "rate the hospital." The committee also supported this goal in concept, at least in part because it brings in all departments, but asked management to bring back further information about actual measurement. The proposed quality goal would measure an improvement in the Culture of Safety, based on AHRQ survey results that will be available on May 9th. A customized methodology to measure improvement was discussed and there are technical issues to be worked out. Staff will come back with a revised goal, pending analysis of	***FY18 Organizational Goals recommended for approval***

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Agenda Item	Comments/Discussion	Approvals/Action
	AHRQ survey results.	
10. COMMITTEE MEMBERSHIP	Chair Reeder asked if the Committee members wished to continue to serve on the Committee in FY18. Diana Russell is declining to serve on the committee for FY18 due to other commitments. All other members expressed that they would like to serve. The Committee is hoping to recruit 2 "patient representative" members.	***Committee list to be provided to the Board Chair***
11. PUBLIC COMMUNICATION	None.	
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:19 p.m. **Movant:** Carragee **Second:** Anderson **Ayes:** Anderson, Carragee, Davis, Fung, Reeder, Ron, Russell, Simon **Noes:** None **Abstentions:** None **Absent:** Bunce, Pinsker and Tsao **Excused:** None **Recused:** None	***Adjourned to closed session at 7:19pm.***
13. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:26 pm. *Agenda Items 13 – 15 were addressed in closed session.* Chair Reeder reported that the Closed Session Minutes of the April 3, 2017 Quality Committee Meeting were approved.	
14. AGENDA ITEM 17 ADJOURNMENT	The meeting was adjourned at 7:28pm. **Motion:** To adjourn at 7:28 p.m. **Movant:** Fung **Second:** Davis **Ayes:** Anderson, Carragee, Davis, Fung, Reeder, Ron, Russell, Simon **Noes:** None **Abstentions:** None **Absent:** Bunce, Pinsker and Tsao **Excused:** None **Recused:** None	***Meeting adjourned 7:28pm***

Attest as to the approval of the foregoing minutes by the Quality Committee and by the Board of Directors of El Camino Hospital:

_____

Dave Reeder
Chair, ECH Quality, Patient Care and
Patient Experience Committee

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Neonatology and Neonatal Intensive Care Unit

Neonatology is a subspecialty of pediatrics that consists of the medical care of newborn infants, especially the ill or premature newborn infant. It is a hospital-based specialty, and is usually practiced in neonatal intensive care units (NICUs).

In the United States, a neonatologist is a physician (MD or DO) practicing neonatology. The principle patients of neonatologists are newborn infants who are ill term infants or Preterm infants requiring special medical care. To become a neonatologist, the physician initially receives training as a pediatrician, then completes an additional training called a fellowship (for 3 years in the US) in neonatology. In the United States of America most, but not all neonatologists, are board certified in the specialty of Pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics and in the sub-specialty of Neonatal-Perinatal Medicine also by the American Board of Pediatrics. Most countries now run similar programs for post-graduate training in Neonatology, as a sub specialization of pediatrics.

While high infant mortality rates were recognized by the British medical community at least as early as the 1860s, modern neonatal intensive care is a relatively recent advance. In 1898 Dr. Joseph De Lee established the first premature infant incubator station in Chicago, Illinois. The first American textbook on prematurity was published in 1922. In 1952 Dr. Virginia Apgar described the Apgar score scoring system as a means of evaluating a newborn's condition. It was not until 1965 that the first American newborn intensive care unit (NICU) was opened in New Haven, Connecticut and in 1975 the American Board of Pediatrics established sub-board certification for neonatology.

The 1950s brought a rapid escalation in neonatal services with the advent of mechanical ventilation of the newborn. This allowed for survival of smaller and smaller newborns. In the 1980s, the development of pulmonary surfactant replacement therapy further improved survival of extremely premature infants and decreased chronic lung disease, one of

the complications of mechanical ventilation, among less severely premature infants. In 2006 newborns as small as 450 grams and as early as 22-week gestation have a chance of survival. In modern NICUs, infants weighing more than 1000 grams and born after 27-week gestation have an approximately 90% chance of survival and the majority have normal neurological development.

Neonatal Intensive Care Units (NICU) now concentrate on treating very small, premature, or congenitally ill babies. Some of these babies are from higher-order multiple births, but most are still single babies born too early. Premature labor, and how to prevent it, remains a perplexing problem for doctors. Even though medical advancements allow doctors to save low-birth-weight babies, it is almost invariably better to delay such births.

Over the last 10 years or so, NICU's have become much more 'parent-friendly', encouraging maximum involvement with the babies. Routine gowns and masks are gone and parents are encouraged to help with care as much as possible. Cuddling and skin-to-skin contact, also known as Kangaroo care, are seen as beneficial for all but the frailest (very tiny babies are exhausted by the stimulus of being handled; or larger critically ill infants). Less stressful ways of delivering high-technology medicine to tiny patients have been devised: sensors to measure blood oxygen levels through the skin, for example; and ways of reducing the amount of blood taken for tests.

Neonatal Intensive Care Unit (Level III)

The 2004 AAP guidelines subdivided Level III units into 3 categories (level IIIA, IIIB & IIIC). Level III units are required to have pediatric surgeons in addition to care providers required for level II (pediatric hospitalists, neonatologists, and neonatal nurse practitioners) and level I (pediatricians, family physicians, nurse practitioners, and other advanced practice registered nurses). Also, required provider types that must either be on site or at a closely related institution by prearranged consultative agreement include pediatric medical subspecialists, pediatric anesthesiologists, and pediatric ophthalmologists. In addition to providing the care and having the capabilities of level I and level II nurseries, **level III neonatal intensive-care units** are able to,

- Provide sustained life support
- Provide comprehensive care for infants born <32 wks gestation and weighing <1500 g
- Provide comprehensive care for infants born at all gestational ages and birth weights with critical illness
- Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists
- Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide
- Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography

The NICU environment provides challenges as well as benefits. Stressors for the infants can include continual light, a high level of noise, separation from their mothers, reduced physical contact, painful procedures, and interference with the opportunity to breastfeed. Many measures have been developed to improve these stresses.

Every single day an infant survives in a Neonatal Intensive Care Unit, increases the chance of that infant going home. This is in contrary to Adults in Adult Critical Care Units.

[redacted]

Jennifer Meaney
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Dear Jennifer,

I would like you and other members of the El Camino Hospital Staff know how much I appreciated the excellent care and treatment provided to my mom, [redacted]

My 102 year-old mom was admitted to the Hospital on April 13, diagnosed with pneumonia in the Emergency Room. Throughout her entire week-long stay I observed the staff members who were caring for my mom in Tower C, Room 2328 making her as comfortable as possible. My mom's physical condition and dementia made it difficult and painful for her to move so it was a definite challenge to provide the necessary treatment, perform tests such as X-rays and to regularly change her position and keep her clean. However, the doctors, nurses, CNAs and technicians found the way to administer intravenous medications and nourishment, as well as monitor my mom's progress. I thank everyone for keeping me informed throughout the entire process.

My sincere gratitude to my mom's attending physicians (Dr. Siddiqui and Dr. Chaudhury), my mom's nurses (Sharon, John, Cely, Rowena, Tomi, Sherwin, Stacy, Madonna, Nina and Yasmine), my mom's CNAs (George, Maryanne, Francisca, Ann Marie, Milet and Luz) my mom's speech therapist (Hallie), my mom's MSW (Allyson), my mom's care coordinator (Ashley) and the members of Housekeeping and Food Services who serviced my mom's room. I would also like to thank the Random Acts of Flowers organization for delivering a beautiful floral arrangement to my mom. Unfortunately, I do not have the names of all the Hospital Staff members who helped my mom and who I would like to thank. But please extend my appreciation to everyone who was there for my mom and me between April 13-20.

My mom received the special care and treatment that eventually cleared up her aspiration pneumonia. Unfortunately, she had been refusing food and liquids for a couple of days prior to her admittance to the Emergency Room. And any future intake of food and liquids poses the danger of the aspiration pneumonia recurring.

However, my mom is now in her home with me and hospice care and resting comfortably.

Thank you again El Camino Hospital Staff.

Very best regards,

[redacted]

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

FY2017 PACING PLAN

FY2017: Q1		
JULY - No Meeting	**AUGUST 1, 2016**	**AUGUST 29, 2016 (*In place of Sept Meeting*)**
Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2017 Committee Goal Completion Status ▪ Pacing Plan ▪ Quality Council Minutes ▪ Patient Story ▪ Research Article	▪ Review and discuss quality summary with attention to risks and overall performance ▪ Committee Recruitment ▪ Review FY17 Committee Goals **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ APPROVE FY 2017 Organizational Goals (Metrics) ▪ Update on PFCC **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**
FY2017: Q2		
OCTOBER 3, 2016	**NOVEMBER 2, 2016**	**DECEMBER 5, 2016**
▪ Approve FY 16 Organizational Goal Achievements ▪ Year-end review of RCA **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ iCare Update ▪ Safety Report for the Environment of Care (consent calendar) **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ iCare Update ▪ ~~Committee Goals for FY17 Update~~ **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

FY2017 PACING PLAN

FY2017: Q3		
JANUARY 30, 2017	**FEBRUARY 27, 2017**	**MARCH – No Meeting**
▪ Patient and Family Centered Care ▪ Service Line Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Begin Development of FY 2018 Committee Goals (3-4 goals) ▪ Peer Review/Care Review Process **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	
FY2017: Q4		
APRIL 3, 2017	**MAY 1, 2017**	**JUNE 5, 2017**
▪ Finalize FY 2018 Committee Goals ▪ Proposed Committee meeting dates for FY2017 ▪ Review DRAFT FY2018 Organizational Goals ▪ ~~Annual Review of Committee Charter~~ ▪ Use of opioids **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Review DRAFT FY18 Organizational Goals (as needed) ▪ Finalize proposed committee meeting calendar for FY 2018 **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ PFAC Update (6 months since Jan) ▪ Develop Pacing Calendar for FY18 ▪ Review Draft Management of Serious Safety Events and Red Alert Patient Safety Events Policy ▪ Approve FY18 Committee Goals **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Quality, Patient Care and patient Experience Committee Meeting Date: June 5, 2017
	Responsible party:	Cindy Murphy, Board Liaison
	Action requested:	For Information
	Background: IN FY16 we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. This written report is intended to supplement the Chair's verbal report.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : To inform the Committee about recent Board actions	
	Suggested discussion questions: None.	
	Proposed Committee motion, if any: None. This is an informational item	
	LIST OF ATTACHMENTS: Report on May 2017 Board Actions	

May 2017 ECHD Board Actions*

1. May 15, 2017
    a. Expanded Hospital Board membership to add 2 additional appointed/subject matter experts. Also voted to change CEO to a non-voting member of the Board.
2. May 22, 2017
    a. Appointed Robert Rebitzer to the El Camino Hospital Board of Directors.

May 2017 ECH Board Actions*

1. May 10, 2017
    a. Biennial Board Officer Election (for a two year term, effective July 1, 2017):
        i. Hospital Board Chair – Lanhee Chen
        ii. Hospital Board Vice Chair – John Zoglin
        iii. Hospital Board Secretary/Treasurer – Julia Miller
    b. Approved Revised Board Director Compensation Policy
    c. Approved El Camino Hospital Auxiliary Slate of Officers

*This list is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

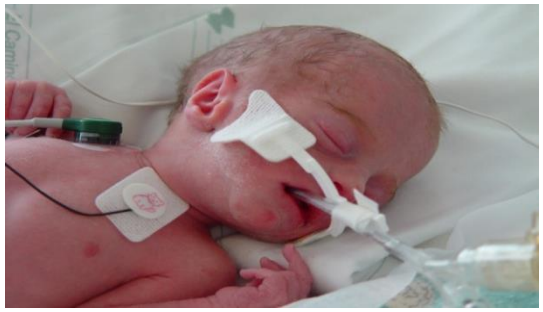
Neonatal Intensive Care Unit Update
Quality Committee

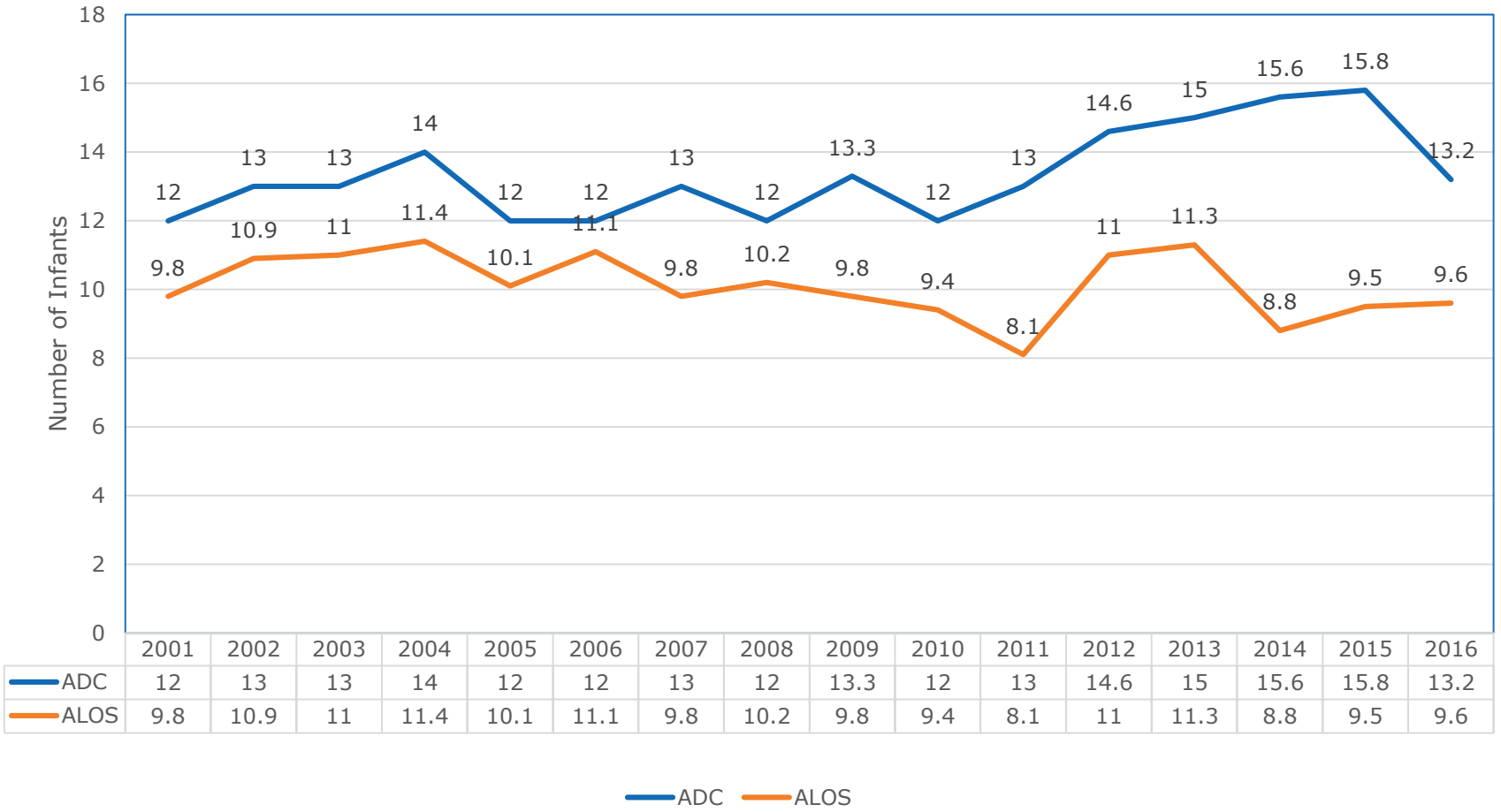
Dharshi Sivakumar, MD
Medical Director, NICU
June 5, 2017

Our Journey Over 17 Years

- A new 16 bed unit opened doors in Orchard Pavilion in 1991.
- First infant weighing less than 750 g was fully managed in the unit in 2000.
- Rehabilitation services were initiated in 2002.
- High Frequency Ventilators purchased and staff trained in 2001-02.
- Central line insertion team formed in 2003.
- EMR (Site Of Care) usage was initiated in July 2005.
- Banked Breast Milk was available to use from 2005.
- Joined CPQCC in 2004 and Neonatal Network in 2005 for data collection.
- Increased the bed status to 20 in 2008.
- Inhaled NO in 2008 and New Drager ventilators in 2011.
- PAMF MFM joined ECH medical staff in 2010-11 and NICU census increased with fewer maternal transports out.
- More Neonatologists coverage from 2013 (increased from 4 to 7).
- Retinal Camera (Ret Cam) for eye examinations in October, 2014.
- Introduction of Human Milk fortification from mother's milk (Prolacta) in 2015

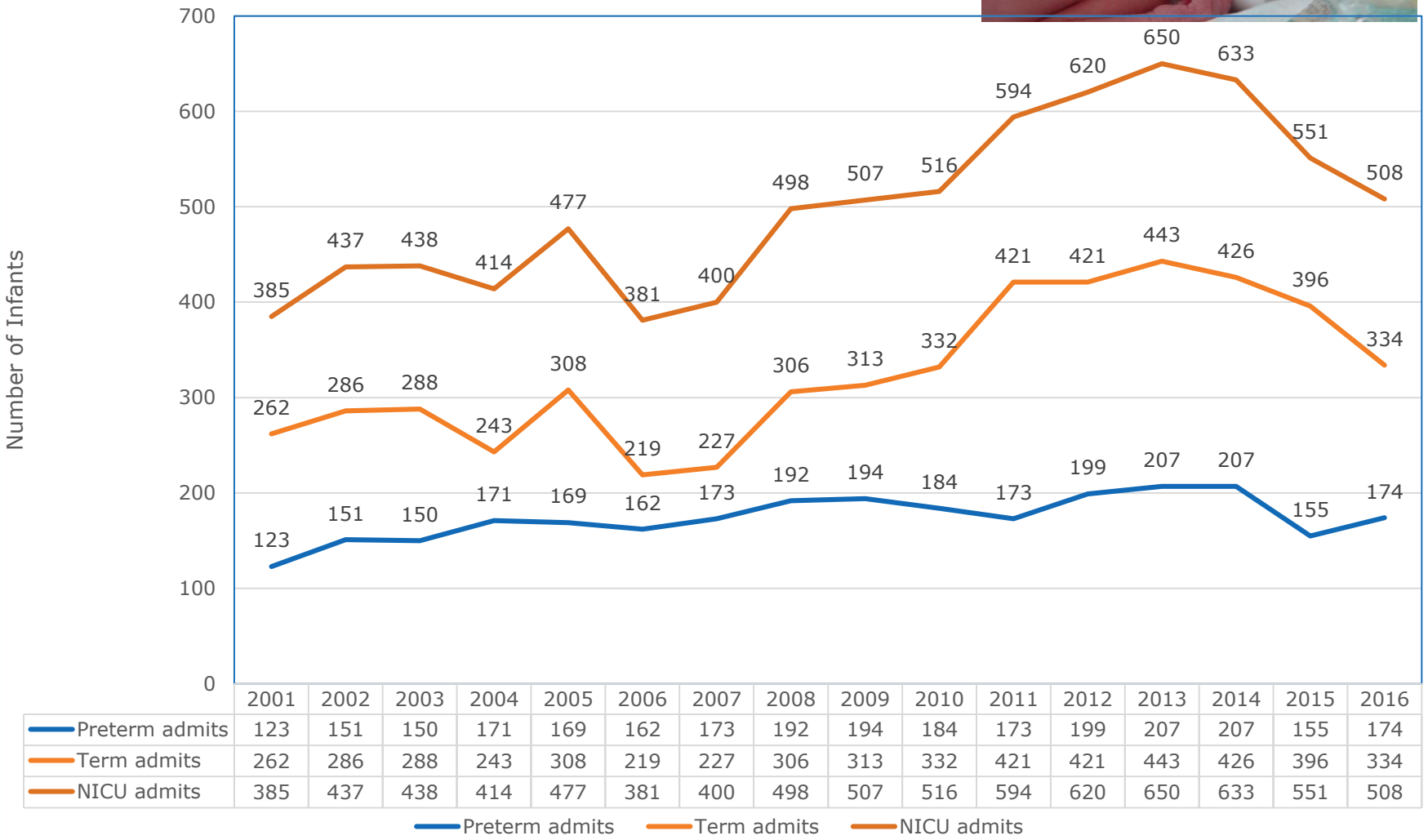
NICU Statistics 1





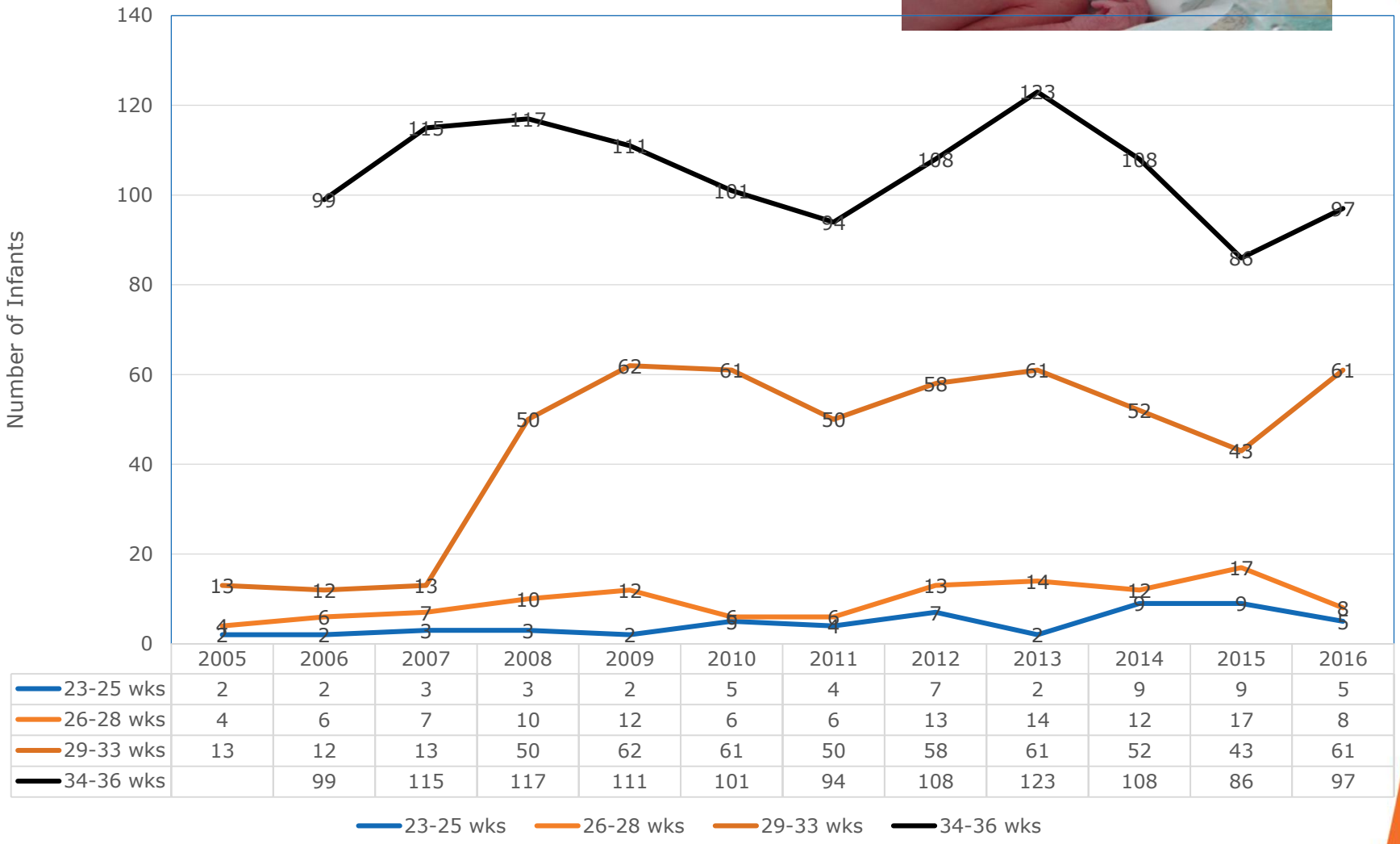
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
ADC	12	13	13	14	12	12	13	12	13.3	12	13	14.6	15	15.6	15.8	13.2
ALOS	9.8	10.9	11	11.4	10.1	11.1	9.8	10.2	9.8	9.4	8.1	11	11.3	8.8	9.5	9.6

NICU Statistics 2



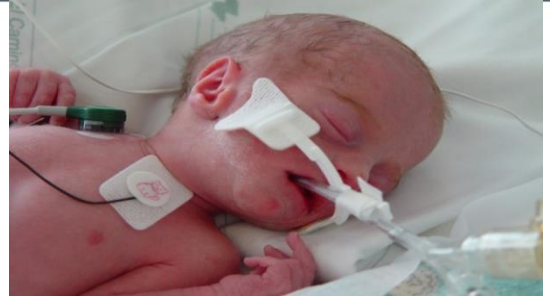
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Preterm admits	123	151	150	171	169	162	173	192	194	184	173	199	207	207	155	174
Term admits	262	286	288	243	308	219	227	306	313	332	421	421	443	426	396	334
NICU admits	385	437	438	414	477	381	400	498	507	516	594	620	650	633	551	508

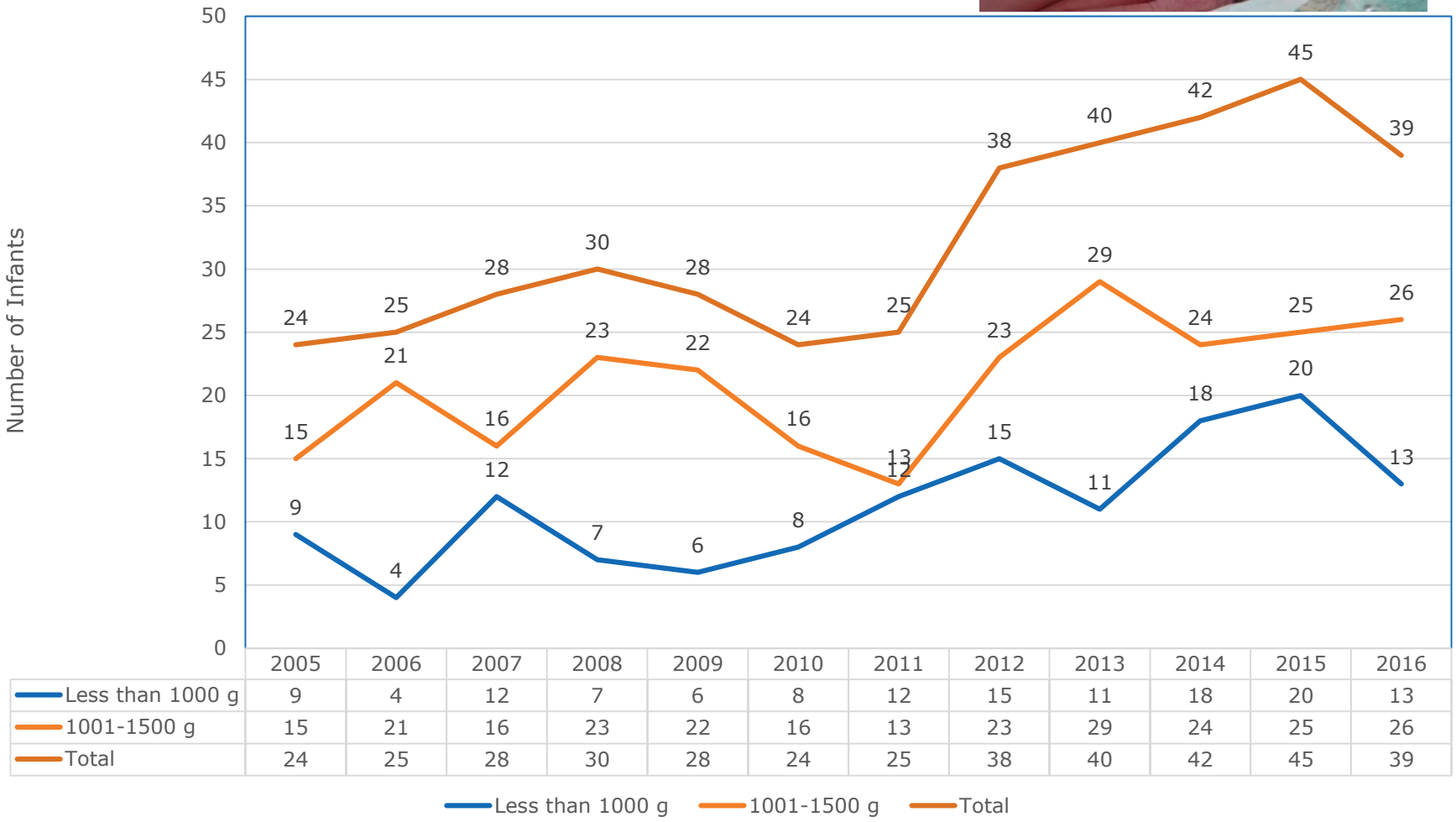
NICU Statistics 3



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
23-25 wks	2	2	3	3	2	5	4	7	2	9	9	5
26-28 wks	4	6	7	10	12	6	6	13	14	12	17	8
29-33 wks	13	12	13	50	62	61	50	58	61	52	43	61
34-36 wks		99	115	117	111	101	94	108	123	108	86	97

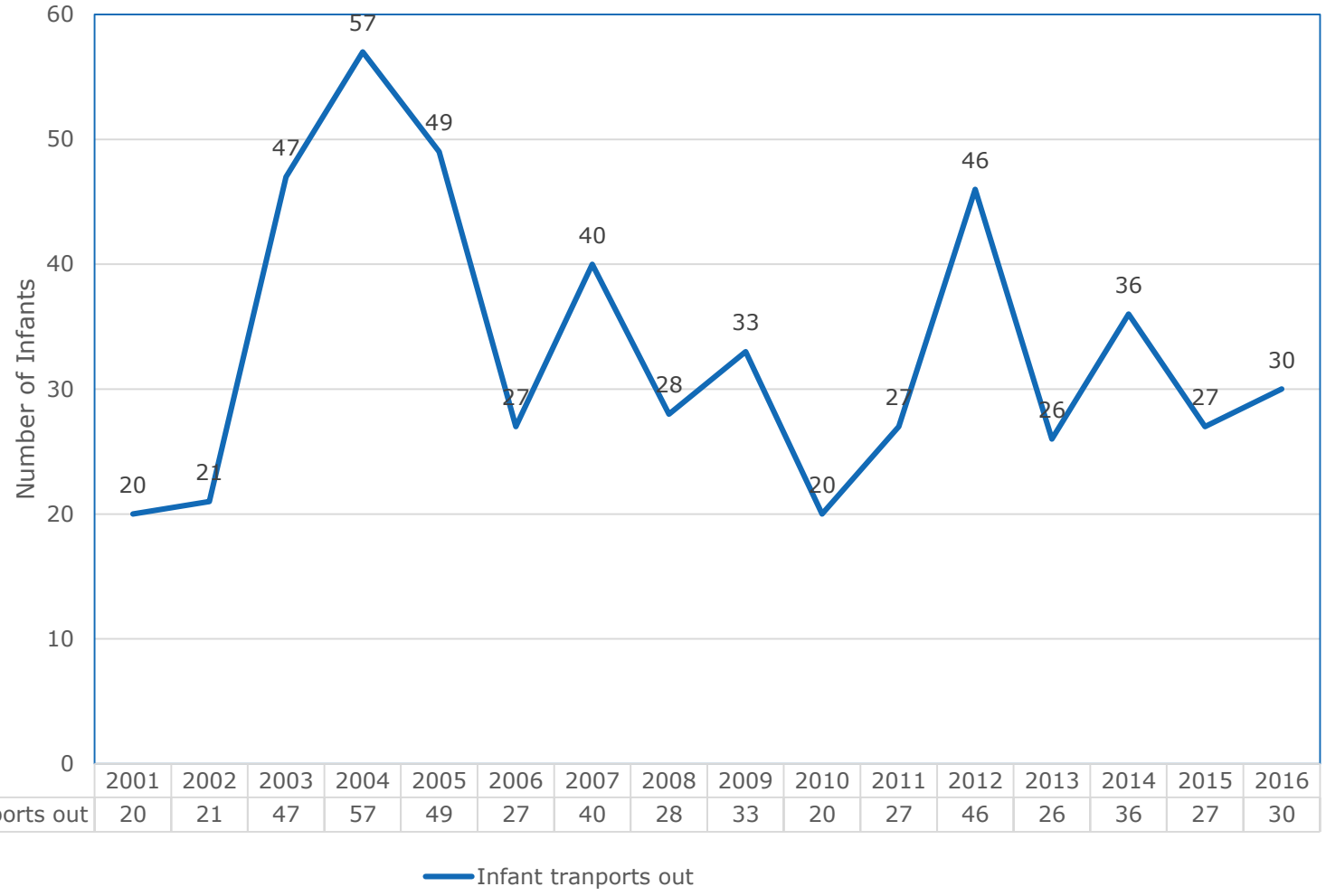
NICU Statistics 4





	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Less than 1000 g	9	4	12	7	6	8	12	15	11	18	20	13
1001-1500 g	15	21	16	23	22	16	13	23	29	24	25	26
Total	24	25	28	30	28	24	25	38	40	42	45	39

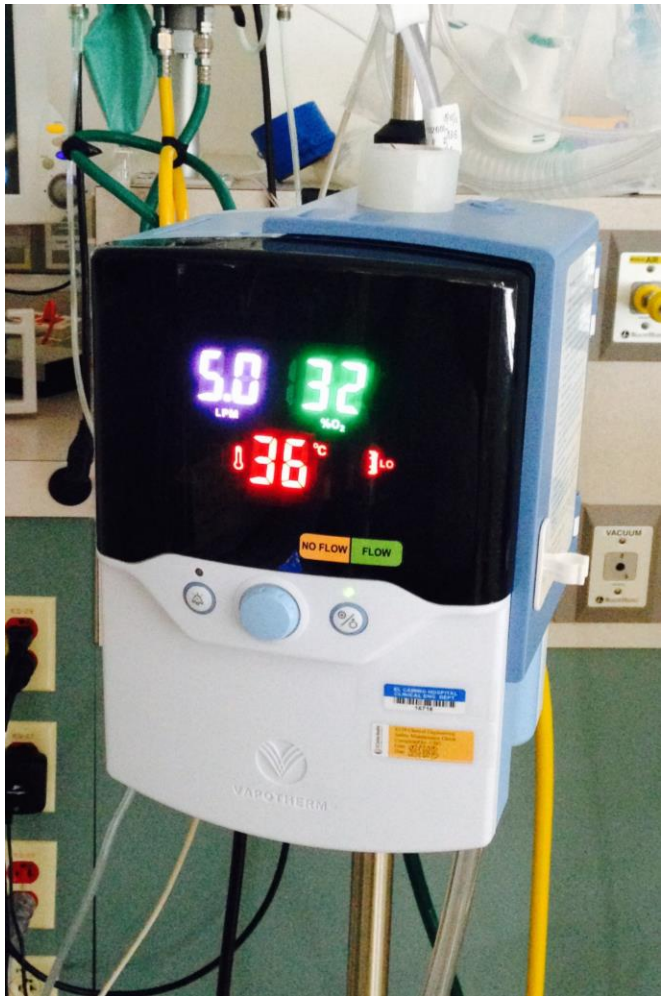
NICU Statistics 5



2016 Transports Out by Specialty

	Cases	% Distribution
Neurology	8	27%
Pediatric Surgery / Neurosurgery	7	23%
Cardiac	4	13%
OT Evaluation / Feeding	4	13%
Complex Cases	2	7%
Other	2	7%
Respiratory Management	2	7%
ENT	1	3%
Total	30	100%

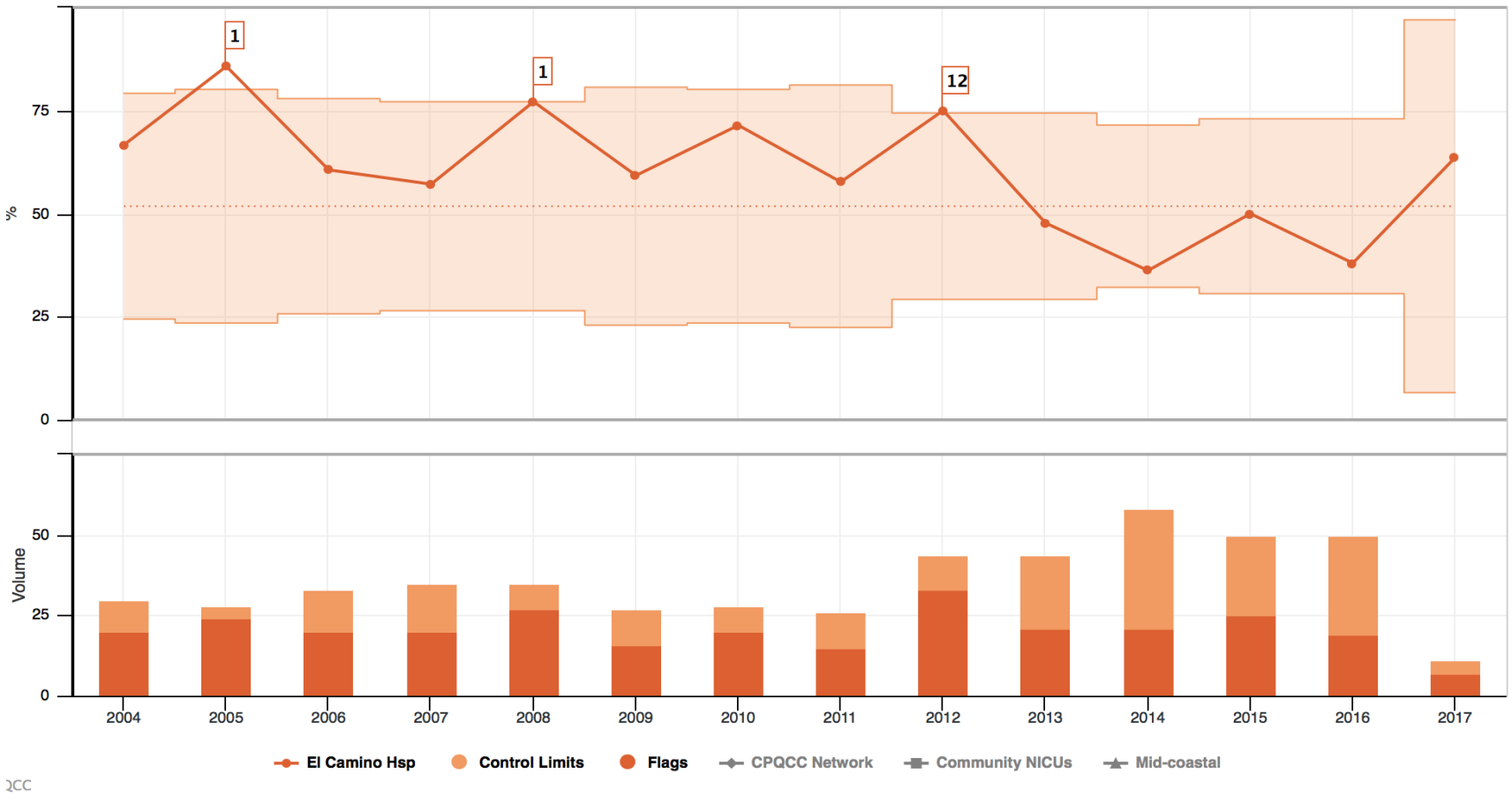
Respiratory Technology in the NICU



- High frequency ventilation available since 2001, used for 3 patients in 2016.
- Inhaled Nitric oxide (NO) available since March 2008, for infants with refractory respiratory failure (e.g. pulmonary hypertension or pneumonia). In 2016, 3 babies were treated with iNO.
- State of the art Drager Baby Log ventilators purchased in 2011 to provide additional modes of ventilation to prevent lung injury and CLD (assist control with volume guarantee, and pressure support mode) 31 infants were ventilated in this mode of ventilator in 2016.
- Vapotherm for Hi Flow Nasal Cannula has been in use since 2014 to promote early transition from Ventilator support.
- SiPAP machine since 2015, to use for NCPAP when on CPAP for longer period and to deliver accurate PEEP.

Conventional Ventilation after Initial Resuscitation

Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/23/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital



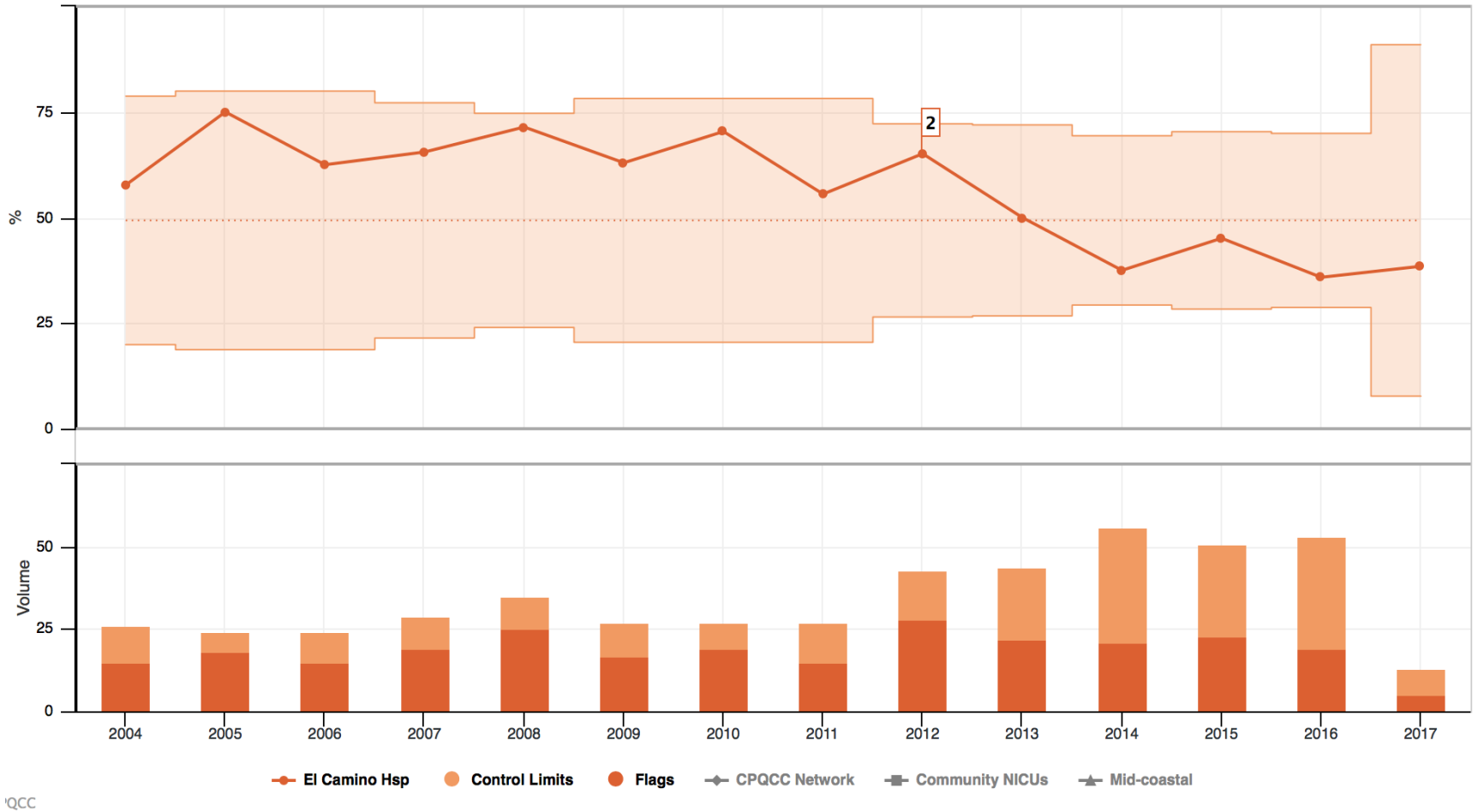
Show Control Chart by ...

Birth Year | Birth Quarter | Birth Month

☑ Show Volume ☐ Show Cusum

Surfactant Given at Any Time

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/25/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital



'QCC

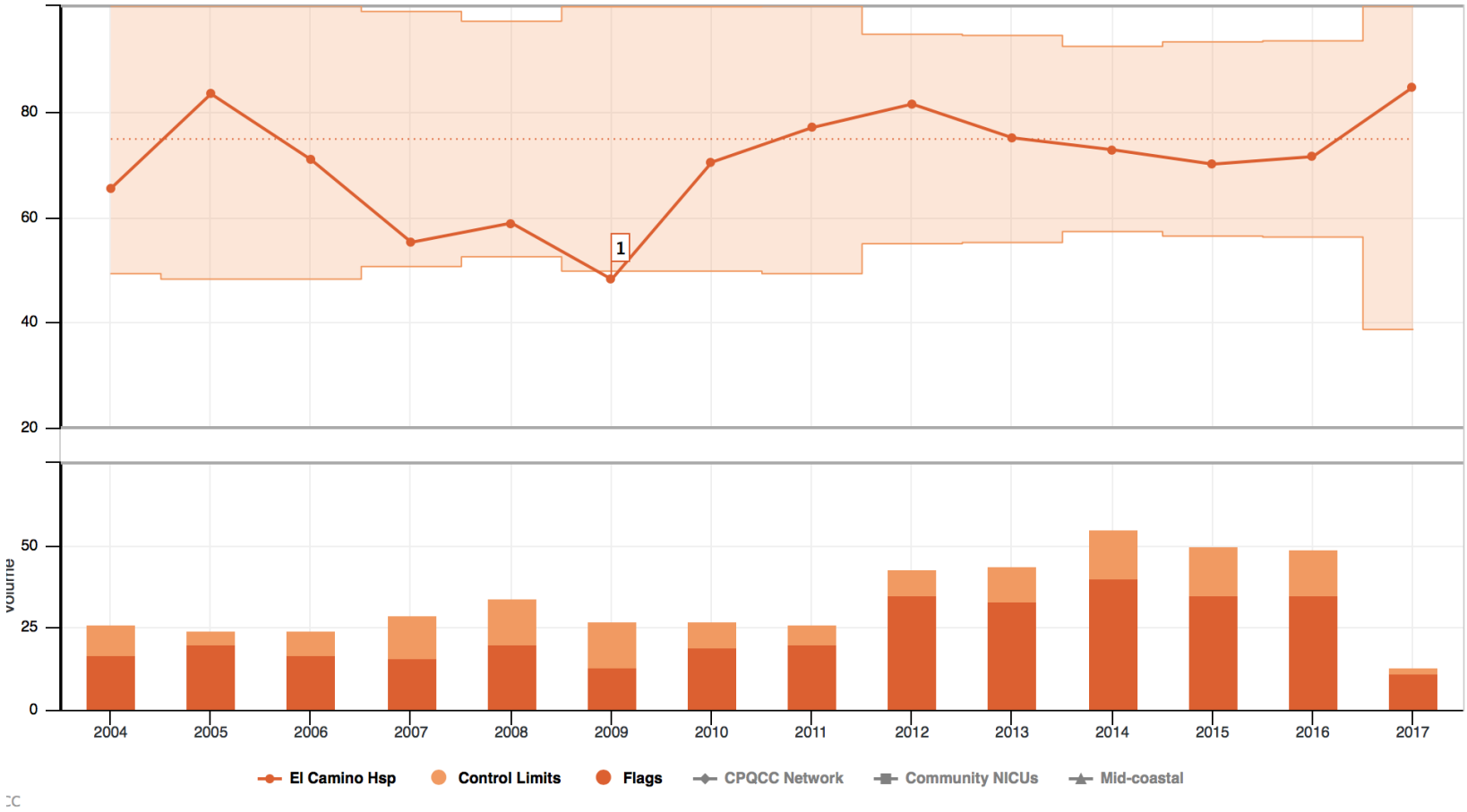
Show Control Chart by ...

Birth Year | Birth Quarter | Birth Month

☑ Show Volume ☐ Show Cusum

Nasal CPAP after Initial Resuscitation

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/25/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital

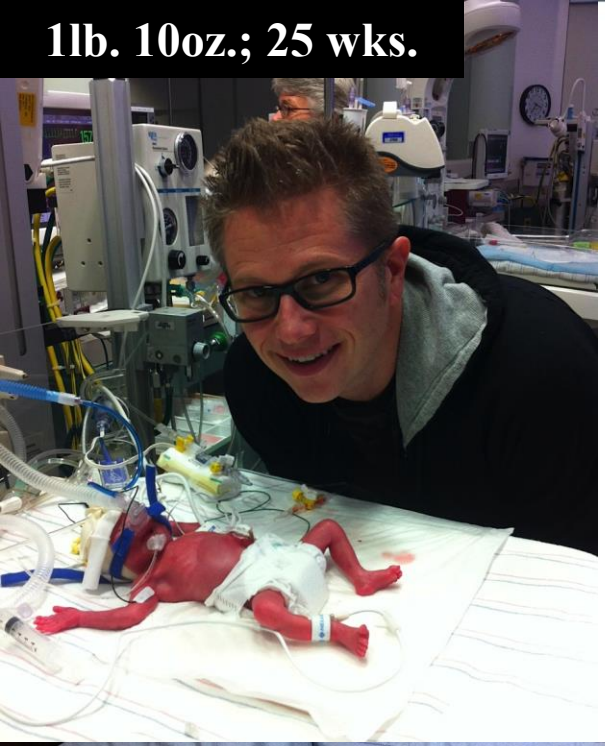


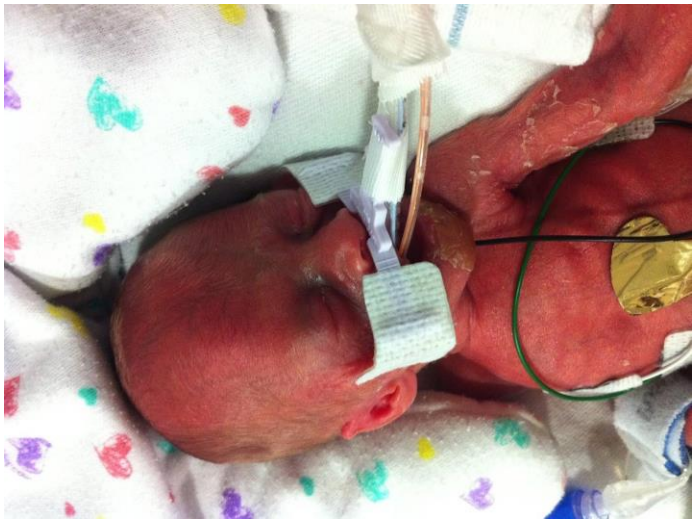
how Control Chart by ...

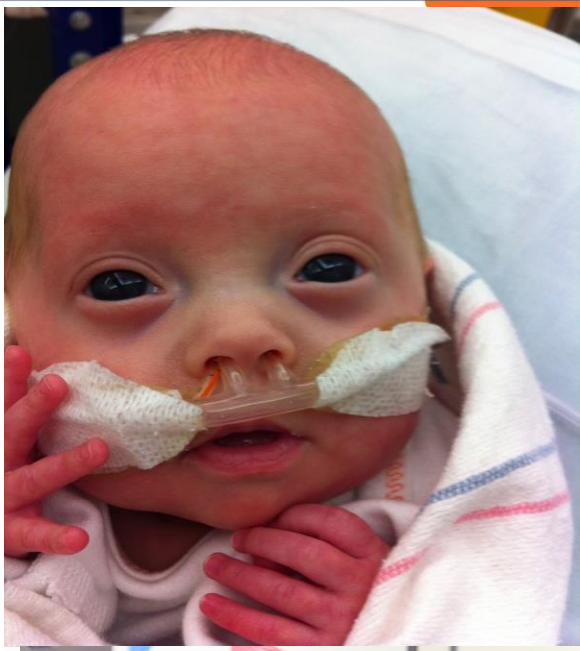
Birth Year | Birth Quarter | Birth Month

Show Volume Show Cusum

1lb. 10oz.; 25 wks.





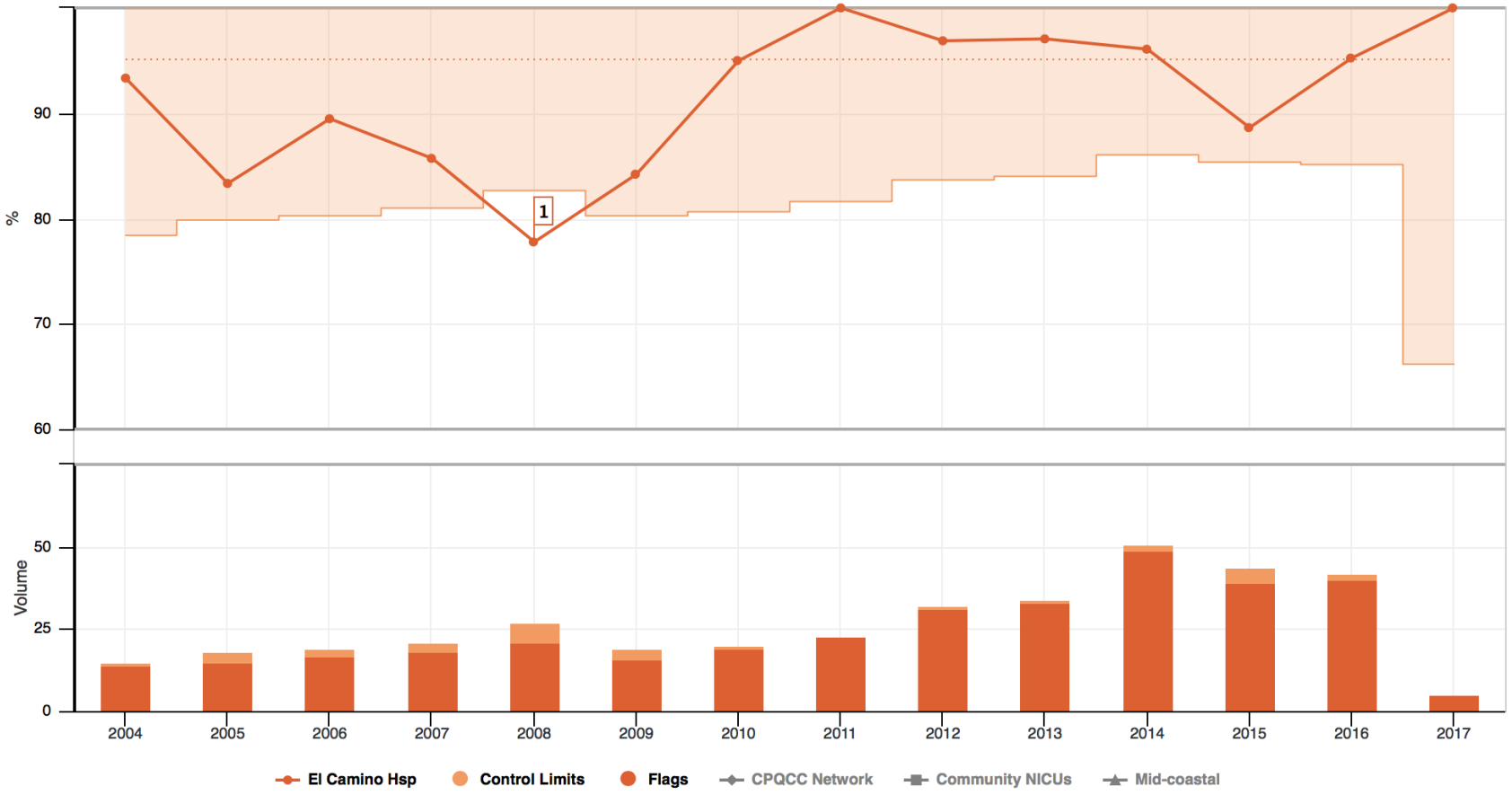


Past Quality Improvement Projects

- High frequency Ventilation training in Utah 2001-2002
- Central line team training and competency 2003 -2004.
- Simulation resuscitation training at CAPE 2006-2007.
- Improving breast milk usage in NICU 2009-2010 with CPQCC.
- Delivery room management of Infants weighing less than 1500 g, 2010-2011 with CPQCC.
- Reducing readmissions of Late Preterm Infants 2011-2012 with NPIC.
- Reduction of CLABSI in NICU "Give our infants a Hand Hygiene" 2012-2014 our own project.
- Alarm fatigue and Infant safety 2014-2015 with VON.
- Reducing antibiotic use in Late Preterm and Term infants 2015-2016 our own initiative.
- Neuro NICU training for staff 2016.
- Delayed cord clamping in preterm infants with CPQCC.

Human Milk Nutrition at Home Discharge

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/23/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital



PQCC

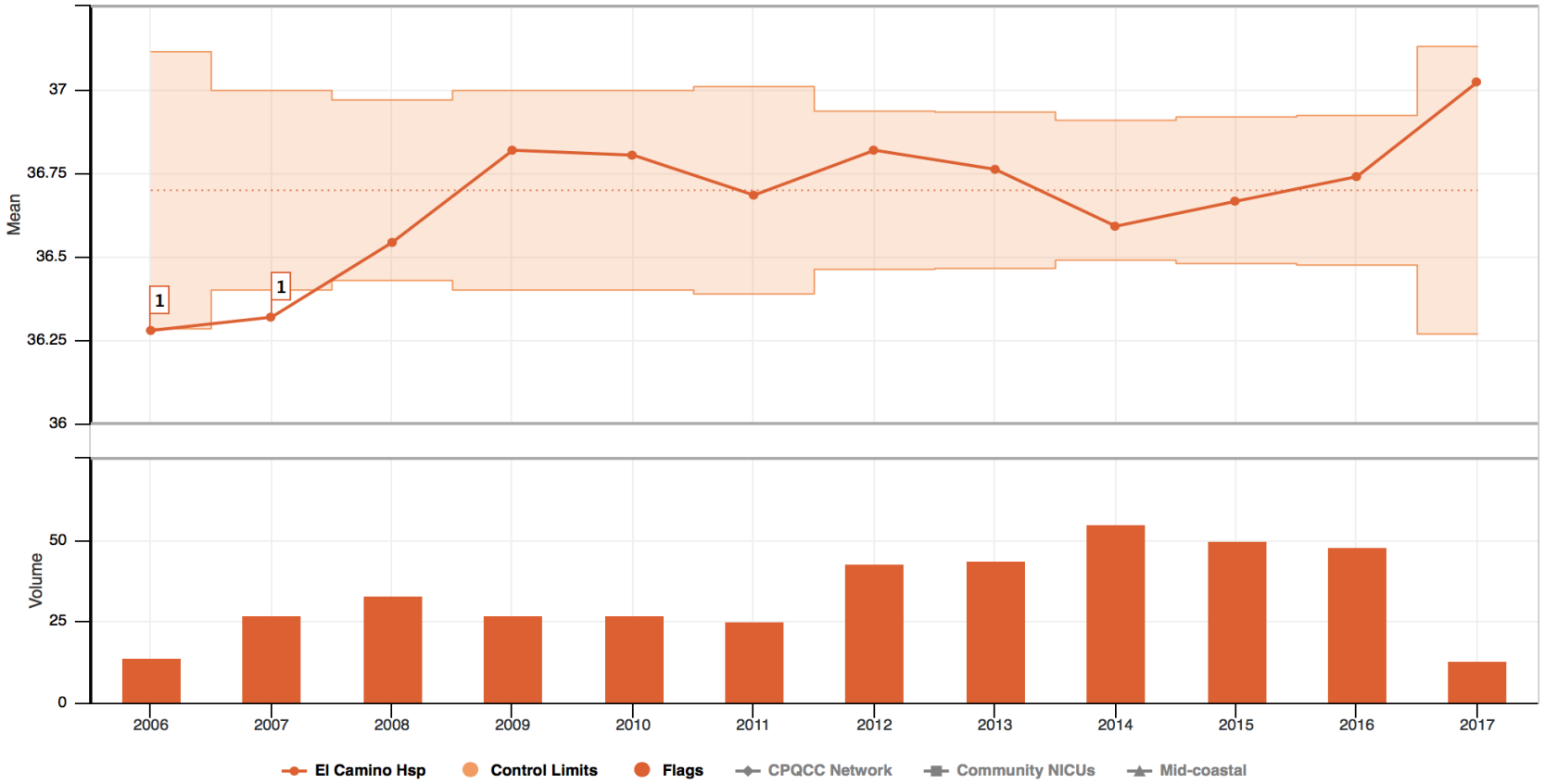
Show Control Chart by ...

Birth Year | Birth Quarter | Birth Month

☑ Show Volume ☐ Show Cusum

Temperature within 1st Hour of Initial NICU Admission

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2006 and 05/23/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital



CPQCC

Show Control Chart by ...

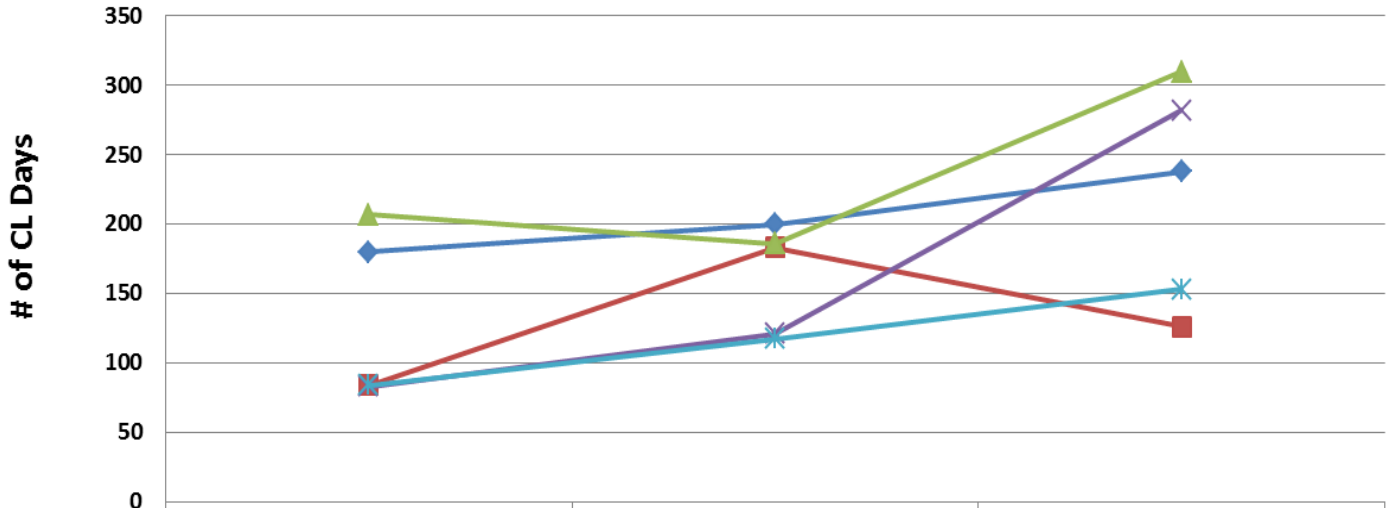
Birth Year | Birth Quarter | Birth Month

☑ Show Volume ☐ Show Cusum

Dash Board

	CY 2013	CY 2014	CY 2015	CY 2016
Newborn Volume (Live Births)	4,355	4,494	4,118	4,135
NICU Discharges	506	502	546	509
NICU Average Length of Stay	10.7	10.1	11.0	9.6
Neonatal Deaths	2	2	4	0
Newborn Tranfers Out	26	31	22	33
Readmission for Hyperbilirubinemia	31	43	45	75
Late Preterm Volume	267	196	200	220
Late Pre-Term Infants Readmit Rate to NICU	1.5%	7.1%	3.4%	9.1%

Central Line Days - NICU



	2014	2015	2016
< 750 gm	180	200	238
751 - 1000 gm	84	183	126
1001 - 1500 gm	207	186	310
1501 - 2500 gm	83	121	282
> 2500 gm	84	117	153
Total Catheter Days	638	807	1109

Central Line Associated Blood Stream Infections

- In **2016** a total of **1109** line days, with **no CLABSI**
- In **2015** a total of **807** line days, with **no CLABSI**
- In **2014** a total of **638** line days, with **no CLABSI**

- **From August 21st 2013, to April 14th 2017, No CLABSI**
  - **For 1331 calendar days**
  - **For 2554 line days**

- In **2013** a total of **576** line days.
  - **1** CLABSI late onset coagulase neg Staph infection was confirmed in a 23 and 6/7 week infant weighed 560g

- In **2012** for a total of **650** line days.
  - **6** episodes of late-onset sepsis with central line in place (**1** was 1000-1499g, **5** were 500-999g)

    2 Candida, **1** Enterococcus, **3** coagulase neg Staph.

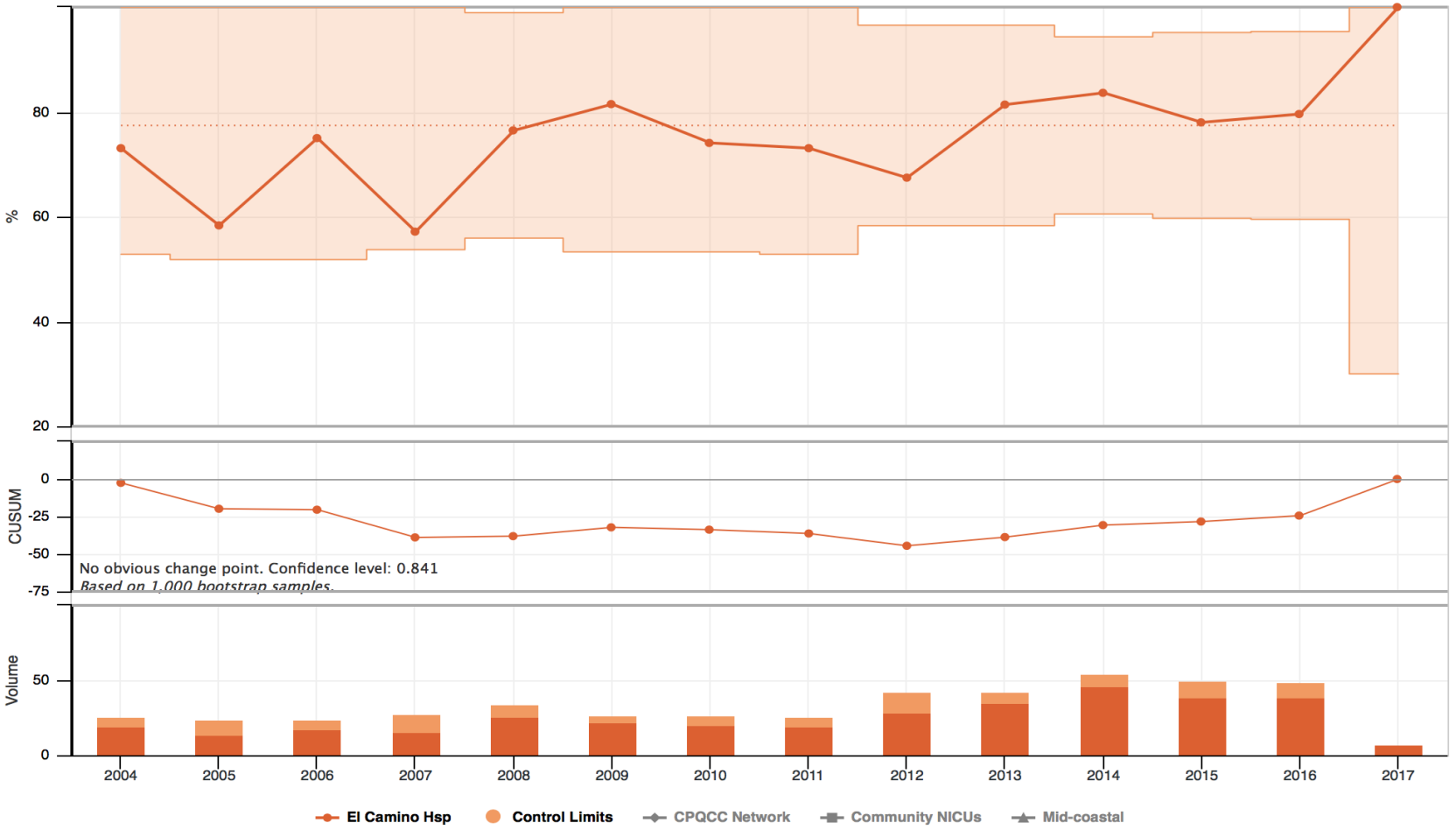
1 lb. 4 oz.

4 Months; going home

5 lbs. 4 oz

Survival without Severe ROP or ROP Surgery, NEC, Severe IVH, NI or CLD

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/23/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital



QCC

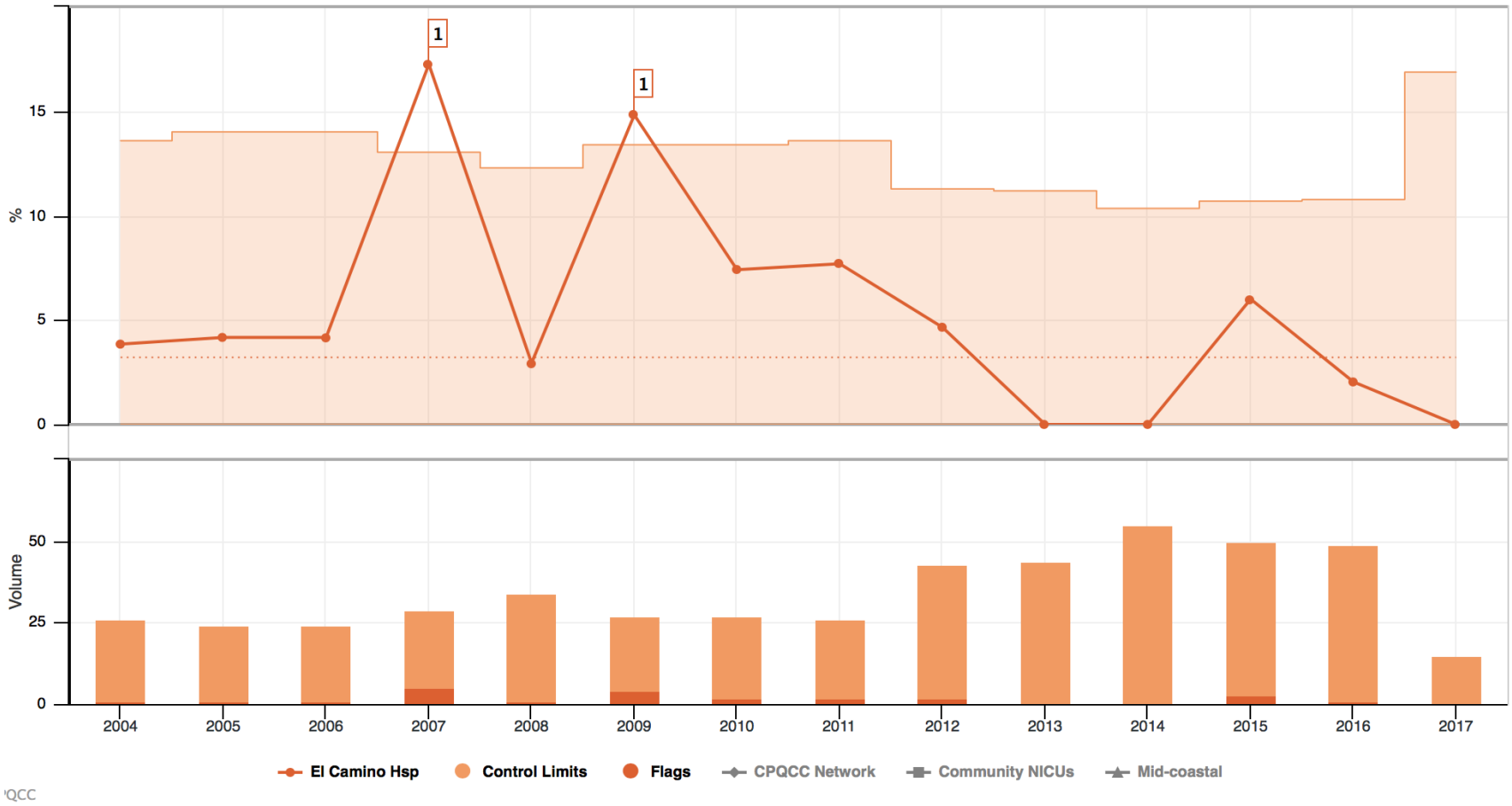
Show Control Chart by ...

Birth Year | Birth Quarter | Birth Month

Show Volume Show Cusum

Infant Death

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/23/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital



'QCC

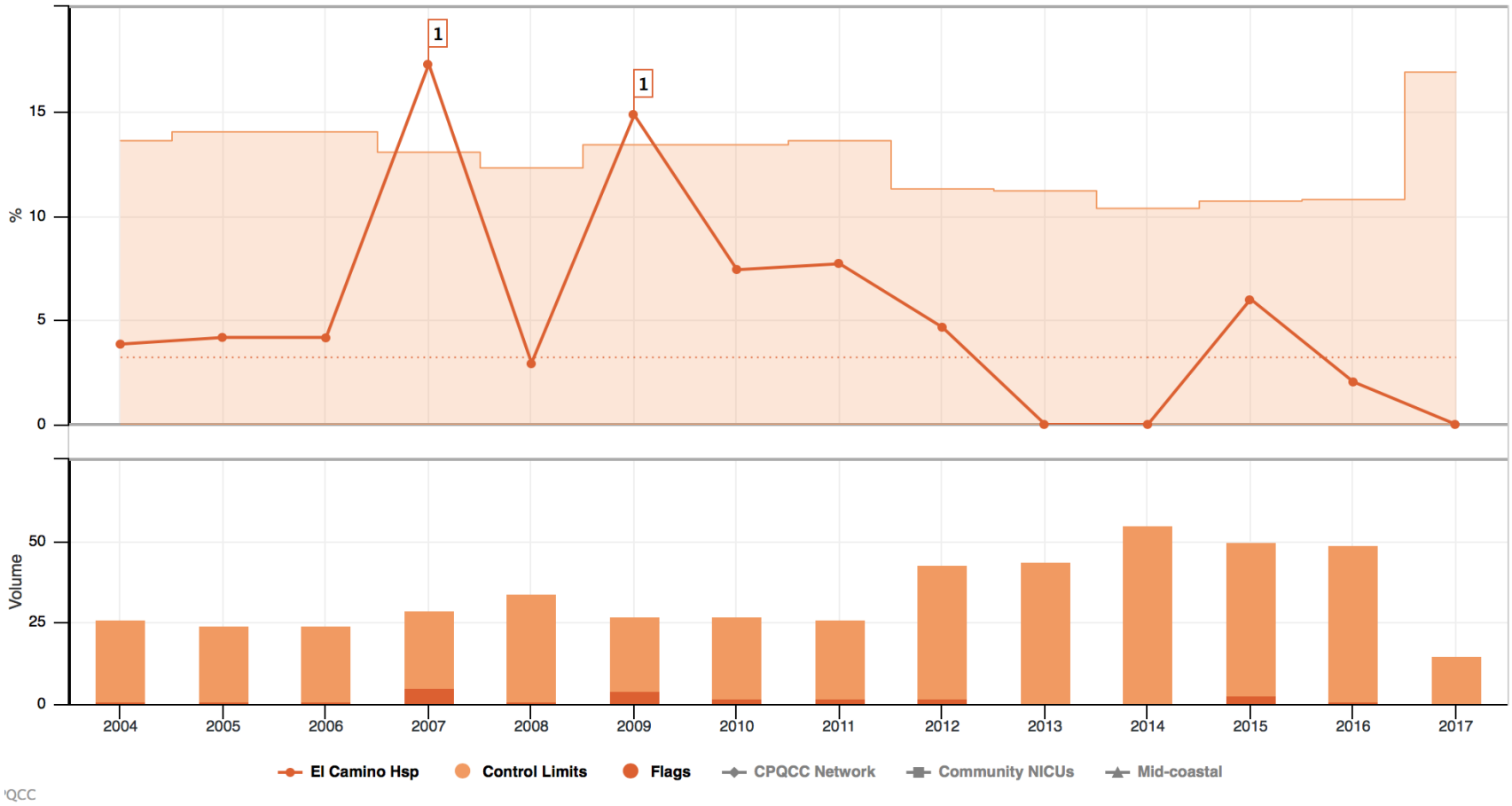
Show Control Chart by ...

Birth Year | Birth Quarter | Birth Month

☑ Show Volume ☐ Show Cusum

Infant Death

Inborn Infants 401 to 1500 grams or 22 to 31 Completed Weeks Gestation born between 01/01/2004 and 05/23/2017
This chart is final for years 2015 and earlier. The chart is preliminary for 2016 and 2017 as the data collection is on-going.
El Camino Hospital

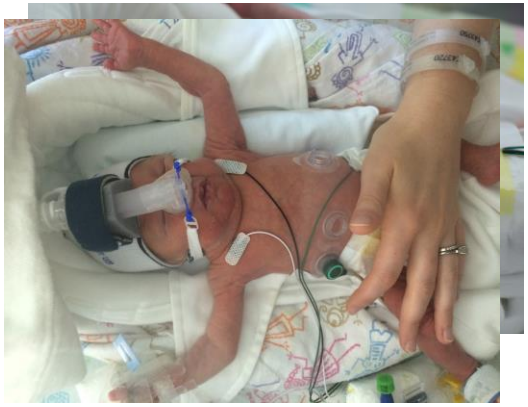


Show Control Chart by ...

Birth Year | Birth Quarter | Birth Month

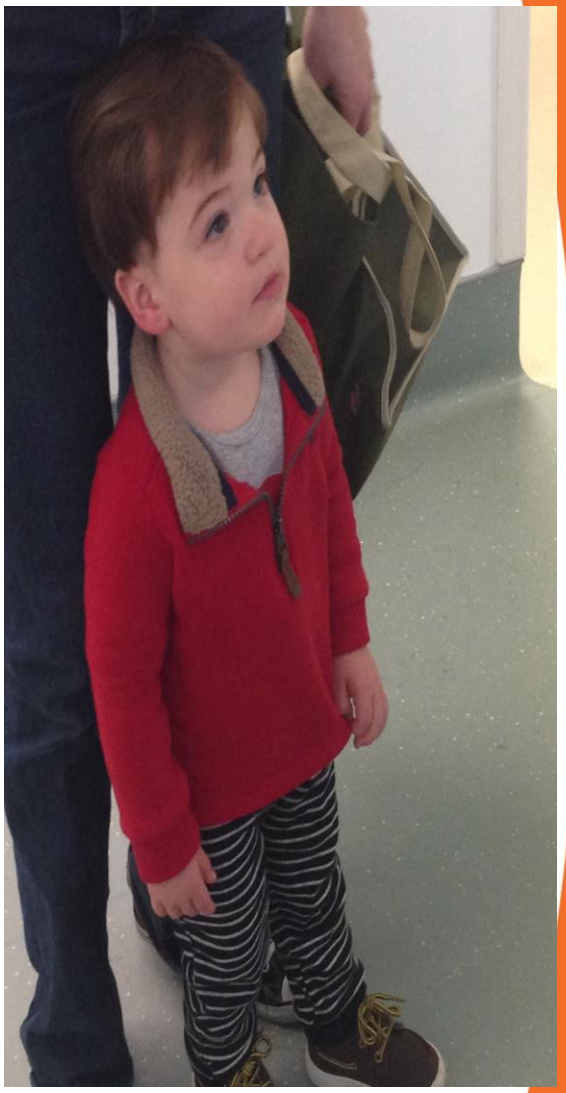
Show Volume Show Cusum

24 Week Twins



7 months

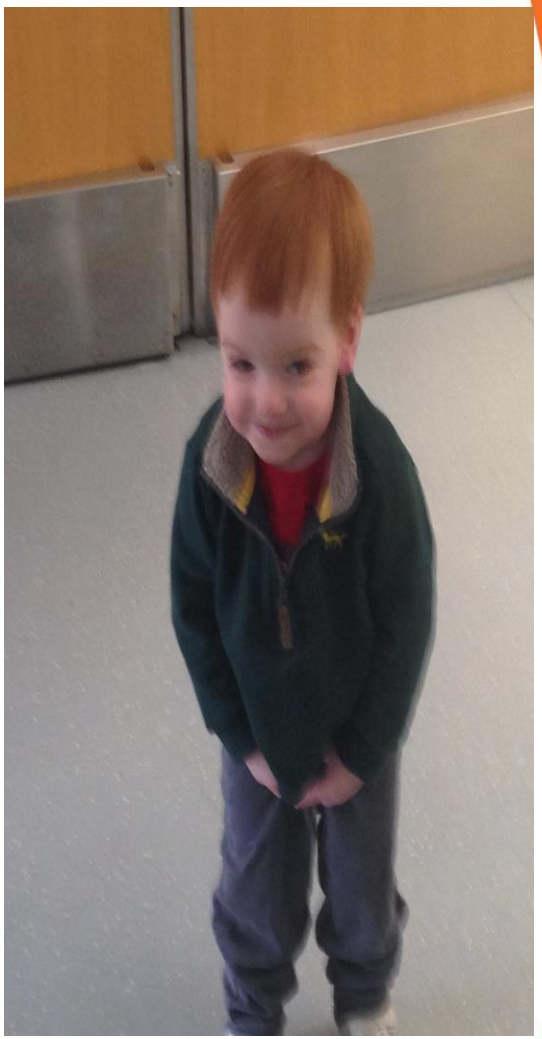
28 months



24 Week Twins

7 months

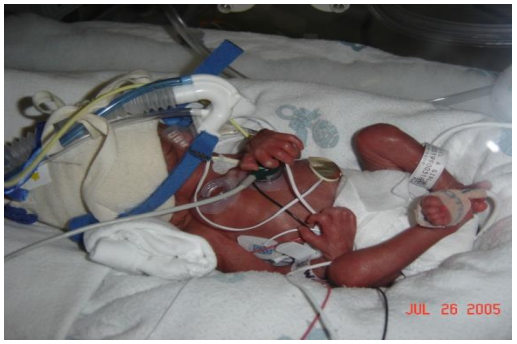
28 months

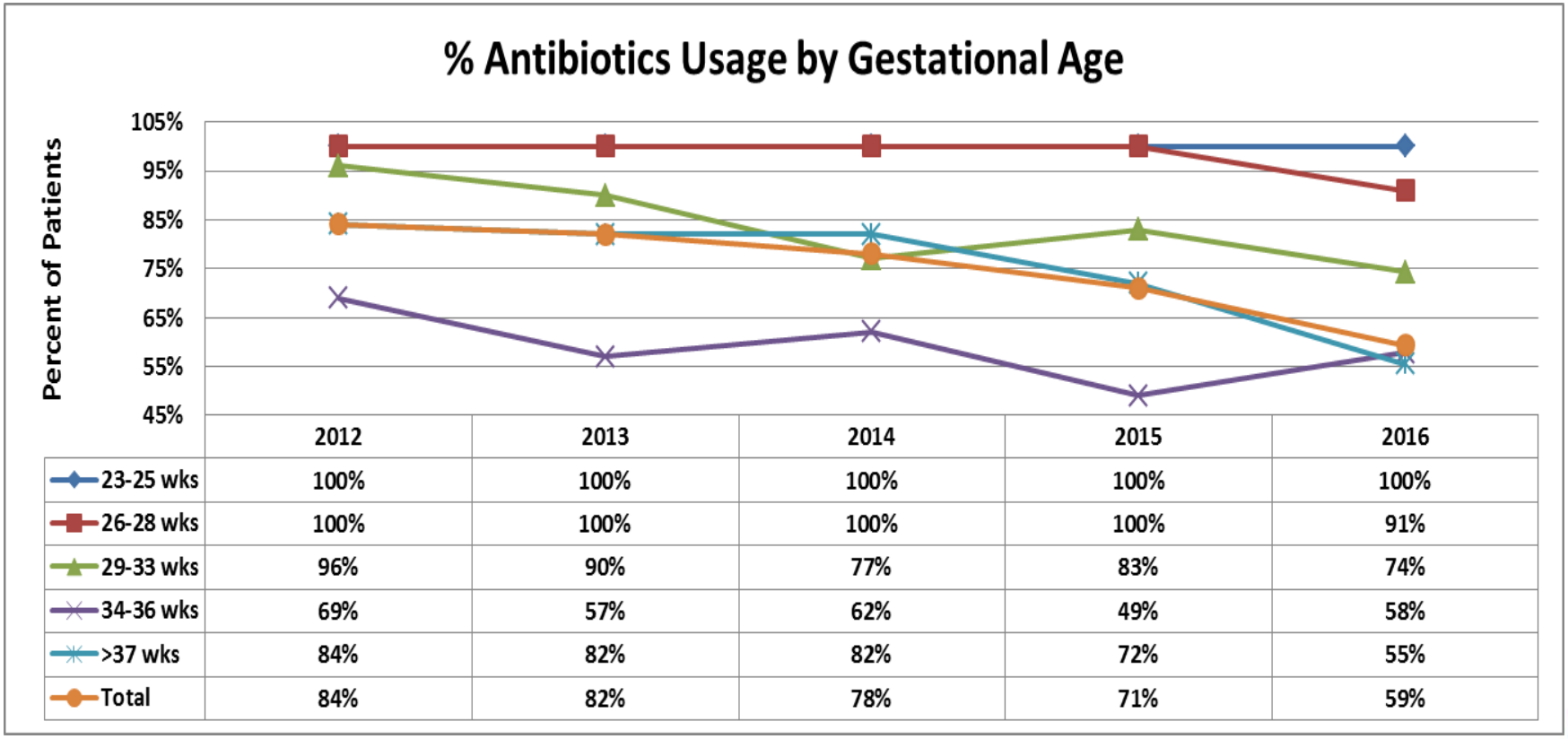


Quality Improvement Measures in 2016

- Family Centered Care Project
  - Family Advisory Board (FAB) was formed and have quarterly meeting
  - iPads (3) were donated by FAB to use in NICU
  - Discharge teaching videos were made
  - Parent education was created and down loaded in the iPads as iBook
  - Developmental document created in iCare. This will be given to parents weekly to update the infant's progress
- Infant Sub-Code Committee
  - Standardize our practice in resuscitation for newborns in the hospital.
  - Resuscitation carts were organized in every unit in MCH and ED.
  - Video recording of Mock Code Resuscitation initiated with skills days in NICU
  - Plan to train all the staff in MCH and ED with regular Mock Codes
  - Explore the use of Video camera on resuscitation warmer for education purpose.
- CPQCC Antibiotic Stewardship Collaborative
  - Reduce antibiotic use in the Newborn period
  - Overall Antibiotic Usage Rate was ~29% prior to starting the project.
  - Antibiotic stewardship team was formed in August 2016 to monitor and discontinue antibiotics on time
  - Changes were made in the Sepsis Pathway in March 2017

Antibiotic Usage





	2012	2013	2014	2015	2016
23-25 wks	100%	100%	100%	100%	100%
26-28 wks	100%	100%	100%	100%	91%
29-33 wks	96%	90%	77%	83%	74%
34-36 wks	69%	57%	62%	49%	58%
>37 wks	84%	82%	82%	72%	55%
Total	84%	82%	78%	71%	59%

Achievements in 2016

- Two Stanford Senior Pediatric Residents and one third year Neonatology Fellow rotated in NICU
- Monthly Staff Education to nursing staff and respiratory therapists by Neonatologists called, "Doc Talk" program
- Patient enrollment continuing for the two Neonatal Network Trials and more to come.
- Video EEG machine was purchased by radiology department. Two aEEG monitors were purchased to screen for seizures in Preterm and Term infants. Staff were trained with LPCH neuro NICU program in ECH over two days. Credentialing process for four Pediatric Neurologists' (LPCH) to read Video EEG remotely was completed.
- Hospital Board approved to have full rehabilitation program for NICU patients with PT/OT services and feeding evaluations.
- A new NIH pilot study measuring, "Bilirubin Binding Capacity" in preterm infants was initiated in July 2016, by joining Stanford.
- Completed CPQCC pilot study on "Delayed Cord Clamping" (DCC) for Preterm Infants. DCC was performed in 65% (33/51) of Small Babies and 47% (16/34) of Big Babies admitted to NICU from April to December 2016.
- Initial work has been done on collecting Data Reports in iCare.

Future Goals

- Research and Quality Improvement Project
  - Mock Resuscitation Code training to all MCH Staff
  - Video recording of resuscitation for "Staff Education"
  - Completing Antibiotic Stewardship with CPQCC by December 2017.
  - Developing "Peer Buddy Program" through Family Advisory Board members.
- Subspecialty Services to ECH
  - Implementation of Pediatric Neurology services with video EEG
  - Rehabilitation program with feeding evaluation including swallow study
  - Exploring Pediatric Surgery and ENT services in the new NICU
- Implementing delayed cord clamping for all deliveries per NRP
- Neurological monitoring of infants with abnormal Cord Gases during transition period to recognize mild HIE.
- Establishing Better Data Collection for Outcome Analysis from iCare and developing CPQCC data submission form, in iCare.
- Cost- Benefit analysis of introducing transcutaneous bilirubin measurements
- Designing the new 31 bed Hybrid NICU with private rooms and other amenities.

NICU graduates

2012
23 wks
510

690 g
2011
25 wks

865 g
2010
26 wks

1250 g
27 wks
2005

1080 g
2011
27 wks

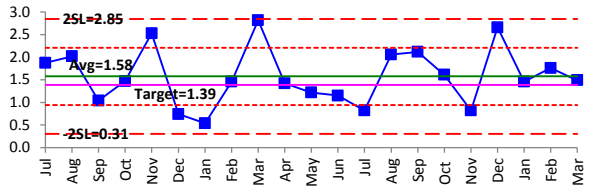
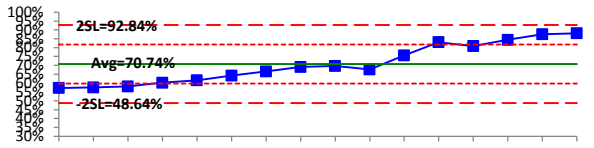
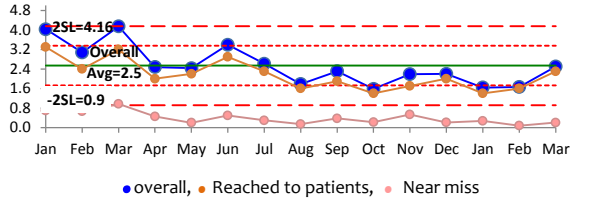
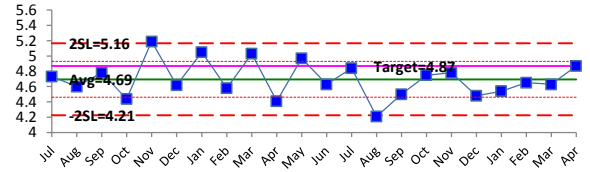
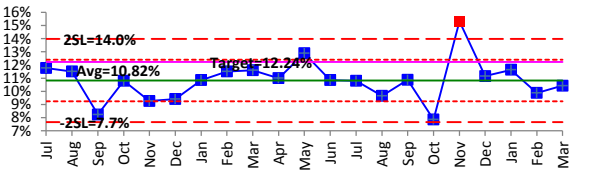
24wks
2013
660 g

Thank You

- Fellow Neonatologists.
- Ms. Jody Charles NICU Nursing Manager and Ms. Debbie Groth MCH Director.
- Ms. Ashlee Fontenot NICU Nurse Practitioner.
- Ms. Danielle Loyola Research Nurse Support and Ms. Terri Muench CPQCC assist.
- Wonderful NICU Nursing Staff and Administrative Assistants.
- Ms. Ulana Bhaviripudi NICU Pharmacist and Amanda Cooley NICU dietitian.
- Ms. Rhonda Winton MSW and Ms. Michelle Thomas Case Manager.
- Perinatologists, Obstetricians and Pediatricians.
- Physical Therapists, Nutritional Services and Lactation Consultants.
- Respiratory Therapists and Phlebotomists.
- NICU Graduates and their Parents.

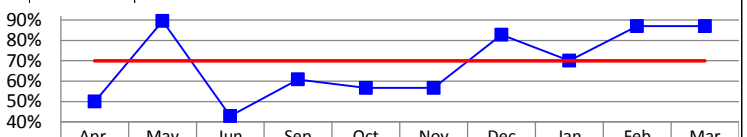
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

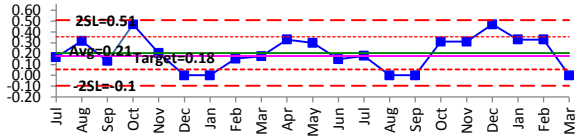
Date Reports Run: 5/11/2017			Baseline	FY17 Goal	Trend	Comments
SAFETY EVENTS	Performance		FY2016	FY2017		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: March 2017*	9/6058	1.49	1.51	1.39 (goal for FY 16)		Falls Team states: Three ways to prevent falls—stay with patient in bathroom, activate bed alarms, and accurately assess fall risk. Fall Prevention Policy compliance audits continue, Trend of falls--increase on Sat/Sun--day shift. Team has reviewed ED process to identify fall risk pts, and Rauland report on bed exit and toilet response time, and other tools for MBU & BHS.
2 ★Organizational Goal **Pain reassessment within 60 mins after pain med administration** *Date Period: April 2017*	8729/9903	88.1%	59.8% (Jan-Jun 2016)	75% (min) 80% (mid) stretch goal=90%		Contine weekly unit recognition, nurse badge buddies distributed, Pain website under development, Order sets under review, Pain Mgmgt Pharmacist starts July 31st.
3 **Medication Errors (Overall: reached to patients and near miss)** *Errors / 1000 Adj Total Patient Days* *Date Period: March 2017*	37/14801	2.50	2.68	0.00		Overall rate is up due to more errors reaching the patient, near miss reports have decreased.
EFFICIENCY	Performance		Jan-Jun 2016 (6-month avg)	FY 2017		
4 ★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: April 2017*	FYTD 4320 March 2017 46	FYTD 4.62 March 2017 4.87	4.78	4.87		In April, 3 very long stay patients finished extensive treatments were discharged or transferred, so their entire LOS becomes part of the months LOS. 1- Valley Fever 10weeks IV treatment, 1-very ill in ICU 21 days tx to LTAC, 1-spinal leak and cardiac issues.
5 ★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: March 2017*	FYTD 425/3839 Mar 2017 49/470	FYTD 11.07 Mar 2017 10.43	11.53	At or below 12.24		Rate is remaining below goal.

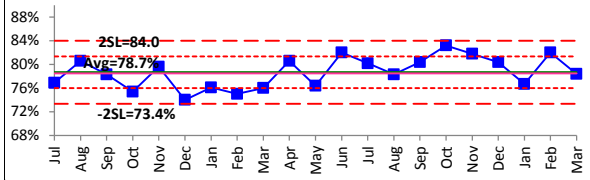
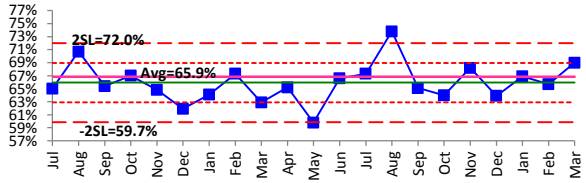
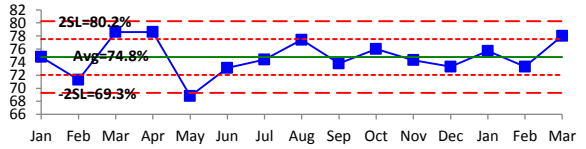
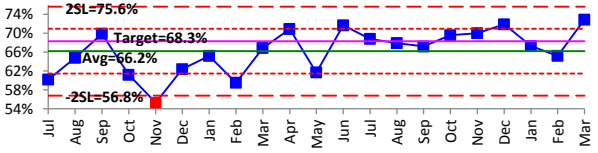
Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
Patient Falls	Sheetal Shah; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when staff attempts to minimize the impact of the fall, it is still a fall). *Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.*		**QRR Reporting and Staff Validation**
Pain Reassessement within 60 minutes after pain med administration	Chris Tarver; Cheryl Reinking		Pain Reassessment is measured as documentation on the iCare EHR Flowsheet in at least one of the 9 designated flowsheet rows, for designated medications marked as "given" on the MAR. The designated medications cover 95% of the PRN pain medications administered as "PRN" (pharmacy class/medication IDs). Exclusion criteria is as follows: Epidural route, Endoscopy Unit, Interventional Services, and the "PRN reasons" of "shivering, none (NULL) and other".		**EPIC report**
Medication Errors	Sheetal Shah; Cheryl Reinking	Medication Safety Committee; P&T Committee	5 Rights MEdication Errors: [# of Med Errors (includes: Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Rout, Incorrect Dose, Incorrect Time, Incorrect Medication order, Medication Reconciliation) divided by Adjusted Total Patient Days (includes L&D & Nursery)]* 1,000 *Near miss and reached patients.*		**QRR Reporting and Staff Validation**
Average Length of Stay	Cheryle Reinking; Mick Zdeblick	LOS Steering Committee	Average LOS of Medicare FFS, Paitents discharged from an Acute Care or Intensive Care unit. Excludes expired patients. Includes final coded patients aged 65 an older at the time of the encounter. The baseline period is from Jan-June 2015 and the performance period is from Jan-June 2016.		**EDW Data Pull, Department of Clinical Effectiveness**
30-Day Readmission (LOS-Focused)	Margaret Wilmer; Cheryle Reinking	Readmission Committee	Percent of Medicare inpatient discharges return for an unplanned IP stay for any reason within 30 days, aged ≥65. Excludes patients who die, leave AMA or are transferred to another acute care facility; excludes admits to ECH Rehab and Psych admissions and for medical treatment of cancer.		**EDW Data Pull, Department of Clinical Effectiveness**

Date Reports Run: 3/12/2017		Baseline	FY17 Goal	Trend	Comments
6	★Organizational Goal **IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) Date Period: March 2017	Goal: 70% (Min); 75%(Max); 80% (Stretch)			The ED Physicians are using the order set more consistently and thus the orders for fluid are provided for more cases.

	Apr	May	Jun	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of Sampled Cases	18	19	21	23	30	30	29	30	30	30
Cases with 30ml/kg ordered or NICOM with 3 hours TOP	0	0	0	1	0	0	0	2	1	0
Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17	9	14	17	17	24	21	26	26
% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%	43%	61%	57%	57%	83%	70%	87%	87%
Min Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

COMPLICATIONS		Performance		FY 2016	FY 2017	Trend	Comments
7	**Surgical Site Infection (SSI)** *SSI per 100 Clean/Clean-contaminated Surgical Procedures* *Date Period: March 2017*	0/709	0.00	0.20	0.18 (goal for FY 16)		Zero SSI for March at both campuses.

SERVICE		Performance		FY 2016	FY 2017	Trend	Comments
8	**Communication with Nurses** *(HCAHPS composite score, top box)* *Date Period: March 2017*	162/207	78.4%	78.0%	78.5%		Results back to 2016 performance and at goal.
9	**Responsiveness of Hospital Staff** *(HCAHPS composite score, top box)* *Date Period: March 2017*	132/192	69.0%	64.9%	66.8%		March shows some improvement.
10	★Organizational Goal **Pain management** (HCAHPS composite score, top box) *Date Period: Mar 2017*	119/162	78.0%	72.5%	73% min 74% max 76% stretch		March with significant improvement, reflecting the pain reassessment improvement.
11	**Communication About Medicines** *(HCAHPS composite score, top box)* *Date Period: March 2017*	136/186	65.2%	72.9%	68.3%		Significant rebound in March.

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock	Catherine Carson			Percentage of Randomly Sampled ED Patients (LG & MV) who had IVF >=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate <3 Excluded)	**EPIC Chart Review**
Surgical Site Infection	Catherine Nalesnik; Carol Kemper, MD	Infection Control Committee	(Number of Deep Organ Space infections divided by the # of all sugery cases)*100 counted by the month procedure under which infection was attributed to and not by the month it was discovered. All Surgery Cases in the 29 Surgical Procedural Categories required by the California Department of Public Health.		**IC Surveillance and NHSN Data Reporting**
Nov 2 cases: 1 Colon w/ resection and tumor debulking, developed abscess & perforated bowel.					
Communication with Nurses	Michelle Gabriel; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	Percent of inpatients responding "Always" to the following 3 questions [% Top Box]: 1. *During hospital stay, how often did the nurses treat you with courtesy and respect?* 2. *During hospital stay, how often did nurses listen carefully to you?* 3. *During hospital stay, how often did nurses explain things in a way you can understand?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Responsiveness of Hospital Staff	Michelle Gabriel	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. *During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?* 2. *How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted (for patients who needed a bedpan)?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Pain management	Chris Tarver, Meena Ramchandani	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. Pain well controlled, 2. Staff do everything help with pain		**Press Ganey Tool**
Communication About Medicines	Michelle Gabriel; Cheryl Reinking; Bob Blair	Patient Experience Committee	Percent of inpatients (who received meds) responding "Always" to the following 2 questions [% Top Box]: 1. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? 2. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**

El Camino Hospital
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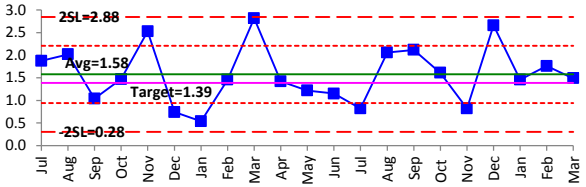
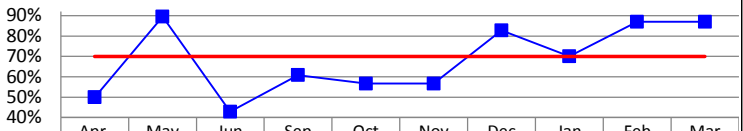
Quality and Safety Dashboard (Monthly)

Date Reports Run: 4/11/2017			Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS	**Performance**		**FY2016**	**FY2018**		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: March 2017*	9/6058	1.49	1.51	1.39 (goal for FY 16)		Falls team evaluating new pajamas with ankle cuffs to avoid pts. tripping on long pant legs. Use of bed and chair alarms reinforced.
2 **Hospital Acquired Infection (SIR rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *Date Period: July 2017*						
3 *Central Line Associated Blood Stream Infection (CLABSI)* *Date Period: July 2017*						
4 *Clostridium Difficile Infection (CDI)* *Date Period: July 2017*						
Efficiency	**Performance**		**Jan-Jun 2016 (6-month avg)**	**FY 2018**		
5 ★Organizational Goal **Arthimetric Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: July 2017*						

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2017 Definition	FY 2018 Definition	Source
Patient Falls	Sheetal Shah; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when		**QRR Reporting and Staff Validation**
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carso/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.		
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Catherine Carso/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Catherine Carso/Catherine Nalesnik				
Arithmetic Observed LOS Average over Geometric LOS Expected.	Cheryl Reinking Catherine Carson (Jessica Hatala)		The Observed LOS over the Expected LOS Ratio is determined by calculatign the average length of stay of all Medicare financial class divided by the GMLOS (geomettric LOS associated with each patient's MD-DRG.		

Date Reports Run: 3/12/2017		Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** *Date Period: July 2017*				
7	★Organizational Goal **IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) *Date Period: March 2017*			Goal: 70% (Min); 75%(Max); 80% (Stretch) 	The goal of 80% is exceeded with only 1 case not receiving the fluid order w/I 2 hrs of presentation.

	Apr	May	Jun	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of Sampled Cases	18	19	21	23	30	30	29	30	30	30
Cases with 30ml/kg ordered or NICOM with 3 hours TOP	0	0	0	1	0	0	0	2	1	0
Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17	9	14	17	17	24	21	26	26
% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%	43%	61%	57%	57%	83%	70%	87%	87%
Min Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

Mortality	Performance	FY 2016	FY 2018		
8	**Mortality Rate** ***Observed/Expected*** *Date Period: July 2017*				

SERVICE	Performance	FY 2016	FY 2018		
9	**HCAHPS Rate Hosptal 0-10** **Top Box Rating 9 and 10** *Date Period: July 2017*				

Measure Name	Definition Owner	Work Group	FY 2017 Definition	Source
Sepsis Core Measure	Catherine Carson/Kelly Nguyen	Sepsis Steering Committee	New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate > 2 or evidence of organ dysfunction, Hospital must meet ALL 4 measures in order to be compliant with this core measure, Patients with septic shock require an assessment of volume status and tissue perfusion within 6 hours of presentation, Patients NOT included are those transferred from another facility or those placed on comfort cares.	**EPIC Chart Review**
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded)Shock	Catherine Carson		Percentage of Randomly Sampled ED Patients (LG & MV) who had IVF >=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate <3 Excluded)	**EPIC Chart Review**
Mortality Rate (Observed/Expected)	Catherine Carson			**Premier Quality Advisor**
HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10	Michelle Gabriel; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	"'9' or '10' (high)" for the Overall Hospital Rating item	**Press Ganey Tool**

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Patient and Family Advisory Council Updates (PFAC)

Cheryl Reinking, RN
Chief Nursing Officer

Michelle Gabriel
Director of Performance Improvement

Facts about PFAC

1. How many members are PFAC right now?
   - 8 Patients/family members of patients
2. What is the rotation plan? How many rotate off this year?
   - Generally all rotate off end of two years
3. How many have joined other committees at the hospital?
   - Alex on Quality Committee of the Board
   - Ina Baumann joined Pain management A3
   - Tayler Cox has made a significant contribution on the ED redesign committee.
   - Amer Haider has represented our hospital at the HIMSS conference recently where he served on a panel as a El Camino Hospital PFAC member.

January 24, 2017 Meeting

1. INFECTION CONTROL PRESENTATION:
   - Infection Control presented about infection control in our hospital, the purpose of isolation, the limitations placed on visitation and staff as well as the PPE requirements
   - Received feedback on what patients think of flu restrictions and ways for staff to script to patients/families the reasons for PPE and visitation restrictions.
2. HYGIENE DISCUSSION
   - Director of MedSurg received feedback on patient hygiene and bathing in a hospital .
   - Presented several new hygiene products for feedback.

March 14, 2017 Meeting

1. PROPOSED STANDARDIZED UNIFORMS FOR HOSPITAL STAFF
   - CNO presented evidence based data on how standardized uniforms has led to increased patient satisfaction and also received patient feedback on styles and colors of uniforms.
   - Received feedback on patient/family perceptions of standardized uniforms by role in the hospital setting.

2. LOST BELONGINGS PROCESS
   - Patient Experience Team gathered feedback on how to improve documentation of patient's belongings in the hospital in order to reduce incidents.

May 9, 2017 Meeting

1. EMERGENCY DEPARTMENT REDESIGN PROCESS
   - Received feedback on the ED Redesign Process and New Passport that is presented to patients upon arrival in the ED.

2. MOON NOTICE FEEDBACK
   - Discussed MOON Notice and how it impacts patients as well as the hospital.
   - Received feedback on the wording of the MOON Notice and how the verbal scripting of the content needs to be explained to patients and families.

Goal for Future

- Engage PFAC members in the improvement work as much as possible.
- Include PFAC members on the Strategic Planning Initiatives.
- Learning from Planetree visit will help inform further development of robust PFAC deployment.

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

PROPOSED FY 18 Pacing Plan

FY2018 Q1		
JULY 2017	**AUGUST 7, 2017**	**August 28, 2017**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2018 Committee Goal Completion Status ▪ FY18 Pacing Plan ▪ Quality Council Minutes ▪ Patient Story ▪ Research Article	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items 1. Committee Recruitment 2. Update on Patient and Family Centered Care 3. FY17 Organizational Goal Achievement Update 4. Review proposed new format for Quarterly Quality and Safety Review 5. BPCI program 6. Appoint Committee Vice Chair	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda items: 1. Committee Recruitment 2. FY 17 Organizational Goal Achievement Update/Approval 3. FY 18 Organizational Goal Metric Approval 4. Review proposed new format for quarterly Quality and Safety review
FY2018 Q2		
OCTOBER 2, 2017	**OCTOBER 30, 2017**	**DECEMBER 4, 2017**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. FY 17 Organizational Goal Achievement Update/Approval 3. Year-End Review of RCA (10/25 – Joint Board and Committee Session)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Peer Review Process Changes Implementation Update 2. Safety Report for the Environment of Care 3. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 7. Update on Patient and Family Centered Care 8. Credentialing Process Report

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FY2018 Q3		
JANUARY 2018	**FEBRUARY 5, 2018**	**MARCH 5, 2018**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 7. Update on Patient and Family Centered Care 8. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 7. iCare Update 8. Proposed FY19 Organizational Goals
FY2018 Q4		
APRIL 2, 2018	**APRIL 30, 2018**	**JUNE 4, 2018**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 7. Update on Patient and Family Centered Care 8. Proposed FY 19 Committee Goals 9. Proposed FY 19 Committee Meeting Dates 10. Review Committee Charter 11. Proposed FY 19 Organizational Goals (4/25 – Joint Board and Committee Session)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 7. Proposed FY 19 Committee Goals 8. Proposed FY 19 Organizational Goals 9. Review Biennial Committee Self-Assessment Results 10. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 7. Update on Patient Centered Care 8. Approve FY19 Pacing Plan

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Quality, Patient Care and Patient Experience Committee
Goals for FY 2018 - PROPOSED

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality 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 Quality Committee helps to assure that exceptional patient care and 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.

Staff: Will Faber, MD, Chief Medical Officer

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff, VP of Patient Care Services, physicians, nurses, and members from the Community Advisory Councils or the community-at-large. The CEO is an ex-officio of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	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 the Quality, Patient Care, and Patient Experience Committee.	▪ Q1 – Goals ▪ Q3 - Metrics	▪ Review, complete, and provide feedback given to management, the governance committee, and the board.
2. Alternately (every other year) review peer review process and medical staff credentialing process. Monitor & Follow through on the recommendations made through the Greeley peer review process.	Q2	▪ Receive Update on Implementation of Peer Review Process Changes ▪ Review Medical Staff Credentialing Process

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Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
3. Develop a plan to review the new Quality, Patient Care, and Patient Experience Committee Dashboard and ensure operational improvements are being made to respond to outliers.	▪ Q1 – Q2 Proposal ▪ Q2 – Implementation ▪ Monthly Q1 – Q4	▪ Receive a proposed format for Quarterly Quality and Safety Review, make a recommendation to the Board and implement new format. ▪ Monthly Review of FY18 Quality Dashboard
4. Oversee development of a plan with specific tactics, and monitor the HCAHPs scores for Patient and Family Centered Care.	▪ Q2	▪ Review the plan and approve.
5. Monitor the impact of interventions to reduce hospital acquired infections	▪ Quarterly	▪ Review progress towards meeting quality (infection control) organizational goal.

Submitted by:
Dave Reeder, Chair, Quality Committee
Will Faber, MD, Executive Sponsor, Quality Committee

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FY18 Organizational Goals: For Discussion and Approval

- Format and framework of the organizational goals has been approved by the Executive Compensation Committee (ECC) of the Board.
- Specifically;
  - a threshold goal based on financial performance to budget
  - three goals that collectively impact the entire organization, generally focused on Quality, Service Affordability, and being Patient Centric
  - ½X, X, ½X format for Minimum, Target and Maximum. This is a change from last year, supported by the ECC May 23, 2017
- The Quality Committee of the Board needs to review and recommend to the Board the three specific Quality, Service, Affordability, or Patient Centric goals

FY18 Organizational Goals: For Discussion and Approval

ECH FY18 Organizational Goals

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Organizational Goals FY18	Benchmark	2017 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe
Threshold Goals							
Budgeted Operating Margin	90% threshold	Achieved Budget	90% of Budgeted			Threshold	FY 18
Arithmetic Observed LOS Average / Geometric LOS Expected for Medicare population (ALOS / GMLOS)	External : Expected via Epic Methodology	*FY2016: 1.21 (ALOS 4.86 / GMLOS 4.00)* *FY2017 YTD April:* ***1.18*** *(4.81/4.08)*	1.12	1.11	1.09	34%	4Q FY18
HCAHPS Service Metric: Rate Hospital	External Benchmark	HCAHPS Baseline: 10/2016 - 12/2016: **75.5** 1/2017 - 3/2017: **75.1**	77	78	79	33%	4Q FY18
Standardized Infection Ratio (SIR) Observed HAIs / Predicted HAIs (Hospital Acquired Infections)	External Benchmark	July - Dec 2016: CAUTI 1.37, CLABSI .25, C.DIFF .59 **Avg of .738**	0.670	0.602	0.534	33%	FY18

FY18 Organizational Goals: For Discussion and Approval

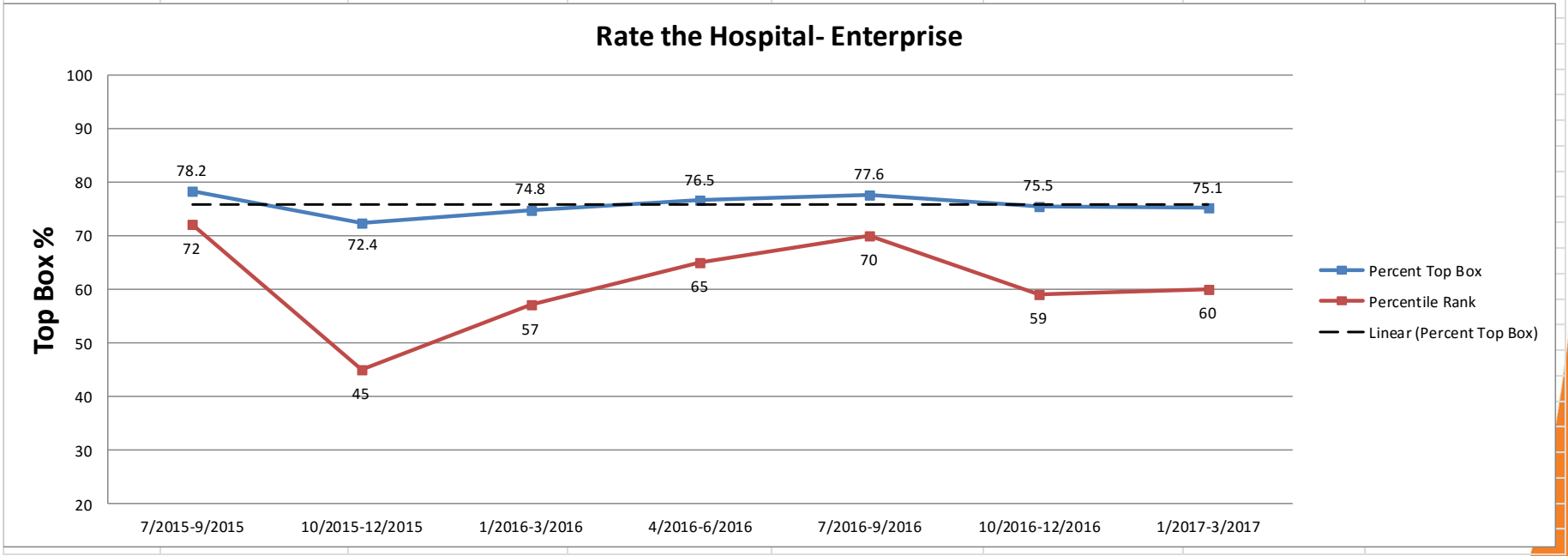
- For the last two years we have set internally focused LOS and Readmission goals, i.e. trend improvement. This year we are advancing the concept via an external component, expected GMLOS.
- By using an Observed (actual ECH performance) over Expected (GMLOS) ratio it captures both improvement in LOS management and better coding/ documentation (CDI effort).

CMI impacting GMLOS	Baseline	4.08
	3.0%	4.20
	4.0%	4.25
	5.0%	4.29
ALOS impacted by day reduction	Baseline	4.81
	625	4.71
	750	4.72
	875	4.69

FY18 Organizational Goals: For Discussion and Approval

- We are recommending "Rate the Hospital" CAHPS as the service goal, it allows for multiple interventions and is a very good capstone metric representing our consumers view of our service.

Rate hospital 0-10	7/2015-9/2015	10/2015-12/2015	1/2016-3/2016	4/2016-6/2016	7/2016-9/2016	10/2016-12/2016	1/2017-3/2017
Percent Top Box	78.2	72.4	74.8	76.5	77.6	75.5	75.1
Percentile Rank	72	45	57	65	70	59	60
n	**660**	**543**	**810**	**918**	**866**	**803**	**635**



FY18 Organizational Goals: For Discussion and Approval

- We discussed goal setting options with Press Gainey and they provided the following perspective:

FY 18 HCAHPS Goal Setting Analysis 5/8/17

El Camino Hospital (Aggregate)

Top box score from 5/1/16 – 4/30/17

					The top 50% of improvers' saw this much change:			The top 30% of improvers' saw this much change:			The top 10% of improvers' saw this much change:		
					Threshold Goal			Target Goal			Stretch Goal		
Service/Level	Peer Group	Score Type	Your Score	Your Rank	Top Box Score Increase	Top Box Score Goal	Percentile Rank Goal	Top Box Score Increase	Top Box Score Goal	Percentile Rank Goal	Top Box Score Increase	Top Box Score Goal	Percentile Rank Goal
HCAHPS													
Rate hospital 0-10	All PG DB	Top Box	75.8	64	0.8	76.6	65	2.2	78.0	71	4.2	80.0	80

Top xx% of improvers saw this much change: 50%, 30%, 10%: 76.6 78.0 80

Based on ECC feedback the Maximum goal was set at 79
A straight line progression of improvement.

FY18 Organizational Goals: For Discussion and Approval

- After good discussion with the Quality Committee of the Board, we have revised our third Organizational Goal to be focused exclusively on quality. We are proposing SIR, specifically focused on CAUTI, CLABSI, and C-DIFF.

STANDARDIZED INFECTION RATIO (SIR)

What is a standardized infection ratio (SIR)?

The standardized infection ratio (SIR) is a summary measure used to track HAIs at a national, state, or local level over time. The SIR adjusts for patients of varying risk within each facility. The method of calculating an SIR is similar to the method used to calculate the Standardized Mortality Ratio (SMR), a summary statistic widely used in public health to analyze mortality data. In HAI data analysis, the SIR compares the actual number of HAIs reported with the baseline U.S. experience (i.e., NHSN aggregate data are used as the standard population), adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. In other words, an SIR greater than 1.0 indicates that more HAIs were observed than predicted, accounting for differences in the types of patients followed; conversely, an SIR less than 1.0 indicates that fewer HAIs were observed than predicted.

FY18 Organizational Goals: For Discussion and Approval

HAI	Facility – MV	# of HAI	Facility- LG	# OF HAI	AVE SIR	Target SIR	
CAUTI	2016 H2 – 1.817	11	2016 H2 – 0.932	1	1.375		
HX 2015-2016	0.767	20	0.6385	3	0.703	1.039	
CLABSI	2016 H2 – 0.492	2	2016 H2 - 0	0	0.246		
HX 2015-2016	0.31	5	0	1	0.155	0.201	
C.DIFF	2016 Q4-1.185	2016 Q4 - 10	2016 - 0	2016 Q4 - 0	0.593		
HX 2016	0.753	23	0.331	1	0.542	0.567	
AVE SIR CURRENT					0.738		
AVE SIR HX					0.467		
Delta					0.271		
						Infection Rate Index: Target	
1/4 if Delta = Min					0.068	0.670	Minium
½ Delta = X					0.136	0.602	Target
Max = Delta					0.203	0.534	Max

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- Minimum is ¼ to historical best (last 4 years)
- Target improvement is ½ to historical best
- Maximum is historical best on all three indicators

- An alternative would be 1 of 3, 2 of 3, 3 of 3 achievement of target SIR per each HAI. This was not supported by ECC discussions.

In raw numbers the occurrences are small, but the impact is significant.

HAI Type	Fiscal Yr 2016	Fiscal Yr 2017 to date (April 2017)
CAUTI	8	18
CLABSI	1	6
C.Diff	17	15