AGENDA

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

Monday, March 5th, 2018, **5:30 p.m.**
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Ina Bauman will be participating via videoconference from 11768 China Camp Road Truckee, CA 96161.

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**	Dave Reeder, Quality Committee Chair		**5:30 – 5:31pm**
2.	**ROLL CALL**	Dave Reeder, Quality Committee Chair		**5:31 – 5:32**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**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.*	Dave Reeder, Quality Committee Chair	*public comment*	**Motion Required** **5:33 – 5:36**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (February 5, 2018) ***Information*** b. Patient Story c. Research Article d. FY18 Pacing Plan e. Progress Against FY 2018 Committee Goals			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion** **5:36 – 5:39**
6.	**COMMITTEE SELF-ASSESSMENT** **ATTACHEMENT 6**	Dave Reeder, Quality Committee Chair		**Discussion** **5:39 – 5:59**
7.	**FY18 QUALITY DASHBOARD** **ATTACHMENT 7**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **5:59 – 6:14**
8.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE** **ATTACHMENT 8**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:14 – 6:24**
9.	**CDI DASHBOARD** **ATTACHMENT 9**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:24 – 6:34**
10.	**CORE MEASURES** **ATTACHMENT 10**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:34 – 6:44**
11.	**JOINT COMMISSION PREPAREDNESS** **ATTACHMENT 11**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:44 – 6:54**

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
12. PUBLIC COMMUNICATION	Dave Reeder, Quality Committee Chair		**Information** **6:54 – 6:57**
13. ADJOURN TO CLOSED SESSION	Dave Reeder, Quality Committee Chair		**Motion Required** **6:57 – 6:58**
14. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Dave Reeder, Quality Committee Chair		**6:58 – 6:59**
15. CONSENT CALENDAR *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required** **6:59 – 7:02**
Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (February 5, 2018) ***Information*** b. Quality Council Minutes (December 6, 2017)			
16. ADJOURN TO OPEN SESSION	Dave Reeder, Quality Committee Chair		**Motion Required** **7:02 – 7:03**
17. RECONVENE OPEN SESSION/REPORT OUT	Dave Reeder, Quality Committee Chair		**7:03 – 7:04**
To report any required disclosures regarding permissible actions taken during Closed Session.			
18. ADJOURNMENT	Dave Reeder, Quality Committee Chair		**Motion Required** **7:04 – 7:05pm**

Upcoming FY18 Meetings

- April 2, 2018
- April 30, 2018
- June 4, 2018

Upcoming Board & Committee Educational Gatherings

- April 25, 2018

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, February 5, 2018
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder, Peter Fung, MD; Katie Anderson, Ina Bauman, Mikele Bunce, Nancy Carragee, Wendy Ron, and Melora Simon	Jeffrey Davis, MD	

**Katie Anderson joined the meeting at 5:40pm*
**Melora Simon joined the meeting at 5:41pm*
**Mikele Bunce left the meeting at 7:05pm*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 5th of February, 2018 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 Chair Dave Reeder at 5:32 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Dr. Jeffrey Davis was absent. Katie Anderson joined the meeting at 5:40pm and Melora Simon joined the meeting at 5:41pm.	***None***
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.	***None***
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 (December 4, 2017). **Movant:** Fung **Second:** Ron **Ayes:** Anderson, Bauman, Bunce, Carragee, Fung, Reeder, Ron, Simon **Noes:** None **Abstentions:** None	

Agenda Item	Comments/Discussion	Approvals/Action
	Absent: Davis **Excused:** None **Recused:** None	
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee. He highlighted: • Two new members to the El Camino Hospital Board of Directors: Gary Kalbach and Julie Kliger. • Mr. Kalbach has more than 30 years of experience in finance/entrepreneurship, strategic planning and partnership formation and served on more than 50 technology-based companies as a venture capital investor. He has served on the Governance Committee of the El Camino Hospital Board of Directors since 2012 and the Investment Committee of the Board of Directors since 2015. Prior to this, Mr. Kalbach was the Founding President and Chair of the Board of the Fogarty Institute of Innovation at El Camino Hospital. Additionally, since his retirement from a venture capital firm in 2006, he has served on numerous not-for-profit organizations. • Ms. Kliger is Managing Director of management consulting firm Alvarez & Marsal and is a key member of their West Coast Health Care Practice. She has more than 25 years of experience in leading large-impact care model redesign, strategic conversions, restructuring, corporate governance, and change management implementation. Prior to her work in strategic consulting, Ms. Kliger worked as a nurse at Stanford Children's Hospital and Highland Hospital in Oakland California. Ms. Kliger is a Fellow of the California Health Care Foundation.	***None***
6. QUALITY PROGRAM UPDATE: INTERVENTIONAL RADIOLOGY	Dr. Fabio Komlos and Dr. Bart Dolmatch presented an overview of El Camino's Interventional Radiology Services, which have grown by approximately 15% per year for the past ten years, resulting in 3,186 procedures in 2017 accounting for more cath lab activity than even Interventional Cardiology at ECH. Through the use of radiographically guided, minimally invasive techniques (chiefly intravascular catheters) these specialists decrease morbidity, mortality and hospitalization days by coiling bleeders, placing chemotherapy specifically where it is needed, obtaining biopsies in areas not accessible through other techniques, and avoiding many open	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	surgeries that would have longer and more painful recoveries. Over 99 percent of their patients have no complications at two months post-procedure. Both physicians asked for feedback and questions from the Committee and a brief discussion ensued.	
7. WENDY RON'S STORY	Committee member Wendy Ron relayed her own personal story of multiple hospitalizations at ECH related to a life-threatening illness. She gave the committee special insight into the sometimes-unanswered questions of patients, the boredom a chronic patient may encounter, the unanticipated impacts her illness had on her life, and the ways in which ECH effectively addressed her needs.	
8. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Ashlee Fontenot, RN, Manager of Patient Experience, updated the committee on the Patient and Family-Centered Care: Improving Patient experience through Nurse Communication Workgroups and Onsite Assessment by DTA. She highlighted several tactics ECH is now deploying to address known deficits identified through HCAHPS, including the use of Thank You cards given to patients at discharge, increased bedside handoffs and hourly rounding and the establishment of the Joy Committee. Ms. Fontenot asked the Committee members for feedback and a brief discussion ensued.	***None***
9. FY18 QUALITY DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, reviewed the quality dashboard with the committee. Ms. Carson reported that there were no new CLABSI or C.Diff but 2 new CATUI's in December that was related to hygiene. Ms. Carson further detailed the goal from the geometric LOS Expected for Medicare Population has lower ALOS through Epic banner usage, while CDI continues to improve GMLOS through better documentation of co-morbidities. She further explained the O/E mortality rate is 0.63 and we are approaching our goal of the top decile of western US hospitals due to the work of the CDI team. Ms. Carson also noted we are now at 78.7%, close to the maximum goal achievement of 79% for HCAHPS Rate The Hospital since the data is now by "received date".	

Agenda Item	Comments/Discussion	Approvals/Action
10. READMISSION DASHBOARD	Ms. Carson shared the new format for the FY 2018 Medicare 30 Day All-Cause, Unplanned Readmission Dashboard with the committee. She explained how our Hospital Readmission Reduction Program is doing very well. She briefly described the 7 diagnosis type for penalties for readmission and explained the actions that have taken place for the success such as a weekly readmission meeting and "Nose to Toes" program.	
11. PSI-90 PT. SAFETY INDICATORS	Ms. Carson explained that the PSI-90 Total Inpatient report is pulled from June 2017 to October 2017. The facility composite value was 0.686907 which is lower than the Premier PSI-90 score at 0.80 but ECH still has room for improvement to meet Premier PSI-90 top decile score of 0.57. She noted 6 out of 8 Patient Safety Indicators are less than AHRQ expected: Central Venous Catheter-Related Blood Stream, Postop Hip Fracture, Perioperative PE or DVT, Postop Sepsis, Postop Wound Dehiscence, and Accidental Puncture or Laceration.	
12. QUALITY RATINGS	Ms. reviewed different quality ratings being utilized nationally. She presented a rationale for using the nine Truven quality indicators as our true north for consolidated quality metrics, as opposed to using Premier or Leapfrog as the source of our goals. By cross walking the Truven Top 100 quality metrics with our Quality Advisory database and concentrating on our areas of deficit (while holding our position with other metrics) the quality improvement team believes we can earn CMS Five Star status.	
13. OPIOIDS USAGE DISCUSSION	William Faber, MD, Chief Medical Officer, reported that opioids usage is a national crisis and described some approaches that El Camino Hospital is using: hired a Pain Pharmacist, created a pain management steering committee, utilizing the CURES program, instilling protocols with limiting the numbers of opioids prescribed in the ED, monitoring patients receiving intravenous opioids, and instituting an outpatient pharmacy on site. In addition, Dr. Peter Fung shared the statistics of an article highlighting who should be responsible for taking care of opioid addicts. Dr. Faber asked the Committee members for feedback and a brief discussion ensued.	
14. CMO REPORT	William Faber, MD, Chief Medical Officer, reviewed his CMO report with the Committee. Items of note for the month included:	

Agenda Item	Comments/Discussion	Approvals/Action
	• Manager of Clinical Variation, Fran Franks, has started. • EGH Los Gatos Services was recognized as part of 111 hospitals for reducing cesarean births for first-time mothers with low-risk pregnancies by California Health and Human and on the 2017 Hospital C-Section Honor Roll.	
15. PUBLIC COMMUNICATION	None.	***None***
16. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:39 pm. **Movant:** Anderson **Second:** Simon **Ayes:** Anderson, Bauman, Carragee, Fung, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Bunce, Davis **Excused:** None **Recused:** None	***Adjourned to closed session at 7:39 pm.***
17. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:42 pm. *Agenda Items 17 – 19 were addressed in closed session.*	
18. AGENDA ITEM 22: ADJOURNMENT	The meeting was adjourned at 7:42 pm. **Motion:** To adjourn at 7:42 pm. **Movant:** Ron **Second:** Anderson **Ayes:** Anderson, Bauman, Carragee, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Bunce, Davis, Fung **Excused:** None **Recused:** None	***Meeting adjourned at 7:42 pm***

Attest as to the approval of the foregoing minutes by the Quality Committee of El Camino Hospital

_____

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

[redacted]

Hospital Administration
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Re: [redacted]

Dear Sir or Madam:

My [redacted] with dementia and kidney failure was taken by ambulance to your emergency room on [redacted] because of severe back pain. He was examined by one of your doctors and was sent home with a diagnosis of arthritis in his back. He was prescribed hydrocodone, col-rite and prednisone. By [redacted] he was screaming in pain, could not walk or get out of bed and was throwing up. He was taken again by ambulance to your hospital emergency room. After a few hours in your emergency room, he was examined and eventually admitted to room 4110.

At this time, someone in your care coordination department has stated that my brother [redacted] was explained about outpatient observation and I was told he signed paperwork that he understood what this meant. He has no knowledge of any form that he signed and was not explained about outpatient observation. If he signed this form, why was he not given a copy of it? We have taken my [redacted] to many other hospitals and have never encountered this situation. I find it very upsetting that everyone I have spoken to from the nurses to administrative staff are aware of this classification of outpatient observation. One Medicare agent advised me that he has warned his elderly parents about this and to never sign anything agreeing to outpatient observation. He explained to me that because of the way services are billed the hospital gets more money. This sickens me to think that the well-being of the patient, whether financial or physical, is not the top priority. Is your hospital administration more concerned about getting more money from Medicare than the patients well being?

I found three papers in my [redacted] belongings, two signed by [redacted] about emergency room treatment and one unsigned document about outpatient observation. We have requested a copy of the signed document and have not been provided with it. We have reviewed the unsigned paperwork and no one in our family has agreed to this outpatient observation classification and no family member understood what this meant.

[redacted] spent five days in your hospital clearly being treated for his back, pain and kidneys. How can someone spend five days in your hospital bed be considered an outpatient only being observed? If we understood this why would we not take [redacted] to his regular dialysis clinic which is covered by his insurance? He underwent dialysis in your hospital on Thursday and again on Saturday.

His first day in the hospital an MRI was performed and it was determined that he had a compression fracture and a kyphoplasty procedure would be performed. This procedure was not performed until his third day in your hospital. I do agree that this is a minor non-invasive procedure for a healthy person. But for a [redacted], who is on dialysis three days a week and is unable to walk without assistance from back pain, I believe it would be necessary to admit him into your hospital. He was in a bed in your hospital, unable to walk for five days. Your hospital performed an MRI, kyphoplasty and dialysis twice. How can this be considered outpatient observation?

Based on this information, I am asking that his records be reviewed again and that consideration be given to [redacted]'s age, mental capacity and kidney disease and his status changed from "outpatient" to "admitted". I believe that your doctors did not take the time to fully evaluate [redacted]'s condition and only looked at the computer records in their decision. In addition, if we were aware that he was only in the hospital as an outpatient, we would have taken him to another hospital for admittance.

Please advise our family what can be done about this matter. We are very dissatisfied with this situation and we hope that your hospital administration will take the necessary steps to change the status of [redacted].

We would appreciate a response in writing about this situation.

Thank you in advance for your assistance in this matter.

Sincerely,

[redacted]

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

MINUTES
Grievance Committee
[redacted]

Call to Order	11:08 a.m.	
Attendees	[redacted]	
Topic	**Discussion/Recommendations**	**Action**
New Case(s)		
[redacted]	**Responsible Unit**: 4A **Date of Service**: 10-30-17 | **Date Received**: 11-3-17 **Type of Grievance**: Clinical Care Concern **Committee Discussion**: Dr. [redacted] reports that the patient was admitted for severe lower back pain after being sent home once. He came back five days after the initial visit in the Emergency Department (ED). He was admitted and dialyzed. The family was told they signed paper work and understand the implications. However, the family stated that they were never told of it and never signed anything. When they did receive the patient's paperwork, the observation paperwork was not signed. The family has requested any signed copies that have never been provided to them also. Furthermore, the family did not agree to observation status. Kyphoplasty was performed and dialyzed during the patient's five-day stay. They are requesting for the status to change from outpatient to inpatient; if status remains the same, they are responsible for 20% of the bill. Per Dr. [redacted], the patient was too complicated to be discharged to return for an outpatient procedure. He would not have sent him home, given how debilitated and how much pain he was in with a compression fracture. Pt. Experience staff state that the patient's brother signed for outpatient observation status not the sister who has Dual Power of Attorney (DPOA). In addition to the hospital cost, they would also have to pay for the SNF bill. Care Coordination Manager has been notified about the grievance. Holding letter will be sent shortly. Director of Risk states that we don't know if we can change the status after the discharge. She questions why we were unable to catch this before he left. Per Dr. [redacted], most hospitals follow the two-midnight rule; they switch patients to inpatients after the 2nd midnight automatically. ECH is the only hospital that doesn't participate in the two-midnight rule. We're the only hospital that is sending patients to Executive Health Resources (EHR). A lot of hospitals have stopped using	Case sent to Director of Care Coordination regarding not contracting physician to change status to Inpatient, and to review case regarding use of Medicare 2 midnight rule. Also regarding clarity of discussion with Pt. or family members regarding impact of Observation status. Due to Observation status, the patient did not qualify for Medicare coverage of post-discharge SNF stay, due to lack of 3-day qualifying Medicare inpatient hospital stay. ECH wrote off the patient's portion of the hospital bill.

	EHR. ECH Care Coordination is very aggressive to keep patients as observation using old criteria. This patient would have met the inpatient criteria if we practiced the two-midnight rule. Dr. [redacted] has mentioned that he has attempted to speak to Care Coordination many times; unfortunately, there isn't anyone to think of the decision to change practices.. The patient's total charge is $82,071.79. Their responsibility is roughly $13K, with some adjustment (about 20% off the Medicare charges of $78K). Director of Risk states that we should figure out if this patient should have been inpatient. If both Drs. [redacted] have reviewed this case and determined that this patient should have been inpatient since he was too sick, we may have had a gap in our process, which would make it easier to support waiving the bill.	

Quality and Patient Safety Medical Director Date

The New York Times | https://nyti.ms/2F28mnd

SundayReview | OPINION

Doctors, Revolt!

By RICH JOSEPH FEB. 24, 2018

Boston — The 96-year-old patient with pneumonia in Bed 11 was angry. “Do you really need to check my vital signs every four hours?” he asked.

Checking things like temperature, blood pressure and respiratory rate every four hours on hospitalized patients has been the standard of care since the 1890s, yet scant data indicates that it helps. In fact, data shows that close to half of patients are unnecessarily awakened for such checks, perhaps to the detriment of their recovery. My patient wanted to know how, with all that poking and prodding, he was supposed to rest and get better.

“I understand your frustration,” I replied, “and wish I could help to change the situation.”

I may have been a lowly intern, but it was a feeble reply. And he knew it. “Understanding is not enough,” he said. “You should be doing something to help fix this system.”

The hospital, he lamented, is more like a factory — “it tests every ache and treats every laboratory abnormality, but it does little to heal its patients.” Treating and healing are both necessary, but modern health care too often disregards the latter.

Few understand this better than the patient in Bed 11. He turned out to be Bernard Lown, emeritus professor of cardiology at Harvard, a senior physician at Brigham and Women’s Hospital in Boston, and the founder of the Lown Cardiovascular Group. He is celebrated for pioneering the use of the direct-current

defibrillator for cardiac resuscitation and an implant called the cardioverter for correcting errant heart rhythms. He also co-founded the International Physicians for the Prevention of Nuclear War, which was awarded a Nobel Peace Prize and helped to educate millions on the medical consequences of nuclear war.

But Dr. Lown identifies first and foremost as a healer. In 1996, he published "The Lost Art of Healing," an appeal to restore the "3,000-year tradition, which bonded doctor and patient in a special affinity of trust." The biomedical sciences had begun to dominate our conception of health care, and he warned that "healing is replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technological procedures."

He called for a return to the fundamentals of doctoring — listening to know the patient behind the symptoms; carefully touching the patient during the physical exam to communicate caring; using words that affirm the patient's vitality; and attending to the stresses and situations of his life circumstances.

This time he was the patient in need of healing. And I was the doctor, the product of a system that has, if anything, become even more impersonal and transactional since he first wrote those words.

Despite his reputation, Dr. Lown was treated like just another widget on the hospital's conveyor belt. "Each day, one person on the medical team would say one thing in the morning, and by the afternoon the plan had changed," he later told me. "I always was the last to know what exactly was going on, and my opinion hardly mattered."

What he needed was "the feeling of being a major partner in this decision," he said. "Even though I am a doctor, I am still a human with anxieties."

The medical team was concerned that because Dr. Lown was having trouble swallowing, he was at risk for recurrent pneumonias. So we restricted his diet to purées. Soon the speech therapist recommended that we forbid him to ingest anything by mouth. Then the conversation spiraled into ideas for alternative feeding methods — a temporary tube through the nose followed, perhaps, by a feeding tube in the stomach.

“Doctors no longer minister to a distinctive person but concern themselves with fragmented, malfunctioning” body parts, Dr. Lown wrote in “The Lost Art of Healing.” Now, two decades later, he’d become a victim of exactly what he had warned against.

As the intern and the perpetrator of the orders, I felt impossibly torn and terribly guilty. So after Dr. Lown was discharged the next week, I kept in touch, hoping to continue this important conversation.

We have since spent time together at his home, where he is back to living peacefully and swallowing carefully (no alternative feeding methods necessary).

I had known Dr. Lown as a doctor and a patient; now I got to know him as an activist. We agreed that the health care system needed to change. To do that, Dr. Lown said, “doctors of conscience” have to “resist the industrialization of their profession.”

This begins with our own training. Certainly doctors must understand disease, but medical education is overly skewed toward the biomedical sciences and minutiae about esoteric and rare disease processes. Doctors also need time to engage with the humanities, because they are the gateway to the human experience.

To restore balance between the art and the science of medicine, we should curtail initial coursework in topics like genetics, developmental biology and biochemistry, making room for training in communication, interpersonal dynamics and leadership.

Such skills would not only help doctors care for our fellow human beings but would also strengthen our ability to advocate for health care as a human right and begin to rectify the broken economics and perverse incentives of the system.

Finally, hospitals should be a last resort, not the hallmark of the health care system. The bulk of health care resources should go instead into homes and communities. After all, a large majority of health problems are shaped by nonmedical factors like pollution and limited access to healthy food. Doctors must

partner with public health and community development efforts to create a culture of health and well-being in patients' daily lives.

As I navigate my professional journey, Dr. Lown's example inspires me to go to work every day with the perspective of a patient, the spirit of an activist and the heart of a healer.

Rich Joseph is a resident physician at Brigham and Women's Hospital.

Follow The New York Times Opinion section on Facebook and Twitter (@NYTopinion), and sign up for the Opinion Today newsletter.

A version of this op-ed appears in print on February 25, 2018, on Page SR12 of the New York edition with the headline: Doctors, Revolt!.

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan

FY2018 Q1		
JULY 2017	**AUGUST 7, 2017**	**August 28, 2017 (for September's meeting)**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Progress Against FY 2018 Committee Goals (Oct 30, March 5, June 4) ▪ FY18 Pacing Plan ▪ Med Staff Quality Council ▪ Patient Story ▪ Research Article	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 17 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 17 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda items: 1. Annual Patient Safety Report 2. Pt. Experience (HCAHPS) 3. ED Pt. Satisfaction (Press Ganey) 4. ECH Strategic Framework
FY2018 Q2		
OCTOBER 2, 2017	**OCTOBER 30, 2017 (for November's meeting)**	**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 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Culture of Safety Survey Results 6. Committee member recruitment (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 4. CDI Dashboard 5. Core Measures 6. Update on Patient and Family Centered Care 7. Update on Culture of Safety Results 8. Committee member recruitment	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. Pt. Experience (HCAHPS) 3. ED Pt. Satisfaction (Press Ganey) 4. Committee member recruitment

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan

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: 1. Update on Patient and Family Centered Care 2. Quarterly Quality and Safety Review 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Opioids Usage Discussion 6. Quality Ratings	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. iCare Update~~ 2. Proposed FY19 Organizational Goals 3. CDI Dashboard 4. Core Measures 5. Update on Patient and Family Centered Care
FY2018 Q4		
APRIL 2, 2018	**APRIL 30, 2018 (for May's meeting)**	**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: 1. Update on Patient and Family Centered Care 2. Proposed FY 19 Committee Goals 3. Proposed FY 19 Committee Meeting Dates 4. Review Committee Charter 5. Proposed FY 19 Organizational Goals 6. Leapfrog Survey Results 7. Value Base Purchasing Report 8. iCare Update (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: 1. Proposed FY 19 Committee Goals 2. Proposed FY 19 Organizational Goals 3. Review Biennial Committee Self-Assessment Results 4. Quarterly Quality and Safety Review 5. Pt. Experience (HCAHPS) 6. ED Pt. Satisfaction (Press Ganey) 7. Update on Patient and Family Centered Care 8. Credentialing Process Report	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 Centered Care 2. Approve FY19 Pacing Plan 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Update on Patient and Family Centered Care

FY18 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality Committee") is 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, 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 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: **William Faber, MD**, Chief Medical Officer

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 may participate in the meetings upon the recommendation of the CMO and at the discretion of the CEO and the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurse, and members from the community advisory councils or the community at-large. The CEO is an ex-officio member 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 FY18 – Goals • Q3 FY18 - Metrics	• Review, complete, and provide feedback given to management, the Governance Committee, and the Board. • The Board has approved the FY18 goals and the Committee is monitoring LOS, HCHAPS, GMLOS, and Standardized Infection Ratios.
2. Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the recommendations made through the Greeley peer review process.	• ~~Q2~~ Q4 FY18	• Receive update on implementation of peer review process changes • Review Medical Staff credentialing process
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 FY18 – Proposal • Q2 FY18 – Implementation • Month Q1 – Q4 FY18	• Receive a proposed format for quarterly Quality and Safety Review; make a recommendation to the Board and implement new format. • FY18 Quality Dashboard is completed and supplemented by 2 additional Quality Metrics reports which are being review at every meeting • Monthly review of FY18 Quality Dashboard
4. Oversee the development of a plan with specific tactics and monitor the HCAHPs scores for Patient and Family Centered Care.	• ~~Q2~~ Q3 FY18	• Review the plan and approve
5. Monitor the impact of interventions to reduce hospital-acquired infections.	• Quarterly	• Review process toward meeting quality

		(infection control) organizational goal • 1st quarter reviewed quality dashboard including standardized infection ratios

SUBMITTED BY:

David Reeder **Chair**, Quality Committee
William Faber, MD **Executive Sponsor**, Quality Committee

Approved by the ECH Board of Directors on June 14, 2017

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Quality, Patient Care and Patient Experience Committee Meeting Date: March 5, 2018
	Responsible party:	Cindy Murphy, Director of Governance Services
	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 Board Actions	

February 2018 ECH Board Actions*

1. February 14, 2018
    a. Approved Changes to Executive Compensation Philosophy, Executive Base Salary Administration Policy and Executive Incentive Plan Policy
    b. Approved FY18 CIO Base Salary – Deb Muro named CIO
    c. Approved FY 18 SVMD President Base Salary – Bruce Harrison named President of SVMD
    d. Approved the Government Investigations and Physician Financial Arrangements Policies
    e. Approved the PACS Image and Archive System Replacement ($2.2 million)
    f. Approved ED Call Panel Agreements for Interventional Radiology, Stroke &Neurology, and Urology at both campuses
    g. Approved FY18 Period 5 and 6 Financials
    h. Appointed Director Julie Kliger to the Quailty, Patient Care and Patient Experience Committee and the Executive Compensation Committee.
    i. Considered a proposal to delegate certain decision making authority to the Executive Compensation Committee, and gave direction to the Committee to develop procedures for exercising the proposed authority.
    j. Approved a revised Board and Committee Education Policy.

*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.

NYGREN CONSULTING
GOVERNANCE STRATEGY LEADERSHIP

El Camino Hospital

Quality, Patient Care and Patient Experience Committee
FY2017-18 Assessment Report

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Submitted on: January 25, 2018
Prepared for: Quality, Patient Safety and Patient Experience Committee
Prepared by: JoAnn McNutt, PhD and Zach Morfín, PhD

Introduction

Background

In keeping with the ECH Hospital Board's commitment to effective governance, Nygren Consulting was engaged to conduct the biennial performance assessment of the board committees, providing them with an opportunity to reflect on their performance during the Fiscal Year 2017-2018. The goal of the assessment was to identify the committees' strengths and areas for improvement, which would be integrated into their annual goals. This report provides the results of the Quality, Patient Care and Patient Experience Committee's ("Quality Committee") self-assessment.

Interpreting the Results

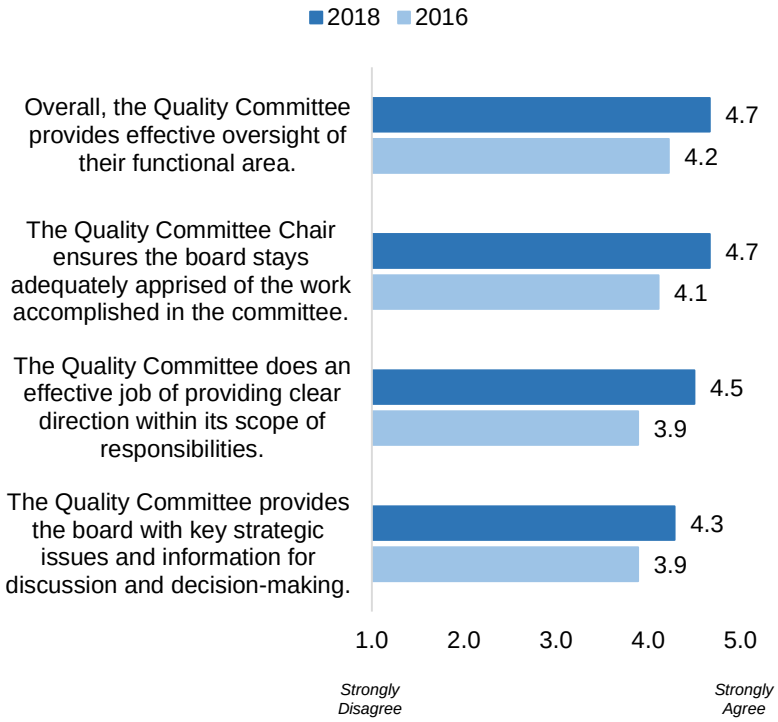
The Quality Committee assessment tool was comprised of twelve core items and three open-ended questions that applied to all committees, as well as five committee-specific items. Please note that because committee assessments are conducted on a biennial basis, the year-over-year analysis compares the committee's performance in 2018 against 2016.

The purpose of the assessment was to provide directional feedback to the Quality Committee. The quantitative scores herein are meant to provide insight into how the Quality Committee perceives its own performance. The assessment is not intended to provide statistically significant results, which cannot be achieved with a small sample size. Average scores are rounded to the nearest tenth decimal point as this will show variation in the ratings.

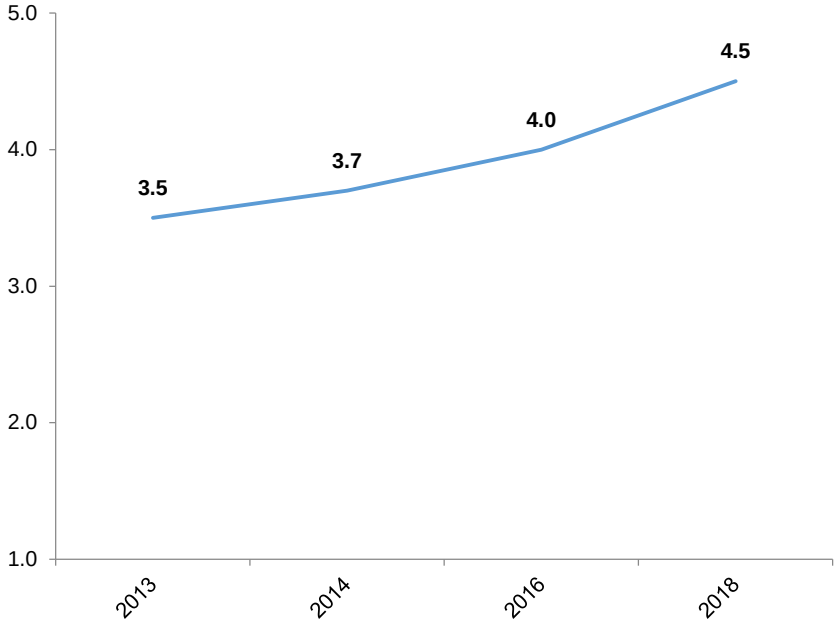
We set 3.5 as the threshold to determine whether a response is favorable. It is rare to achieve a perfect score of 5.0. Occasionally, we see an average score of 4.5 and above on exceptional cases.

Hospital Board's Assessment of the Quality Committee

Board's Assessment of the Quality Committee on the Four Standard Items



Board's Assessment of the Quality Committee Over Time



High-Level Summary of the Committee's Self-Assessment

Participation:

- 11 out of 11 stakeholders participated in the assessment (100%):
  - Non-director committee members = 6
  - Board members = 3
  - Executive leadership team members = 2

Self-Assessment Averages:

2018 = 4.0

2016 = 4.3

2014 = 4.1

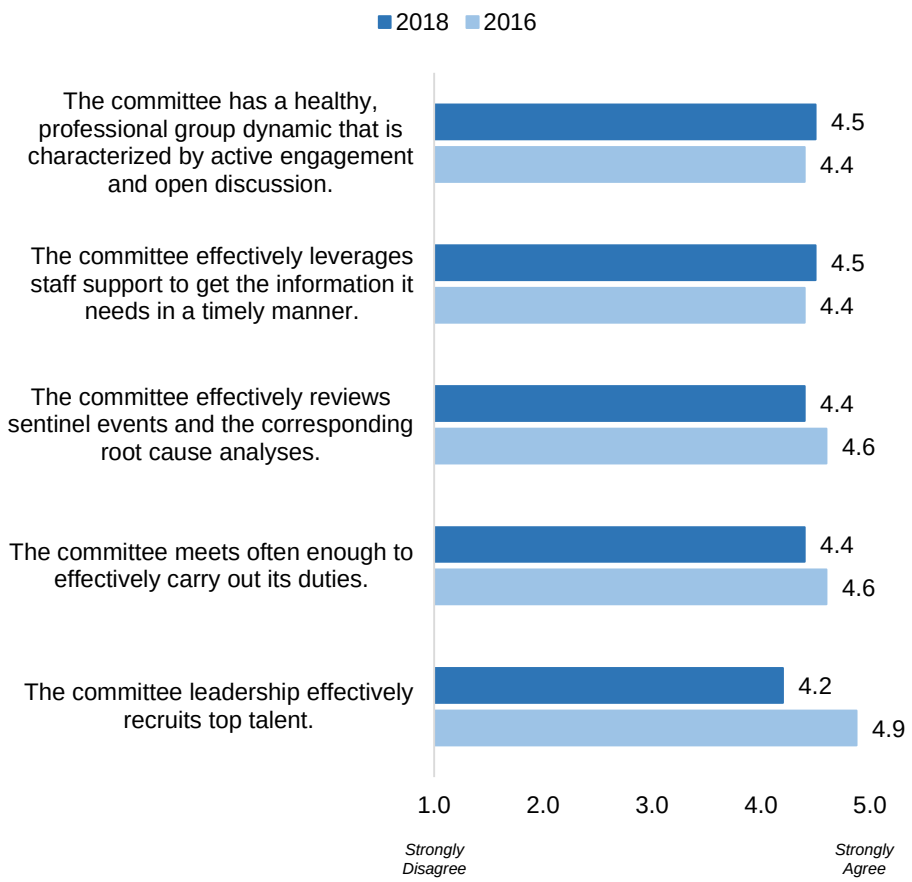
2013 = 3.5

Key Findings:

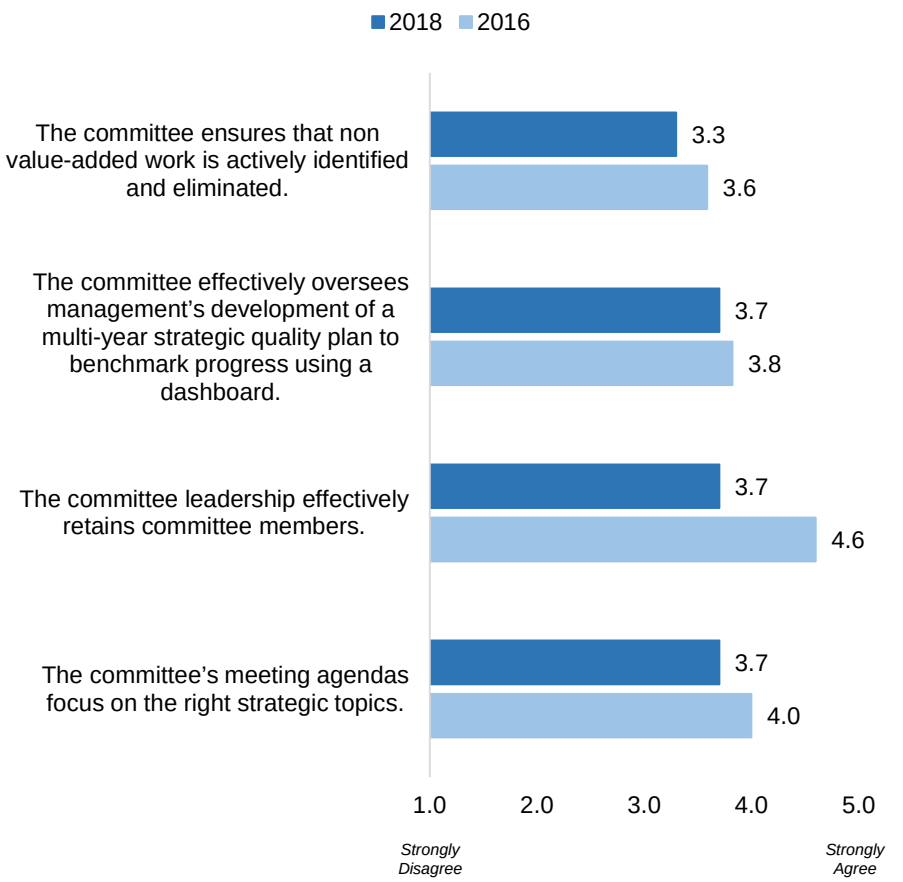
- The committee rated its performance lower on 15 of the 17 items when compared to its 2016 assessment. The items with the largest gaps were the following:
  - The committee leadership effectively retains committee members. (-0.9)
  - The committee leadership effectively recruits top talent. (-0.7)
  - The committee effectively monitors compliance with accreditation and licensing requirements. (-0.4)
  - The committee's decisions are aligned with board goals and organizational strategy. (-0.4)
  - The committee chair provides effective leadership for this committee. (-0.4)
- Open-ended comments pointed to the need for the following:
  - Greater patient focus and less reporting out in committee discussions
  - Reconsideration of meeting frequency
  - More physician and CEO engagement in meetings
  - Alignment with organizational strategy

Highest and Lowest Rated Items

Highest Rated Items



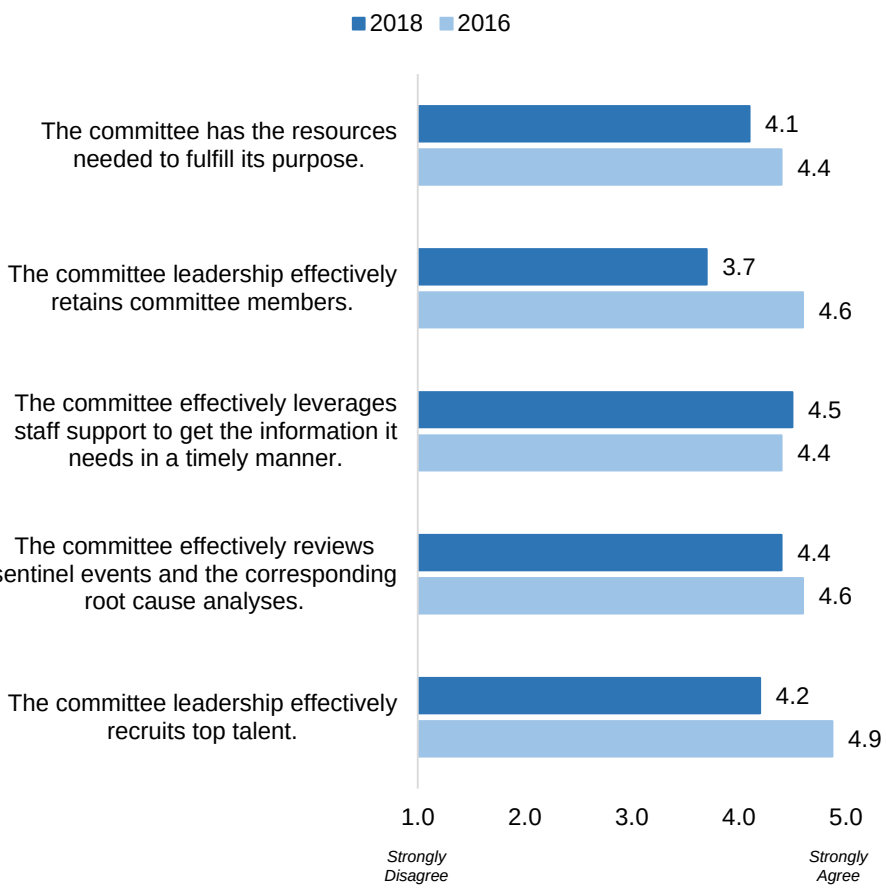
Lowest Rated Items



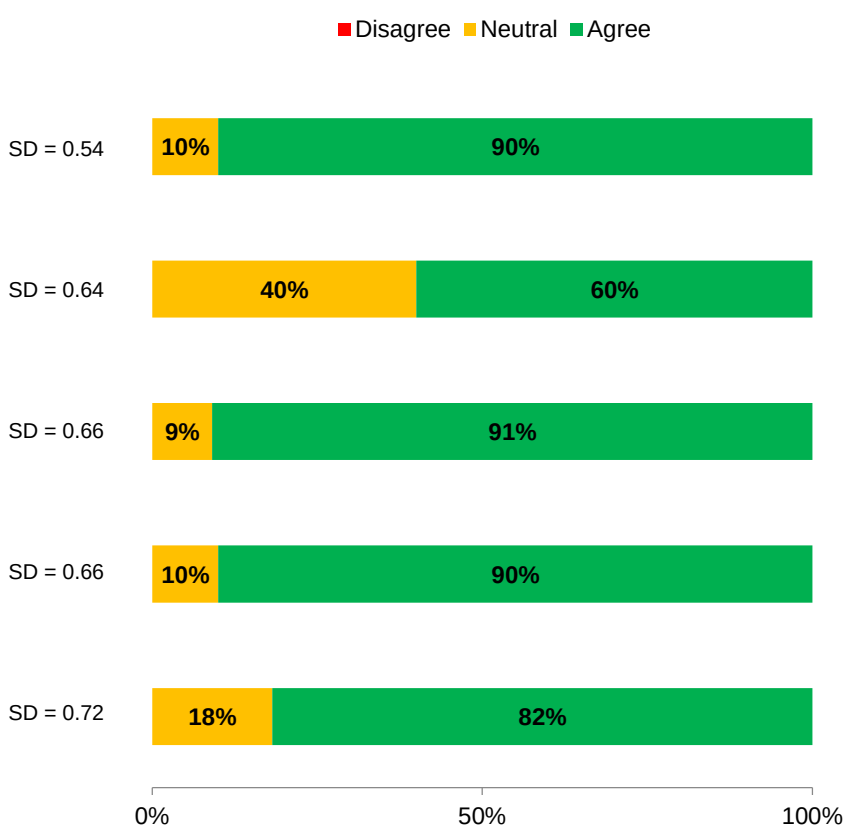
Areas of Greatest Agreement

Areas of agreement are determined by the standard deviation (SD), which is a measure of the dataset's spread around the mean. Higher standard deviations relate to a lower consistency or agreement across ratings for a particular survey item. The lower the SD, the greater agreement there is among respondents. The higher the SD, the less agreement there is among respondents. The distribution of ratings shows the corresponding number of individual ratings of 1 or 2, neutral responses of 3, and favorable responses of 4 or 5.

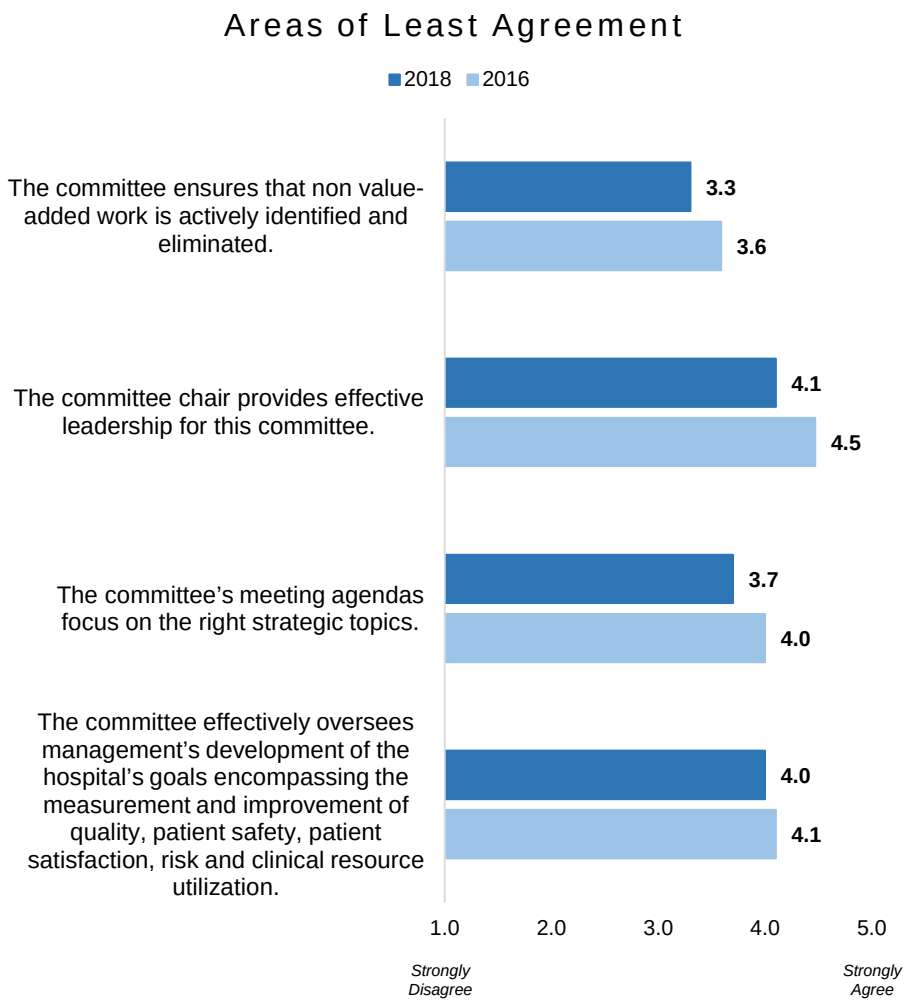
Areas of Greatest Agreement

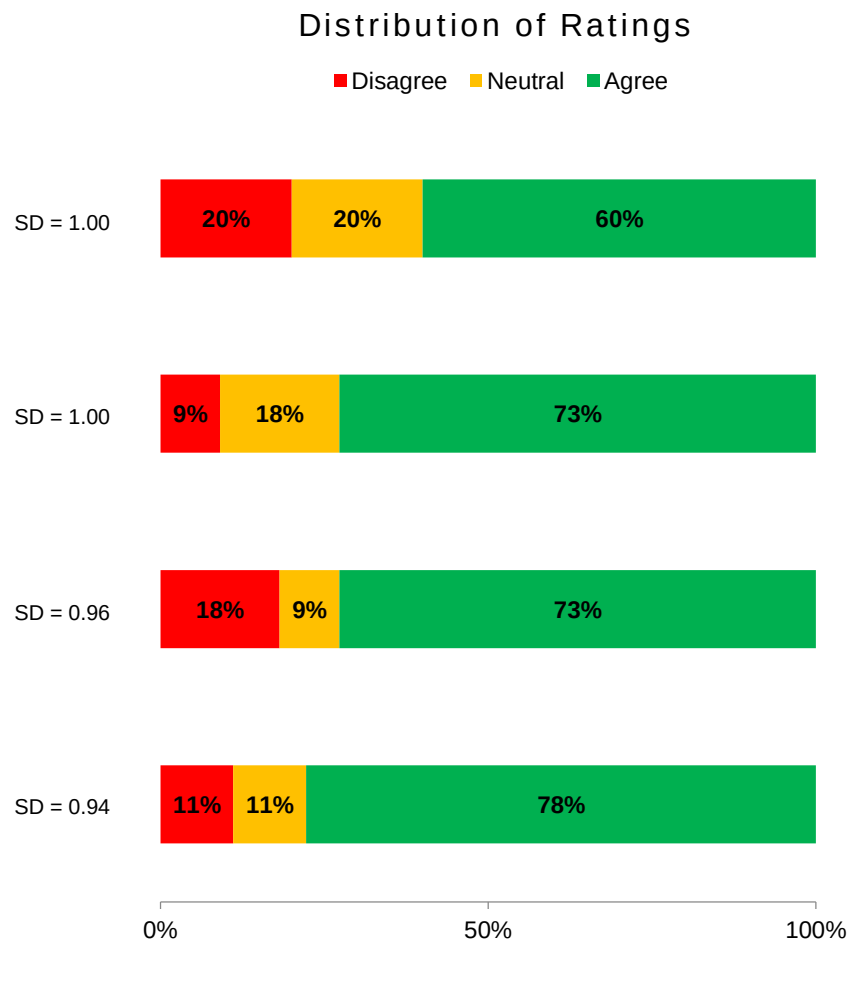


Distribution of Ratings



Areas of Least Agreement





Detailed Results by Item

The table below shows all survey items, sorted highest to lowest by 2018 rating. The *Difference* column represents the difference in ratings between the committee's 2018 vs. 2016 ratings. A positive difference indicates items where committee members rated the committee's performance **higher** than in 2016. Conversely, a negative difference indicates where members rated the committee's performance **lower** than in 2016**.**

Items Sorted Highest to Lowest by Stakeholder Rating	2018	2016	N	Difference
The committee effectively leverages staff support to get the information it needs in a timely manner.	4.5	4.4	11	0.1
The committee has a healthy, professional group dynamic that is characterized by active engagement and open discussion.	4.5	4.4	11	0.1
The committee effectively reviews sentinel events and the corresponding root cause analyses.	4.4	4.6	10	-0.2
The committee meets often enough to effectively carry out its duties.	4.4	4.6	11	-0.2
The committee leadership effectively recruits top talent.	4.2	4.9	11	-0.7
The committee has the resources needed to fulfill its purpose.	4.1	4.4	10	-0.3
The committee efficiently reaches consensus on its decisions or recommendations to the board.	4.1	4.2	10	-0.1
The committee chair provides effective leadership for this committee.	4.1	4.5	11	-0.4
Committee members understand the hospital well enough to add value.	4.0	4.1	10	-0.1
The committee's decisions are aligned with board goals and organizational strategy.	4.0	4.4	10	-0.4
The committee effectively oversees management's development of the hospital's goals encompassing the measurement and improvement of quality, patient safety, patient satisfaction, risk and clinical resource utilization.	4.0	4.1	9	-0.1
The committee effectively monitors and oversees the quality of patient care and service provided.	3.9	4.1	11	-0.2
The committee effectively monitors compliance with accreditation and licensing requirements.	3.9	4.3	11	-0.4
The committee's meeting agendas focus on the right strategic topics.	3.7	4.0	11	-0.3
The committee leadership effectively retains committee members.	3.7	4.6	10	-0.9
The committee effectively oversees management's development of a multi-year strategic quality plan to benchmark progress using a dashboard.	3.7	3.8	10	-0.1
The committee ensures that non value-added work is actively identified and eliminated.	3.3	3.6	10	-0.3

Thematic Summaries of the Qualitative Feedback

Opportunities for Improvement

- The committee should increase its focus on the needs of patients and patient-centered care, bringing the patient's voice into discussions.
- Discussions can also be more focused by reducing report-outs.
- A few individuals mentioned that the committee might be meeting too frequently to have meaningful agendas.
- The committee, overall, feels it is receiving the right information from management. That said, it is unclear whether the committee is effectively using the data.
- More physician engagement in the committee, as well as participation from the CEO, would be helpful.
- The committee needs to clarify how its work is tied to the hospital's broader strategy.

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Office: 415-686-3767 | Fax: 415-358-4804
info@nygrenconsulting.com | www.nygrenconsulting.com

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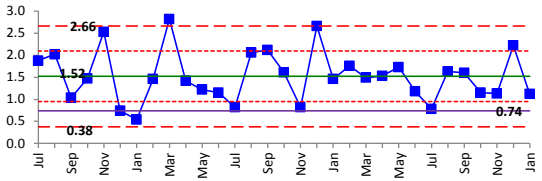
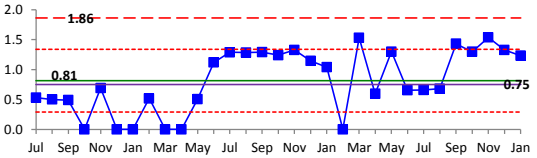
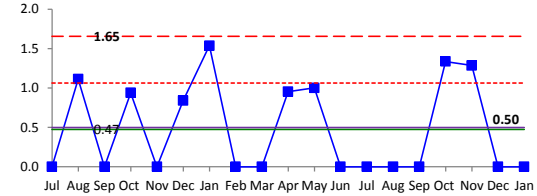
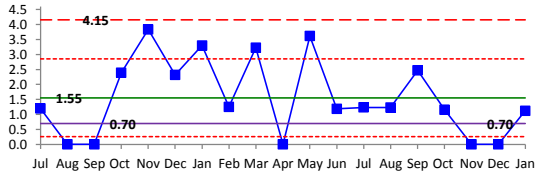
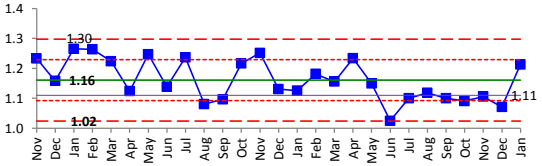
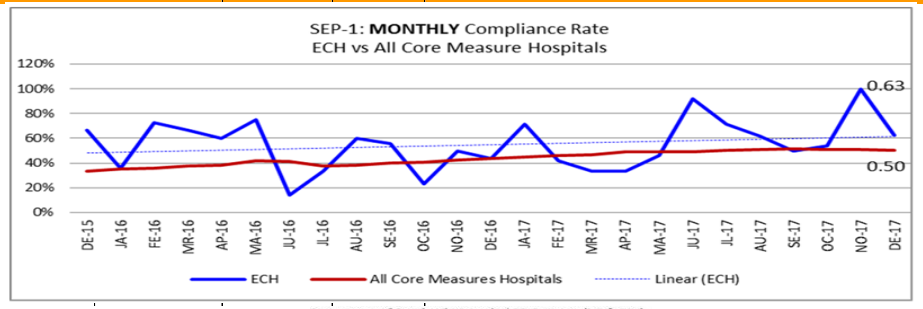
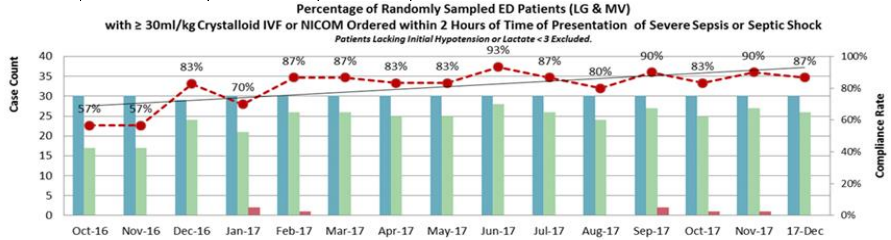
Quality and Safety Dashboard (Monthly)

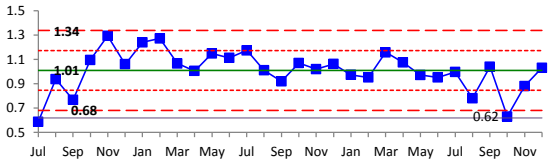
Reports run: 11/20/17			Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS	Performance Month	Performance FYTD	FY2017 Actual	FY2018 Goal		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: Jan 2018*	1.12 (7/6230)	1.38 (52/37587)	1.49	0.74 (Top decile CALNOC)		Falls dropped by half from 14 to 7. 1 Fall with moderate harm (stitches to scalp- neg . CT scan). RCA completed, pt with Hx of Falls, needed CNA to stay with Pt. when up. Alarms for toilet commode arrived, will allow staff to stand outside bathroom, and react when lifts off commode, affording pt. some privacy during toileting. Planning for nursing education on Hendricks Fall Risk Tool, last provided in 2013.
2 *Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Jan 2018* *SIR Goal: <= 0.75*	1.23 (2/1,623)	1.16 (12/10358)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		3 new CAUTI's in January: 1) 102 yo female: CAUTI occurred 6 days after insertion. Pt admit with Small bowel obstruction 2) 63 yo male; CAUTI identified 16 days after Foley insertion. Patient Foley justified for output monitoring in critical patients 3) 57 y/o Female on 3AC, F/C inserted without an order. Good Bathing, F/C and Peri care. Symptoms of CAUTI started 4 days after insertion. Remaining Nursing staff assigned new modules for foley insertion, now requires 2 staff.
3 *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Jan 2018* *SIR Goal: <= 0.50*	0.0 (0/1000)	0.32 (2/6289)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		No new CLABSI infections in December or January ! CLABSI Team adopted Central Line Mgmt. Bundle from Lippincott, All nurses will have 1:1 Peer education on CLABSI dressing changes with their patient, new CLABSI Dressing Kit developed with coaching cards. Adoption of CHG for all Central lines in all locations, dressing change to move to every 7 days (best practice).
4 *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Jan 2018* *SIR Goal: <= 0.70*	1.12 (1/8930)	1.03 (6/58421)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		1 new C.Diff HAI in January: 63 y/o male admitted with general weakness, groin swelling. Loose stools, Pos. C.diff 6 days after admit and neg. surveillance. 10 doses of ABX, 8 doses Protonix. Hx. Of daily use of Protonix & Prilosec prior to admit.
Efficiency	Performance Month	Performance FYTD	FY17 Actual	FY 2018 Goal		
5 ★Organizational Goal **Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: Jan 2018*	1.21	1.11	1.16	1.11		Increase in LOS due to flu patients who have to stay until Tamiful tx. Complete, high volume, and several very long LOS patients discharged. ALOS up to 5.02.

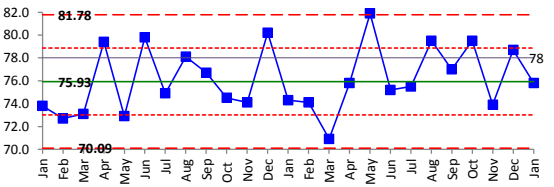
Definitions and Additional Information

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 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**
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carson/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	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.		
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Catherine Carson/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 calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient's MD-DRG.		

Reports run: 9/20/17		Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** SEP-1 100% or O% *Date Period: Dec 2017*				Non-compliance due to: 4 cases in which ABX not given at correct time, 2 cases no crystalloid fluids given, even though pts physiology, fluids detrimental. Core measure does not recognize this.
7	**IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) *Date Period: Dec 2017*				Sepsis TJC Certification application submitted; 2 day survey between April - July. ED physican consistently order appropriate fluids with in 2 hrs of TOP.

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-18
Number of Sampled Cases	30	30	29	30	30	30	30	30	30	30	30	30	30	30	30
Cases with 30ml/kg or NICOM ordered within 2h TOP	17	17	24	21	26	26	25	25	28	26	24	27	25	27	26
Cases with 30ml/kg ordered or NICOM within 3h TOP	0	0	0	2	1	0	0	0	0	0	0	2	1	1	0
Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation	57%	57%	83%	70%	87%	87%	83%	83%	93%	87%	80%	90%	83%	90%	87%

Mortality		Performance Month	Performance FYTD	FY 2017	FY 2018 Goal		
8	**Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Dec 2017*	1.03 (2.38%/2.31%)	0.90 (1.53%/1.69%)	1.02 (1.88%/1.83%)	0.62		Mortality rate slightly above expected at 1.03, with flu complicating many patients with co-morbidities. January data not availble yet in Premier Quality Advisor due to data refresh back to Nov. 2015 not complete.

SERVICE		Performance Month	Performance FYTD	FY 2017 Actual	FY 2018 Goal		
9	«Organizational Goal **HCAHPS Rate Hospital 0-10** **Top Box Rating 9 and 10** *Date Period: Jan 2018*	75.8 (191/252)	77.1(1656/1277)	76.30	78.0%		The high Jan. volume impacts this measure, as pts. were held in ED waiting for beds, and twice "internal disaster due to pt. surge" occurred. Also discharge lounge was utilized, moving pts. out of their beds before family came.

Measure Name	Definition Owner	Work Group	FY 2017 Definition	Source
Sepsis Core Measure- SEP-1: MONTHLY Compliance Rate ECH vs. All Core Measure Hospitals	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; Ashley Fontenot Cheryl Reinking	Patient Experience Committee	"'9' or '10' (high)" for the Overall Hospital Rating item	**Press Ganey Tool**

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Update on Patient and Family Centered Care Quality Committee

March 2nd, 2018

Cheryl Reinking, RN
Chief Nursing Officer

ECH Enterprise FY 18 Inpatient HCAHPS Monthly Report
Measure by: Top Box & Receive Date | Desired Direction: Up | Baseline: FY 17 | Results Through Jan 2018

	Baseline & Rolling 12 Months Top Box	Top Box				%Tile Rank All PG	%Tile Rank Bay Area	50th Percentile from Hospital VBP Perf. Standards	Mean of Top Decile from Hospital VBP Perf. Standards
		Baseline	Dec-17	Jan-18	Target	Jan-18	Jan-18		
Rate Hospital 0-10		76	78.7	75.8	78	62	56	70.23	84.58
Recommend the hospital		82.3	79.6	80.7	79.8	77	67	n/a	n/a
Comm w/ Nurses		79.9	76.8	79.5	79.9	42	65	78.52	86.68
Response of Hosp Staff		66.7	67	63.8	66.7	33	60	65.08	80.35
Comm w/ Doctors		84.5	82.6	86.3	80.8	84	95	80.44	88.51
Hospital Environment		67.2	68	63.7	66.3	34	66	65.6	79
Pain management		74.9	73.1	72.6	70.8	62	61	70.2	78.46
Comm About Medicines		68.6	64	64	63.8	44	60	63.37	73.66
Discharge information		87.4	89.4	87	87.6	38	40	86.6	91.63
Care Transitions		56.8	57.4	56.9	53.3	66	65	51.45	62.44

	Baseline & Rolling 12 Months Top Box	Top Box				%Tile Rank All PG	%Tile Rank Bay Area	50th Percentile from Hospital VBP Perf. Standards	Mean of Top Decile from Hospital VBP Perf. Standards
		Baseline	Dec-17	Jan-18	Target	Jan-18	Jan-18		
Rate Hospital 0-10		76	78.7	75.8	78	62	56	70.23	84.58

Patient Care Experience Updates

- MyChart Steering Committee started 2/2 with goal of deploying MyChart Bedside enterprise wide by Dec 31, 2018.
  - Currently looking at MyChart optimization and increasing enrollment
- Joy and Recognition Committee kickoff meeting on 2/28
- Patient Experience Committee has relaunched as Patient Experience Council
- PFAC is relaunching on 3/8
- Thank You Discharge Cards
- Monthly recognition continues for highest scoring and most improved nursing units in Nursing Communication.

Patient Care Experience Updates

- Listening Carefully Toolkit
  - Manager and super-user orientation on March 1st
  - Kick-off and informational sessions for all staff on March 5th, 7th and 9th
- Care Team Coaching
  - Recruiting 9 new coaches!
- Rounding
  - Leader rounding session on 3/13 and 3/21 for managers
  - Will review best practices for staff and patient rounding

Clinical Documentation Improvement Dashboard (Monthly)

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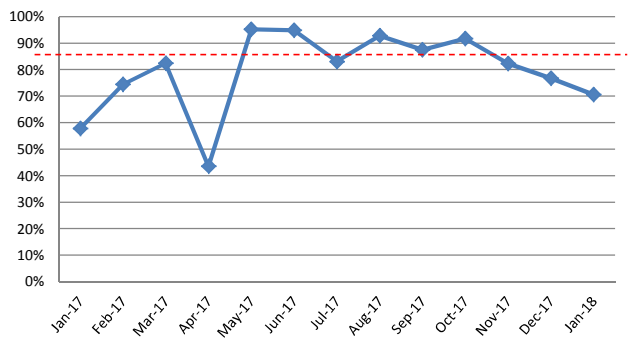
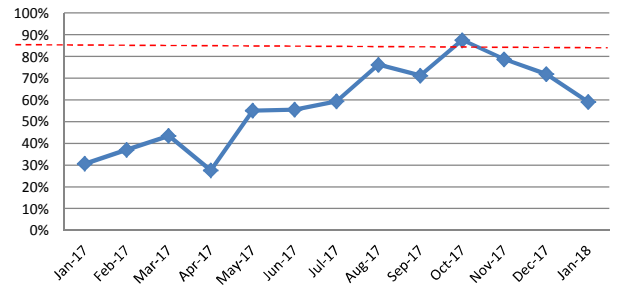
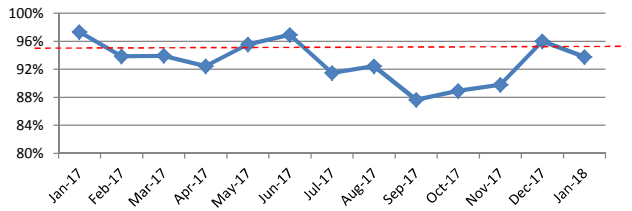
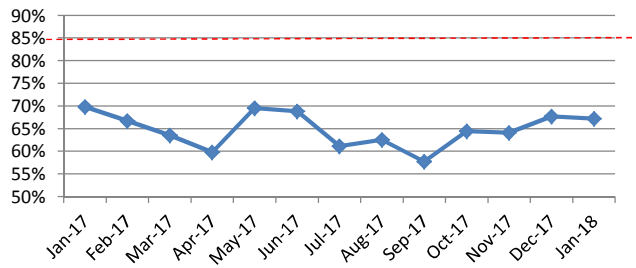
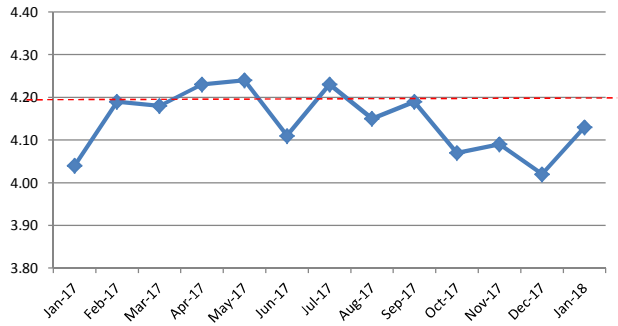
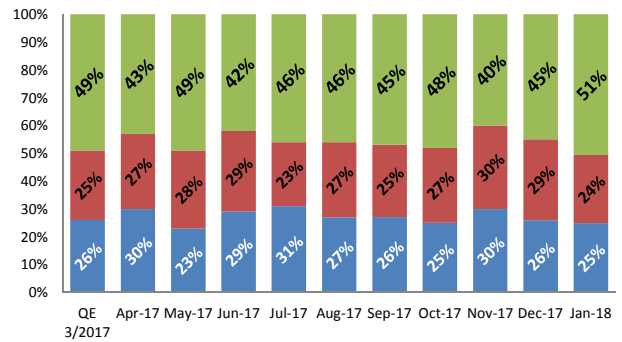
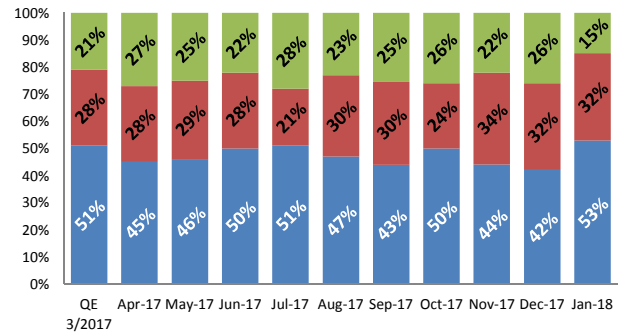
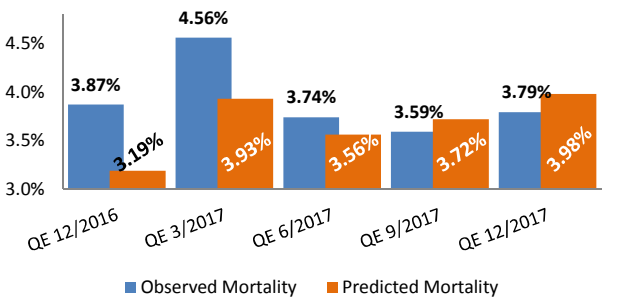
As of Feb 20, 2018			Baseline	FY18 Goal	Trend	Comments
Coverage	Performance		FY2017	FY2018 goal		
1	**Medicare**	Jan 2018 428/606 71% / FYTD 83%	64%	85%		4 new CDS hired between Dec 2016 and May 2017. 1 month ramp up period for new hires April: 2 week Education; No reivews Nov: Decreased number of reviews due to PTO Dec: Same number of Reviews (462), higher denominator due to increased volume. Jan 2018: 1 CDS Resigned, 1 on vacation for 2 weeks
2	**All Payor**	Jan 2018 724/1225 59% / FYTD 72%	35%	85%		All payor review, including HMO and PPO payers, began in July 2017. Nov thru Jan: decreasing coverage rate higher due to a combination of increasing volume of inpatients and loss of one CDS due to resignation.
Physician Response	Performance		FY2017	FY 2018 goal		
4	**Query Response Rate**	Jan 2018 94% / FYTD 91%	90%	>95%		Consistently above 88%. This is an improvement over baseline in FY 2016 and FY 2017. Measures Physician awareness of and participation in the CDI program.
5	**Query Agree Rate**	Jan 2017 67% / FYTD 64%	70%	>85%		Decreasing agree rate is equated with an increased volume of queries sent, lack of physician participation, and poor quality queries. We are sending 4x more queries than in the past (up from 80 queries sent in 8/16 to 305 in 01/18). Team is undergoing continuous compliance and medical education. Physician education continues. CDS are now developing relationships with the physicians by rounding on the pt care floors.

#	Impact	Performance		FY2017	FY 2018 goal		
7	★Organizational Goal **Average GMLOS (days)** *(Medicare, adult, acute care, inpatient)*	**Jan 2018** **4.13**	**FYTD** **4.12**	**4.08**	Min 4.20 Target 4.25 Max 4.33		Higher GMLOS is better. This reflects the severity of the patients we treat at ECH. This is the denominator of the Observed/ Expected LOS Indicator. On schedule to meet Target goal by Q4 of FY2018. QE 12/2017 LOS O/E= 4.52/ 4.12, or 1.097
8	**Medical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Jan 2018** **MCC 51%** **CC 24%** **NCC 25%**	**N/A**	**Nat 80th%** MCC 44% CC 27% No CC 29%	**Nat 80th%** MCC 45% CC 27% No CC 28%		Higher MCC Capture Rate is better. This effects Reimbursement, Expected GMLOS, Expected Mortality %, and CMI. National 80th Percentile is computed by CMS and published annually on 10/1.
9	**Surgical CC/MCC Capture Rate (MS-DRG)** (Medicare, adult, acute care, inpatient)	**Jan 2018** **MCC 26%** **CC 33%** **NCC 41%**	**N/A**	**Nat 80th%** MCC 31% CC 32% No CC 37%	**Nat 80th%** MCC 31% CC 32% No CC 37%		Surgical cases make up 30-40% of our Medicare patient volume. The biggest impact in reimbursement, CMI, GMLOS, and Expected mortality will come from increased Surgical CC/ MCC capture, coupled with sustained Medical CC/MCC capture. Outreach to HVI, General Surgery (Dr. Legha), and OrthoSurg has occured. General Outreach continues.
	Expected Mortality Rate (Medicare, adult, acute care, inpatient) **FY2017 for Mortality O/E is aligned with CMS FY, Oct 1-9/30.	**QE Dec 2017** **3.98**	**FYTD** **3.85%**	**3.62% ****	MedPAR 2018 O/E < 0.90		Higher Expected Mortality (orange column) Rate is better. This is the denominator of the Observed/ Expected Mortality Indicator. MedPAR 2016 O/E= 1.44 MedPAR 2017 O/E= 1.08 **QE 12/2017 O/E = 0.95**

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Color Indicator Legend	95% - 100% = G 90% - 94% = Y <90% = R

HOSPITAL QUALITY REPORTING			CY 2017																				Hospital Compare		
Strategy	Core Measures	Goal	JAN	FEB	MAR	Q1	Truven Q1	APR	MAY	JUN	Q2	Truven Q2	JUL	AUG	SEP	Q3	Truven Q3	OCT	NOV	DEC	Q4	Truven Q4	CY 2017	Truven 2017	National	State	Top 10th Percentile
Inpatient	**PC - SEP**: Perfect Care - Severe Sepsis/Septic Shock SEP-1 Early Management Bundle, Severe Sepsis/Septic Shock	100%	71%	42%	33%	52%	46%	33%	46%	92%	56%	49%	71%	62%	50%	61%	51%	57%	100%	63%	69%	51%	59%	49%	Not Available	Not Available	Not Available
	PC-IMM: Perfect Care - Immunization: Influenza Immunization- Inpatient discharges who were screened for influenza vaccine status and were vaccinated prior to discharge if indicated.	100%	97%	97%	100%	98%	92%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	89%	93%	96%	93%	91%	95%	92%	93%	94%	100%
	PC-PCM: Perfect Care-PCM (Perinatal Care - Mothers) PC-01 Elective Delivery PC-02 Cesarean Section PC-03 Antenatal Steroids	100%	68%	83%	92%	81%	80%	81%	73%	83%	79%	80%	80%	74%	81%	78%	80%	67%	82%	75%	74%	80%	78%	80%	Not Available	Not Available	Not Available
	PC-PCB: Perfect Care-PCB (Perinatal Care - Babies) PC-04 Health Care-Associated Bloodstream Infections in Newborns PC-05 Exclusive Breast Milk Feeding	100%	66%	76%	84%	76%	53%	80%	73%	75%	76%	54%	65%	83%	76%	75%	53%	73%	68%	70%	70%	53%	74%	53%	Not Available	Not Available	Not Available
	PC-VTE: Perfect Care – Venous thromboembolism VTE-6 Incidence of Potentially-Preventable Venous Thromboembolism	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	95%	NA	NA	100%	100%	94%	100%	NA	100%	100%	94%	100%	94%	98%	98%	100%
	ED-1b: Median Time from ED Arrival to ED Departure for Admitted ED Patients - Reporting Measure	300min	402	345	371	380	415	302	332	278	315	366	330	321	306	313	365	306	339	330	321	364	325	NA	297	345	178
	ED-2b: Admit Decision Time to ED Departure Time for Admitted Patients - Reporting Measure	120min	115	95	112	111	217	96	86	74	86	177	81	80	76	81	172	67	83	95	78	193	88	NA	121	155	39
Outpatient	**PC-OP AMI: Perfect Care - Out Patient Acute Myocardial Infarction**: OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival OP-4 Aspirin at Arrival	100%	NA	100%	100%	100%	96%	NA	100%	NA	100%	96%	100%	100%	100%	100%	95%	NA	100%	100%	100%	95%	100%	95%	Not Available	Not Available	Not Available
	PC-OP CP: Perfect Care - Out Patient Chest Pain OP-4 Aspirin at Arrival	100%	NA	NA	NA	100%	96%	NA	100%	NA	100%	96%	NA	NA	0%	0%	95%	NA	100%	NA	100%	94%	67%	95%	95%	95%	100%
	OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients	180min	184	192	205	192	178	170	173	173	173	168	161	168	149	161	169	171	187	175	177	172	175	NA	163	173	91
	OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional	15min	15	18	13	16	49	15	16	14	15	43	12	12	13	12	42	11	11	17	12	44	14	NA	25	29	9
	OP-21: Hospital Outpatient Pain Management Population	30min	60	66	51	55	75	63	55	65	60	69	38	51	57	49	68	67	41	38	50	70	76	NA	49	55	30
	PC-OP STK: Perfect Care - Out Patient Stroke OP-23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	100%	67%	NA	50%	60%	71%	100%	100%	0%	50%	73%	100%	100%	0%	67%	71%	100%	50%	100%	67%	72%	62%	72%	72%	70%	100%
Hospital-Based Inpatient Psychiatric Services (HBIPS)	**PC-IMM: Perfect Care - Immunization**: IMM-2 Influenza Immunization(HBIPS)	100%	93%	95%	100%	96%	92%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	80%	95%	90%	88%	91%	91%	92%	81%	77%	Not Available
	PC-HBIPS: Perfect Care - Hospital Based Inpatient Psychiatric Services HBIPS-5a Multiple Antipsychotic Medications at Discharge with Appropriate Justification – Overall Rate	100%	90%	67%	90%	85%	87%	67%	85%	77%	78%	87%	100%	100%	60%	87%	87%	78%	78%	80%	79%	90%	82%	87%	60%	62%	Not Available
	PC-SUB: Perfect Care - Substance Abuse: SUB-1 Alcohol Use Screening SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	100%	82%	85%	95%	87%	69%	94%	84%	95%	91%	72%	83%	98%	94%	92%	75%	98%	97%	92%	96%	76%	91%	73%	Not Available	Not Available	Not Available
	PC-TOB: Perfect Care - Tobacco Use: TOB-1 Tobacco Use Screening TOB-2 Tobacco Use Treatment Provided or Offered TOB-2a Tobacco Use Treatment TOB-3 Tobacco Use Treatment Provided or Offered at Discharge TOB-3a Tobacco Use Treatment at Discharge	100%	87%	79%	86%	84%	70%	90%	81%	100%	90%	69%	78%	85%	78%	81%	67%	89%	84%	85%	86%	68%	85%	69%	Not Available	Not Available	Not Available

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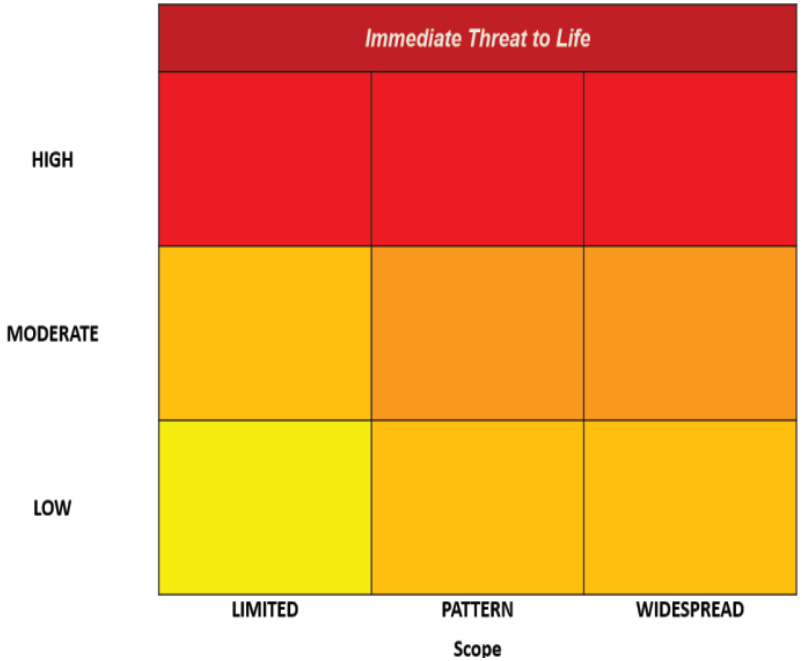
Joint Commission Survey Preparation

Cheryl Reinking, RN
Chief Nursing Officer

TJC New Scoring Methodology: SAFER Matrix

(began Jan 2017)

SAFER™ Matrix



Placement of RFI on SAFER™ Matrix and Follow-Up Activity

SAFER Matrix™ Placement	Required Follow-Up Activity
HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE / PATTERN, MODERATE/WIDESPREAD	
MODERATE / LIMITED, LOW / PATTERN, LOW / WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, and How sections
LOW/LIMITED	

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate the ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.

- New CMS guidance: "see one, cite one."

Joint Commission Survey Preparation

- Next TJC Triennial Survey: August 2018 – January 2019
- Last date of survey: January 11-15, 2016
- Mock Survey w/Premier – 5 Surveyors over 3 days
  - Feb. 6-8, 2018 - Report received Feb. 22, 2018
  - Results:

KEY TO COLORS AND ABBREVIATIONS	FREQUENCY
ITL = Immediate Threat to Life	5
High Harm - Any Frequency	19
Moderate Harm - Pattern or Widespread	16
Moderate Harm - Limited Frequency or Low Harm - Pattern or Widespread	35
Low Harm - Limited Frequency	11
	86

TJC Governance Structure

Executive Leadership Team

- Report every 2 weeks at Tuesday ELT Meeting

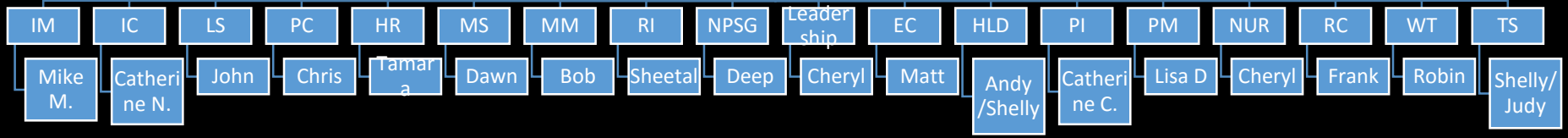
TJC Steering Committee (WF, CR, DC, KK, CC, FE)

- Meets once a week

Continued Survey Readiness Team (focus on Mock Survey findings 2018)

- Meets once a week
- Franz Encisa – Leader
- Cheryl Reinking and Catherine Carson – Advisors

TJC Chapter Chairs/CSR Mock Survey Action Plans



Updated 2/21/18