AGENDA

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

Monday, April 2nd, 2018, **5:30 p.m.**
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER**	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 (March 5, 2018) ***Information*** b. FY18 Pacing Plan c. Progress Against FY 2018 Committee Goals			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion** **5:36 – 5:39**
6.	**PATIENT STORY** **ATTACHMENT 6**	Ina Bauman Quality Committee Member		**Discussion** **5:39 – 5:59**
7.	**FY18 QUALITY DASHBOARD** **ATTACHMENT 7**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **5:59 – 6:09**
8.	**CAUTI DEEP DIVE** **ATTACHMENT 8**	Catherine Carson, RN Sr. Director /Chief Quality Officer		**Discussion** **6:09 – 6:19**
9.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE: PATIENT EXPERIENCE ROADMAP** **ATTACHMENT 9**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:19 – 6:29**
10.	**PROPOSED FY19 COMMITTEE GOALS** **ATTACHMENT 10**	Cindy Murphy Director of Governance Services		**Possible Motion** **6:29 – 6:39**
11.	**PROPOSED FY19 COMMITTEE MEETING DATES** **ATTACHMENT 11**	Cindy Murphy Director of Governance Services		**Possible Motion** **6:39 – 6:49**
12.	**PROPOSED FY19 ORGANIZATIONAL GOALS** **ATTACHMENT 12**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:49 – 6:54**
13.	**VALUE BASE PURCHASING REPORT**	Cheryl Reinking, RN,		**Discussion**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
	ATTACHMENT 13	Chief Nursing Officer		**6:54 – 7:09**
14.	**CORE MEASURE** **ATTACHMENT 14**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **7:09 – 7:14**
15.	**HOSPITAL UPDATE** **ATTACHMENT 15**	Dan Woods Chief Executive Officer		**Discussion** **7:14 – 7:19**
16.	**PUBLIC COMMUNICATION**	Dave Reeder, Quality Committee Chair		**Information** **7:19 – 7:18**
17.	**ADJOURN TO CLOSED SESSION**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:18 – 7:19**
18.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**7:19 – 7:20**
19.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required** **7:20 – 7:23**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (March 5, 2018) ***Information*** b. Quality Council Minutes (February 7, 2018)			
20.	*Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - Red/Orange Alert and RCA Updates	Shreyas, Mallur, MD Associate CMO, LG		**Discussion** **7:23 – 7:28**
21.	**ADJOURN TO OPEN SESSION**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:28 – 7:29**
22.	**RECONVENE OPEN SESSION/REPORT OUT**	Dave Reeder, Quality Committee Chair		**7:29 – 7:30**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
23.	**ADJOURNMENT**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:30 – 7:31pm**

Upcoming FY18 Meetings

- April 30, 2018
- June 4, 2018

Upcoming Board & Educational Committee 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, March 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; Jeffrey Davis, MD Katie Anderson, Ina Bauman, Nancy Carragee, Mikele Epperly, Julie Kliger, Wendy Ron, and Melora Simon.		

** Ina Bauman attended the meeting via teleconference.*
**Melora Epperly left the meeting at 6:56pm.*
A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 5th of March, 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 5:35 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call. Chair Reeder further announced that Cheryl Reinking, CNO will be the executive sponsor for the Quality Committee going forward, as well as further support from Drs. Shin and Mallur.	***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 (February 5, 2018). **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Bauman, Carragee, Davis, Epperly, Fung, Kliger, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** None **Excused:** None	***The open minutes of the February 5, 2018 Quality Committee were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Recused: None Chair Reeder referred to the patient story included as information in the materials and detailed the story as well as the corrective actions now in place. The Committee discussed the letter written by a family member of an elderly Medicare patient who spent five days at ECH on "outpatient observation" as opposed to "admitted in-patient" status. In the letter, the family member commented that the patient had not received an adequate explanation of the implications of outpatient observation status. Cheryl Reinking, RN, CNO explained that the Grievance Committee reviewed the complaint and (1) work is being done with Care Coordination team to ensure that all patients on outpatient observation status understand the implications and (2) ECH wrote off the patient's portion of the bill, which was much higher than it would have been had the patient been on admitted in-patient status. The Committee discussed the Two-Midnight Rule which, if ECH had adopted it, would have caused the patient to automatically be switched to in-patient after Two Midnights in the hospital.	
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee. He highlighted the use of the new cover sheet format that is currently used in Board meetings and asked the Committee for feedback. The consensus of the Committee was general agreement with the use of cover sheets going forward to clearly direct committee discussion items.	***None***
6. COMMITTEE SELF-ASSESSMENT	Chair Reeder presented the committee self- assessment to the members. The Committee engaged in a detailed discussion of the Committee Self-Assessment and how to address gaps in performance. Comments focused on the following areas: 1) The Committee would like a deep understanding of where the organization is trying to go strategically so it can structure its meetings to connect its work back to governance. The Committee also wants to understand the thinking behind some Board decisions. 2) A desire to have less reporting out by staff and committee materials structured so that it is clear what staff wants the Committee to focus on so that the Committee can engage in dialogue that benefits the organization. 3) The Committee wants more focus on patients and families. Two ideas that surfaced were (a) for the Committee to invite members of the "re-booted" PFAC to get current patient perspectives and (b) for the Committee to revisit the "Big Dot" concept to reassess whether "Patient and Family Centered Care" should be ECH's "Big Dot" and get confirmation from the Board. 4) A desire to understand quality, patient safety, and patient experience considerations that go into the capital budgeting process. 5) Decreasing the number of agenda items (decrease	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	frequency of "repeat" items) to provide more time for in depth review and dialogue. **Background information on the Board decision of the Big Dot to be disclosed to Dan and aligned with the Strategic Plan. To be re-address at a later Committee meeting or educational gathering.*	
7. FY18 QUALITY DASHBOARD	Mrs. Reinking reported that ECH is generally doing well with infection prevention, but that CAUTIs remain a challenge. She explained that a policy change to requiring two staff members to insert foley catheters in female patients and a nurse driven protocol to remove them without a physician order if certain criteria are met was recently adopted. At the suggestion of the Committee, the specific results of these efforts will be brought back to the Committee for review.	
8. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Mrs. Reinking reported on enterprise wide Inpatient HCAHPS. She further described efforts in place to improve Responsiveness of Hospital Staff, Communication with Nurses, Hospital Environment, Communications about Medicines, and Discharge Information such as purposeful hourly rounding, leader rounding, and education about careful effective listening. She further highlighted the following implemented efforts: • MyChart Steering Committee started 2/2 with goal of deploying MyChart Bedside enterprise wide by Dec 31, 2018. • Joy and Recognition Committee kickoff meeting on 2/28 • Patient Experience Committee has re-launched as Patient Experience Council • PFAC is re-launching on 3/8 • Thank You Discharge Cards • Monthly recognition continues for highest scoring and most improved nursing units in Nursing Communication. • Listening Carefully Toolkit • Care Team Coaching -Recruiting 9 new coaches! • Rounding - Leader rounding session on 3/13 and 3/21 for manager, Will review best practices for staff and patient rounding	***None***
9. CDI DASHBOARD	Shreyas Mallur, MD, Associate CMO, gave an overview of the CDI dashboard and reported that the CDI initiative is critical for several reasons. If all of a patient's medical conditions are not fully and accurately reported in the EHR (1) Medicare assesses the patient as less complex and our case mix index is artificially low, which affects reimbursement, (2) to the outside world, our expected mortality and expected complication rates are lower, and (3) expected length of stay is lower. Dr. Mallur further reported that staff is working to improve physicians accepting and making changes to documentation based on clinical documentations specialists advice and recommendations.	

Agenda Item	Comments/Discussion	Approvals/Action
10. CORE MEASURES	Chair Reeder deferred Agenda item 10 to the next quality committee meeting.	***Agenda item 10 deferred to 4/2 meeting.***
11. JOINT COMMISSION PREPAREDNESS	Mrs. Reinking discussed the new methodology of The Joint Commission SAFER matrix effective as of January 2017 and the results of the Mock Survey that occurred on February 6-8, 2018. Mrs. Reinking noted that although mock survey results were a little higher than anticipated the executive teams has complete respect for ECH clinical management and their ability to address the concerns. She further addressed the governance structure that is now in place to address oversight and corrective actions.	
12. PUBLIC COMMUNICATION	None.	***None***
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:23 pm. **Movant:** Melora **Second:** Ron **Ayes:** Anderson, Bauman, Carragee, Davis, Epperly, Fung, Kliger, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** None **Excused:** None **Recused:** None	***Adjourned to closed session at 7:23 pm.***
14. AGENDA ITEM 17: RECONVENE OPEN SESSIO REPORT OUT	Open Session was reconvened at 7:24 pm. *Agenda Items 14 – 16 were addressed in closed session.*	
15. AGENDA ITEM 18: ADJOURNMENT	The meeting was adjourned at 7:25 pm. **Motion:** To adjourn at 7:25 pm. **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Bauman, Carragee, Davis, Fung, Kliger, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** Epperly **Excused:** None **Recused:** None	***Meeting adjourned at 7:25 pm***

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

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

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. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Update on Patient and Family Centered Care 4. Review Biennial Committee Self-Assessment Results
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~~ Hospital Update Special Agenda Items: 1. Update on Patient and Family Centered Care: Patient Experience Roadmap 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~~ 9. Core Measure 10. CAUTI Deep Dive (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. Quarterly Quality and Safety Review 4. Pt. Experience (HCAHPS) 5. ED Pt. Satisfaction (Press Ganey) 6. Update on Patient and Family Centered Care ~~7. Credentialing Process Report~~ 8. Leapfrog Survey Results 9. Review Committee Charter	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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY18 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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
		  • The Committee was briefed on an update at the October 30th meeting.
		• Review Medical Staff credentialing process
		  • The Committee decided to put off till next fiscal year pending medical staff review.

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 • Ongoing
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 • Committee will review on 4/2 meeting
5. Monitor the impact of interventions to reduce hospital-acquired infections.	• Quarterly	• Review process toward meeting quality (infection control) organizational goal • 1st, 2nd, and 3rd 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 ECH and ECHD Board Actions Quality, Patient Care and Patient Experience Committee April 2, 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: 1. Report on ECH and ECHD Board Actions	

March 2018 ECH Board Actions*

March 14, 2018

a. Approved Resolution 2018-03 recognizing Emergency Department physicians and staff for their work during this winter's severe flu season
b. Received annual Compliance education
c. Approved the Community Benefit Mid-Year Metrics
d. Approved Resolution 2018-04: required by Premier, Inc. listing the CEO and CFO as authorized individuals to sell stock.

March 2018 ECHD Board Actions

March 20, 2018

a. Approved Resolution 2018-05 acknowledging the District's partnership with the AHA on the "Check.Change.*Control"* Hypertension Initiative.
b. Approved the FY18 YTD Financial Report
c. Completed a Periodic Review of the District's Bylaws and Approved Revisions
d. Approved Resolution 2018-03 Calling a District General Election and Resolution 2018-04 Requesting and Consenting to Consolidation of District Election with the November 2018 Statewide Election.
e. Approved a Revised Community Benefit 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.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Patient Story Quality Committee Meeting Date: April 2, 2018
	Responsible party:	Ina Bauman, Member, Quality Committee
	Action requested:	For Information

Background:

<u>Challenges a Patient May (is Likely to) Encounter:</u>

1. Maze of Appointments, Tests, and Procedures to Arrive at Diagnosis
2. Shock and Emotional Reaction to Diagnosis
3. Surgery
4. More Surgery (this is not typical)
5. Problems with Communication Between Staff, Patient and Family
   a. During Surgical Experience - Updates were not given until way past (1 hour) the time the physician told family that the patient would be in recovery. A lot of unnecessary anxiety for the family.
   b. Immediately Upon Transfer to Post-Operative Nursing Unit - Family members felt that there was little explanation regarding tubes, lines, and the amount of pain to be expected. Not enough time spent to set expectations of what to expect in 1st day or 2 post-op.
6. Significant Delay In Receiving Pain Medication (2.5 hours)
7. Some Evening and Night Nurses had Difficulty Changing Medications On Locked IV pumps
8. Overall lack of "personal touch" to Patient and Family - With the stated exceptions care was good, but not a lot of "TLC." The patient is an "old nurse" and expected more hands on nursing care. Some CNA's delivered it, some nurses did, but was inconsistent. A little bit goes a long way in the take away feeling of the hospital.

<u>Learnings:</u>

1. Senior Management Needs to Stay Focused on:
   a. Providing Continuous Attention to Staffing and In-Servicing to Ensure there are Adequate Numbers of Nurses Trained in all Necessary Skills on All Shifts
   b. Continual Work on Patient Family Communications to Foster Positive Patient Experience. The Hospital seems genuinely committed to improving patient and family communications, and most of the staff genuinely care and want to do the best for their patients. It's a big task and they are sincerely trying.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

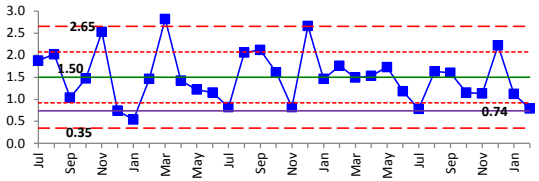
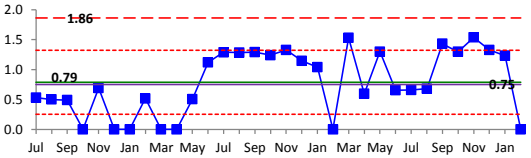
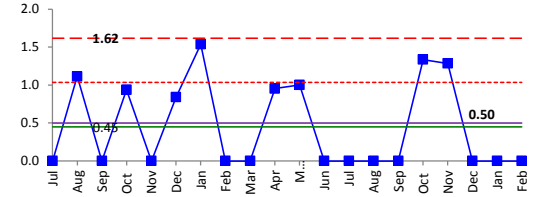
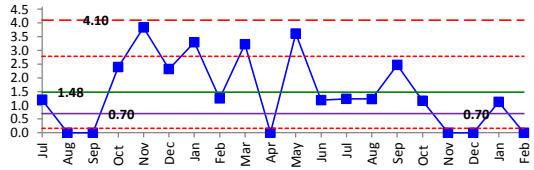
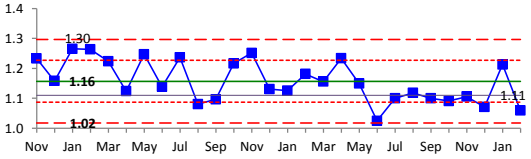
	2. El Camino Hospital Senior Management is Dedicated to Improving Patient Stay
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.
	Summary and session objectives : To Inform the Committee about Patient Experiences at El Camino Hospital and Staff and Management Responses.
	Suggested discussion questions: 1. How did the patient manage to resolve concerns and address care needs during the hospital stay? 2. Were the patient's concerns addressed after the patient left the Hospital?
	Proposed Committee motion, if any: None. This is an informational item.
	LIST OF ATTACHMENTS: None.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	FY18 Quality Dashboard Quality, Patient Care and Patient Experience Committee April 2, 2018
	Responsible party:	Cheryl Reinking, RN Chief Nursing Officer
	Action requested:	For Discussion
	Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2018 Quality, Efficiency and Service Goals. The Sepsis metrics and Patient Falls continued from FY 2017.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide the Committee with a snapshot of the metrics monthly with trends over time and compared to the actual results from FY2017 and the FY 2018 goal. • Annotation is provided to explain actions taken affecting each metric.	
	Suggested discussion questions: 1. Zero new HAI's for February in CAUTI, CLABSI, and C. Diff 2. Falls have declined over 3 months 3. Average LOS recovered after increase in pt. volume and acuity in January 4. Mortality data not available yet in Quality Advisor due to delayed data refresh	
	Proposed Committee motion, if any: None. This is a Discussion item. (OR, insert motion)	
	LIST OF ATTACHMENTS: 1. FY18 Quality Dashboard	

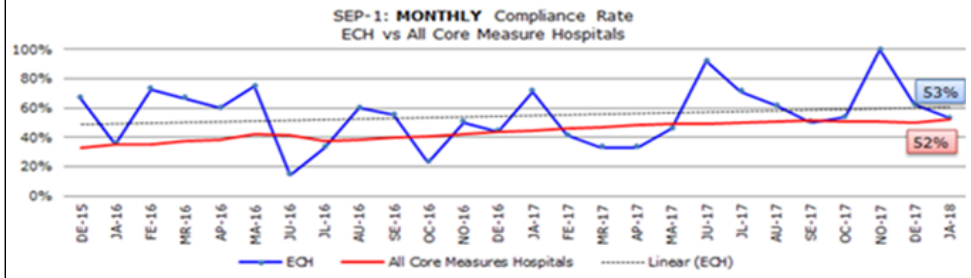
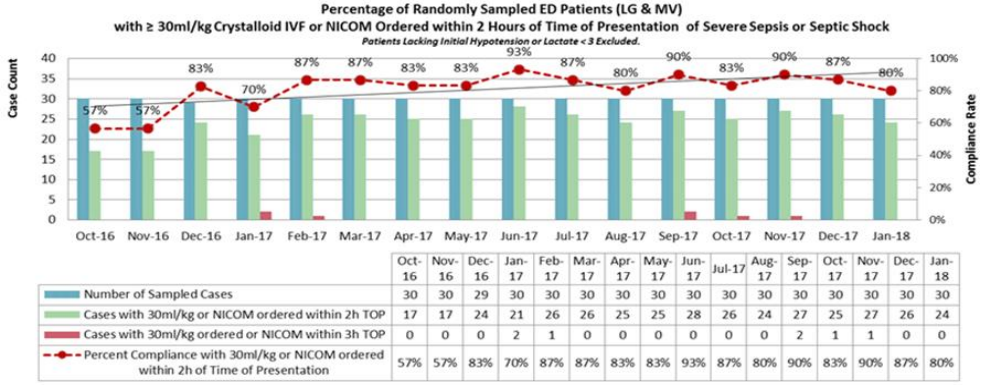
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

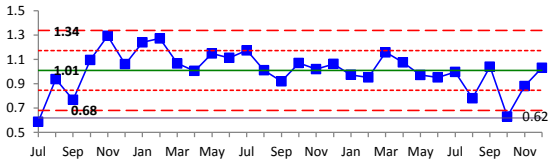
Reports run: 11/20/17			Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS	Performance Month	Performance FYTD	FY2017 Actual	FY2018 Goal		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: Feb 2018*	0.79 (4/5068)	1.31 (56/42655)	1.49	0.74 (Top decile CALNOC)		Falls dropped by half from 14 (Dec.) to 7 (Jan.) to 4 in Feb. Now just above goal of 0.74. Commode alarms implemented allowing more patient privacy during toileting. Team working w/USF Nsg Students on improving the use of the "Get up and go" test within the Fall Risk Assessment tool.
2 *Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Feb 2018* *SIR Goal: <= 0.75*	0 (0/1305)	1.03 (12/11663)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		Zero new CAUTI HAIs in February. New Nurse-driven Foley catheter removal protocol with Houdini criteria to be approved at Feb. MEC and implemented in March. Nursing education on this Standardized procedure in process.
3 *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Feb 2018* *SIR Goal: <= 0.50*	0.0 (0/827)	0.28 (2/7116)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		Zero new CLABSI HAIs in February. Warmers for CHG Bath wipes acquired for nursing units and education to RNs, CNAs on use for daily bath for all CVL pts.
4 *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Feb 2018* *SIR Goal: <= 0.70*	0.0 (0/7534)	0.91 (6/65955)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		Zero new C. Diff HAIs in February. EVS was approved for additional FTEs to expand use of existing Xenex Ultraviolet machines to isolation rooms, daily cleaning of all procedure, MRI, CT rooms. New BPA requestd in EPIC to alert nurses to implement contact isolation when C.Diff antigen test Ordered and order to soap and water handwashing.
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: Feb 2018*	1.06	1.11	1.16	1.11		Large drop in ALOS from 5.01 in Jan. to 4.42 in February affects this ratio.

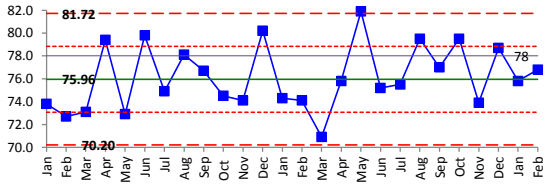
Definitions and Additional Information

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: Jan 2018*				Drop in Sep-1 complaince related to high volume of ED patients in Jan. 8 failures in the sampled cases discussed in detail at Sepsis Committee, and communicated to involved medical and nursing staff.
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: Jan 2018*				Please note in the report that the EDs were severely impacted by flu season (which was worse than past years) yet they managed to perform better than January of last year. There were 177 patients with sepsis treated in the enterprise in January, which is a record. Roughly 80% of those cases came through the EDs

	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-17	Jan-18
Number of Sampled Cases	30	30	29	30	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	24
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	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%	80%

Mortality		Performance Month	Performance FYTD	FY 2017	FY 2018 Goal	Trend	Comments
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		January and February data not availble yet in Premier Quality Advisor due to data refresh back to Nov. 2015 not complete - delayed with errors to April 10, 2018.

SERVICE		Performance Month	Performance FYTD	FY 2017 Actual	FY 2018 Goal	Trend	Comments
9	«Organizational Goal **HCAHPS Rate Hospital 0-10** **Top Box Rating 9 and 10** *Date Period: Feb 2018*	76.8 (175/228)	77.1 (1452/1884)	76.30	78.0%		Slight rebound from January's result. Average to date July-Feb = 76.8.

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**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	CAUTI Deep Dive Quality Committee of the Board Meeting Date: April 2, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director/Chief Quality Officer
	Action requested:	For Discussion
	Background: The FY2018 Hospital Quality Goal involves reduction of the Hospital-acquired Infections (HAI) of Catheter-associated Urinary Tract Infections (CAUTI); Central-line associated Blood Stream Infections (CLABSI) and Hospital-onset Clostridium difficile (C. Diff) infections. The Committee requested more information on the work in this fiscal year to reduce CAUTI.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Understand the work of the HAI Teams to address each HAI in the Quality Goal and the results to date • Provide information regarding CAUTI and best practices for reduction of these infections • Provide details on the actions taken in FY2018 by the HAI CAUTI Team	
	Suggested discussion questions: 1. The focus on reducing harm to patients with the patient safety movement since 2000 has led to the acceptance within healthcare that the consequences of acute hospitalization such as hospital-acquired infections are not acceptable. 2. This premise has resulted in penalties within the ACA (Accountable Care Act) for hospital-acquired infections (CAUTI is one) if the hospital has more HAIs than expected. 3. This has resulted in changes in medical practice regarding use of Foley catheters and development of alternative devices	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: CAUTI Deep Dive Power Point Presentation	

FY 2018 HAI A3 CAUTI Team Update
March 2018

HAI CAUTI Leader: Catherine Nalesnik , RN,BSN,CIC – HAI Leader: Director Infection Prevention

HAI Performance Improvement Facilitator: Suann Cirigliano Schutt, MSN, RN-BC, CEP

Team members: *Alex Tungol, M/S Dir.Los Gatos, Anna Marie Bentic, RN, Beth Willy, Dir. Education, David Perry, CCU Mgr., Heather Roorda, Educator, Jennifer Borrelli, Medical Mgr., Kris Coleman-Haas, CCU Educator, Lotta Alba, ED Mgr., Maria Tinitigan, CCU RN, Meriam Signo, DON Los Gatos, Maritza Lew, iCare Mgr., Raquel Gonzalez, Dir. Materials, Dr.Mallur, Trude Hennessy, Surgical Mgr.*

FY 2018 Organizational Goal Update: 3-20-18

Reduce Hospital-Acquired Infections (HAI)

Last Hospital Onset CAUTI – 1/31/18 ☺

HAI *Hospital Acquired Infection*	**Enterprise Goal NHSN SIR***	**No. Of HAI FY 2017**	**No. Of HAI FY 2018** (To date)	**NSHN: Predicted Number of HAI to Meet SIR Goal**	**FY 2018 1st Q:** *(July – Sept.)* **Number of Infections**	**FY 2018 2st Q:** (Oct. -Dec.) **Number Infections**	**FY 2018 3rd Q:** (Jan-March 2018) **Number Infections**	**Number of Infections MV-LG for remaining 2Q to Meet Target**
CAUTI *Catheter Associated Urinary Tract Infection*	**SIR ≤ 0.75** *SIR Rate Jul-Dec 17 = 1.459*	**21**	**14**	**11** MV: 10 / LG:1	**4** MV: 3 LG: 1	**6** MV: 6 LG: 0	**4** MV: 4 (Jan) LG: 0	**0** (**MV: -3**/ LG:0)
CLABSI *Central Line Associated Bloodstream Infection*	**SIR ≤ 0.5** *SIR Rate Jul-Dec 17 = 0.423*	**7**	**3**	**4** MV:4/ LG: 0	**0**	**2** MV: 2 LG: 0	**1** MV: 1 LG: 0	**1** (MV: 1 / LG:0) **SIR July-Dec. 2017 0.423**
C. Diff *Clostridium difficile*	**SIR ≤ 0.7** *SIR Rate Jul-Dec 17 = 0.30*	**19**	**7**	**25** MV: 22/ LG: 3	**4** MV: 4 LG: 0	**1** MV: 1 LG: 0	**2** MV: 2 LG: 0	**18** (MV: 15 / LG:3) **SIR July-Dec. 2017 0.30**

July-Dec.2017 SIR Update w/HAIs to 12/31/17

SIR rate for Enterprise 12/31/17= 0.525

Target = 0.602 Max = 0.534

CAUTI Prevention – The risk factors[1]

- **Highest CAUTI risk** is associated with length of catheterization. The longer the catheter is in, the higher the risk.
- Additional risk factors include:
  - Female gender
  - Older age
  - Interrupting the closed drainage system
- **Lower CAUTI risk** is associated with hospitals who have clear prevention programs which include:
  - Daily review of indwelling catheter necessity
  - Nurse driven removal protocols using established criteria, such as HOUUDINI
  - Adherence to best practices for insertion and maintenance of indwelling Foley catheters

1. Lo MD, E.; Nicolle MD, L.; Coffin MD MPH, S., Gould MD, C.; Maragakis MD, L.; Meddings MD, J.; Pegues MD, D.; Pettis RN, a.; Saint MD, S.; Yokoe MD, D. Strategies to Prevent Catheter-Associated Urinary Tract Infections in Acute Care Hospitals from Infection Control and Hospital Epidemiology Vol 35, No 5 (May 2014) pp 464 – 479. http://www.jstor.org/stable/10.1086/675718

Best Practice related to CAUTI prevention

The 6 C's of **CAUTI** Bundle/Prevention:

CONSIDER Alternatives (Condom & Purewick external catheters)
CONNECT with securement device/STATLOCK
Keep it **CLEAN.** Observe good hand hygiene.
Keep it **CLOSED.** Do not "break the seal"
COMPLETE bladder scanning
CULTURE urine only from sampling port on Foley, never the bag

Best Practices:

- Observe hand hygiene
- 2 nurses for all indwelling urinary catheter (IUC) insertions. 2nd nurse to observe for breaks in sterile technique
- Empty the collection bag every 8 hours, when bag is 2/3 full, or any transfer.
- MUST keep IUC bag below the level of bladder to prevent back flow.
- Perform and document for daily bath, pericare and Foley care.

***Remember to perform thorough perineal cleansing PRIOR to donning of sterile gloves. This is the "precleaning" phase.**

HAI A3 CAUTI Team Key Accomplishments FY18

1. Daily monitoring of Foley catheter justification

- Review criteria for justification and prompt removal by Nursing Staff
- Presence of foley catheter added to EPIC Banner (pt. chart) so nurses can see this constantly
- Audit of best practice guidelines for Foley care and daily hygiene measures

2. CAUTI Event reviews – Intensive review of each with department staff

- Detailed "just in time" reviews with front line staff for each CAUTI event *(ongoing)* to identify causation
- Comprehensive review by CAUTI HAI A3 Team members *(ongoing)*
- Review by Medical Director of Infection Control (IC) and IC Team *(ongoing)*

3. Staff Education on CAUTI prevention measures

- Implemented new BARD SureStep Foley Kit – emphasized/supports sterile insertion
- Healthstream education modules on BARD SureStep Foley insertion and maintenance
- Educational flurries by Nursing Educators- Enterprise wide - Total **543 of 730** Assigned Nursing Staff educated
- Foley insertion procedure now requires two RNs

4. Foley usage including urine culture ordering

- Emergency Department focused on reducing insertions
- Monitoring and compliance auditing, including reduction in foley device days (reported to NHSN)
- Foley catheters no longer used in Bariatric Surgery
- Use of alternative urinary drainage systems that are not within the bladder, external male/female devices

5. Nurse Driven Protocol for Foley removal *(2017-2018)*

- CAUTI HAI A3 Team Comprehensive review of evidence-based best practice guidelines and community standard
- Includes Houdini protocol for removal

CAUTI Prevention: Physician Partnership

Standardized Procedure for Foley Removal by Nurses

- Approved by Medical Executive Committee & Board: March 15, 2018
- Education to physicians via communication in SCOPE

CAUTI Prevention Information:

Presented by Dr. Carol Kemper MD FIDSA Infection Control Medical Director

- Provided information and education on CAUTI prevention to hospitalists groups
- Informational letter sent to Medical Staff on CAUTI prevention and limiting Foley use
- Emergency Department physicians partnering with CAUTI prevention measures by limiting Foley insertions; ED Medical Director goals
  - Data reviewed monthly

Nurse driven Foley removal procedure

The standard procedure for nurse-driven Foley catheter removal procedure is NOW LIVE. Use HOUUDINI justification criteria daily between 0700 – 1000 for continued Foley use.

- **H – Hematuria**
- **O – Obstruction, retention, continuous bladder irrig., epidural**
- **U – Urologic, gynecologic, or colorectal surgery**
- **U – Urethral, ureter, or bladder injury**
- **D – Decubitus (stage 2 or higher) with incontinence**
- **I – I/O strict – critical/hemodynamically unstable**
- **N – No code/comfort care/hospice if external device not option**
- **I – Immobility (unstable fracture/IABP/sedated/vented)**

1. **Assess patients daily between 0700 – 1000**
2. **Remove Foley if criteria not met and notify physician that Foley has been removed**
3. **Discontinue Foley cath order using "Standardized Procedure – cosign required" order mode**
4. **Place a nursing order for "Straight Cath x 2 per straight cath algorithm" using "Standardized Procedure – cosign required" order mode**
5. **Continue to assess your patient after Foley removal for voiding issues, and straight cath as indicated.**
6. **Include details of Foley removal/voiding progress in nursing handoff report.**

Daily justification for indwelling Foley catheters

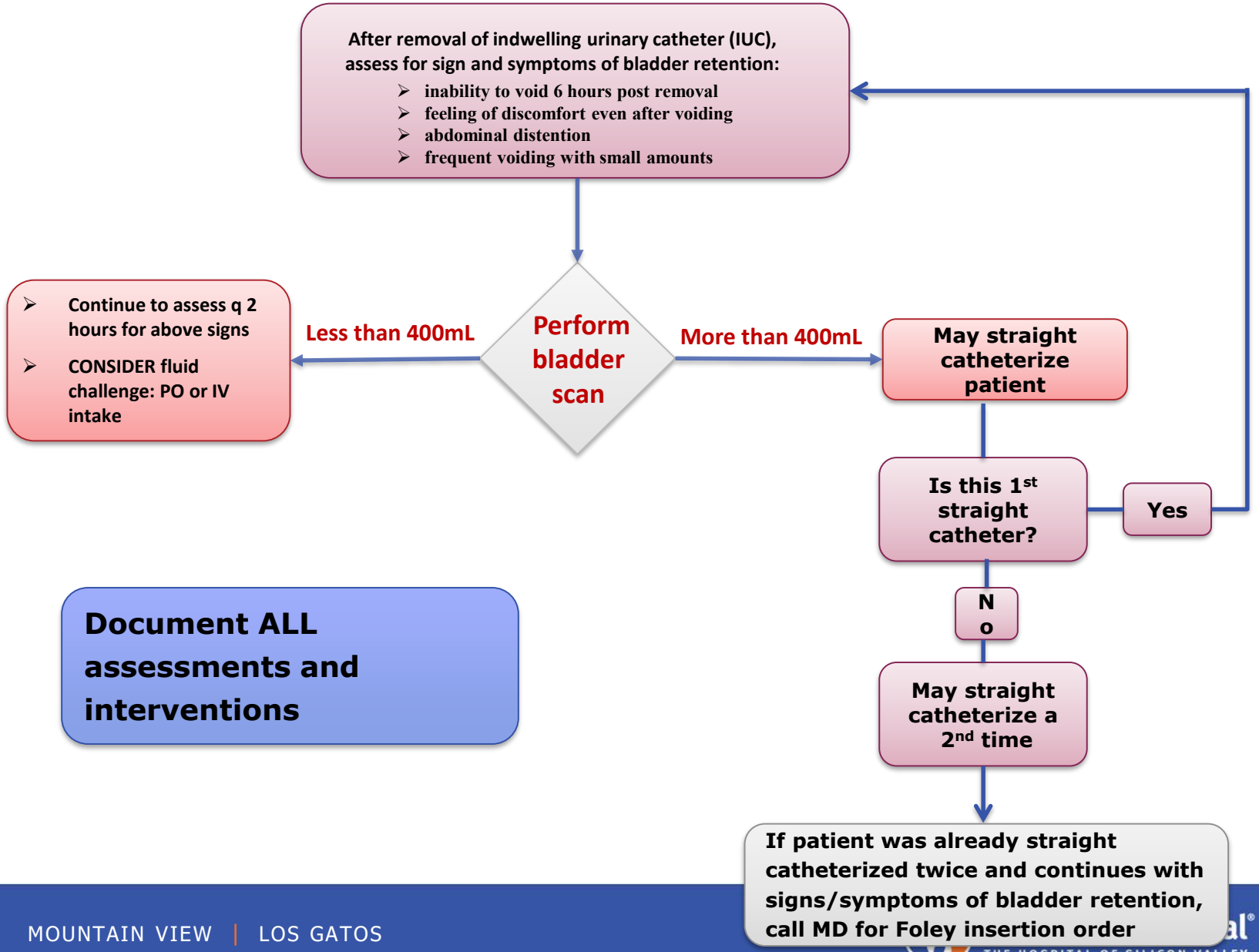
Justification for Continued IUC use Criteria:
"**HOUUDINI**" Acronym

- **H**ematuria
- **O**bstruction, retention, or continuous bladder irrigation, epidural in place
- **U**rologic, gynecologic, or colorectal surgery
- **U**rethral, ureter, bladder injury
- **D**ecubitus injury (stage 2 or higher) with incontinence
- **I**&O critical/hemodynamically unstable. Strict I&O's (UO measurement q1H)
- **N**o code/comfort care/hospice if external device not option
- **I**mmobility due to physical condition: unstable fracture, IABP, sedated/ventilated

❖ If patient does NOT meet above criteria, discontinue Indwelling Urinary Catheter (IUC)

❖ If no voiding 6 hours after IUC removal, use straight catheterization algorithm located in Standardized Procedure

Straight Catheterization Algorithm



ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Update on Patient and Family Centered Care: Patient Experience Roadmap Quality, Patient Care and Patient Experience Committee April 2, 2018
	Responsible party:	Cheryl Reinking, RN Chief Nursing Officer
	Action requested:	For Discussion
	Background: Improving the Patient Experience is an essential activity at ECH that is pursued at all levels of the enterprise.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide an overview of the patient care experience roadmap for the next 18 months. • Provide crosswalk of the patient care experience roadmap to the eight principles of Patient Centered Care. • Receive any feedback from the board members on elements of the roadmap	
	Suggested discussion questions: 1. Are the Patient Experience Roadmap elements effective to achieve improved patient care experience and patient centered care goals? 2. Are the measures for patient care experience adequate?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: 1. Update on Patient and Family Centered Care: Patient Experience Roadmap	

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Patient Care Experience Presentation for Quality Committee

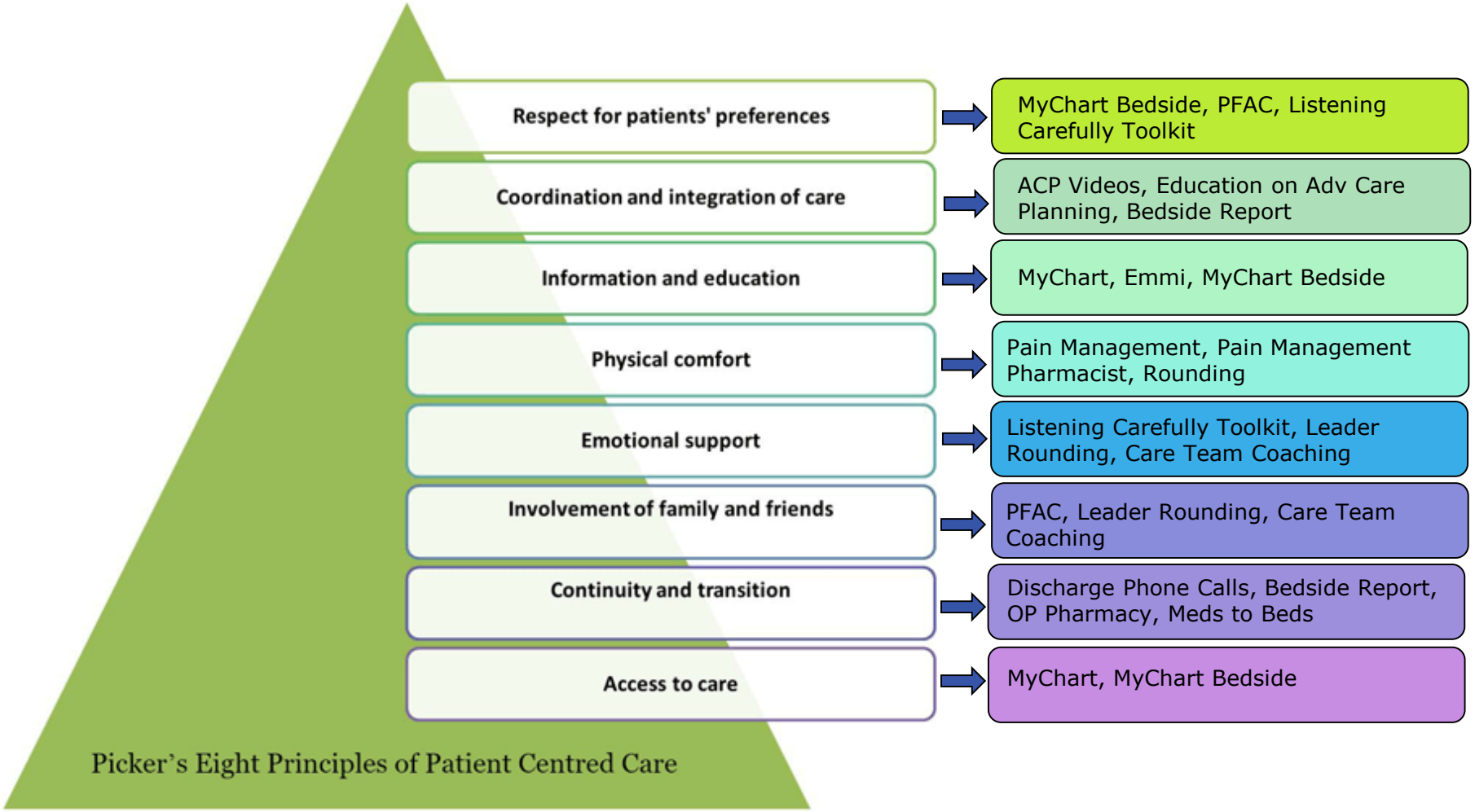
Cheryl Reinking

Patient Care Experience Road Map for El Camino Hospital

Immediate 1-3 Months	Short-Term 3-6 Months	Long-Term 6-18 Months
•***Data Analytics & Prioritization*** •Troubleshoot data & departments in Epic/PG •Highlight successes by unit with trophies •Focus on Nurse Communication & "Nurses listened carefully item" •***Patient Voice Incorporation*** •Share more patient comments and stories, send WowMails when staff mentioned by name, push patient comments to leaders, set expectations leaders share comments •***Program Development*** •Cultivate a presence for the PE Team at both campuses, consider structure & support of team •Bring back the Care Team Coaching & utilize Coaching Reporting Tool •Revisit charter of PEC and potentially adjust time to allow more to attend •***Best Practices and Implementation*** •Pilot bedside shift report on MBU & 4A, and purposeful hourly rounding on PCU & 3B •***Training*** •Provide Leader Rounding Training & reinforce with Care Team Coaching, protect time post-huddle for leader rounding •***Culture*** •Share WOWMail feedback and determine any changes possible •Launch Communications Survey and follow up	•***Data Analytics & Prioritization*** •Develop & train on the Patient Experience Dashboard and standardize reporting •Perform VIS Board Audits •Determine FY 2018 goal attainment metric (received or discharge date) •Determine FY 2019 goals & focus areas may include staff responsiveness or environment (cleanliness) •Consider employee, leader and physician incentives tied to goals and set for FY 2019 •***Patient Voice Incorporation*** •Recruit new PFAC members •***Best Practices and Implementation*** •Determine success of bedside shift report and purposeful hourly rounding pilots, determine spread, develop educational modules to support both •Connect with physician groups and incorporate them into work efforts, offer coaching •Expand discharge phone calls to all patients and revise script •Determine launch of Joy committee •Optimize Interactive TV Technology •Develop manager tool kits •***Training*** •Offer Service Foundations Workshop again	•***Data Analytics & Prioritization*** •Provide Physician Group Level Data •***Program Development*** •Consider hosting PEC on both campuses or alternating •***Best Practices and Implementation*** •Set goals and expectations related to bedside shift report and purposeful hourly rounding, determine tracking, rollout any education to support, follow with Care Team Coaching •***Training*** •Create booster sessions for those who have already completed Service Foundations, follow with Care Team Coaching •Provide service recovery approach, guidelines, and training for staff and leaders •Refresh the content for NMO & GHO •***Culture*** •Provide definition and clarity on vision/focus, philosophy, definition and approach "Patient First" program for ECH.

On-Going	
	Data Analytics & Prioritization: Develop an Executive Dashboard ***Patient Voice Incorporation:*** Find meaningful ways for patients to serve on committees ***Program Development:*** Enable focus of PE Team ***Culture:*** Provide visible presence of Executive Team at both campuses

Eight Principles of Patient-Centered Care



ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Proposed FY19 Committee Goals Quality, Patient Care and Patient Experience Committee April 2, 2018
	Responsible party:	Cindy Murphy, Director of Governance Services
	Action requested:	Possible Motion
	Background: Every year, each of the Advisory Committees develops goals for the upcoming fiscal year. The Proposed Goals are forwarded to the Governance Committee for review and then to the Board for Approval.	
	Committees that reviewed the issue and recommendation, if any: None.	
	Summary and Session Objectives: To obtain the Committee's recommendation for the Board to approve the Draft FY19 Quality, Patient Care and Patient Experience Committee Goals.	
	Suggested discussion questions: 1. Are the proposed Committee goals at the correct strategic level? 2. Do they reflect important governance level issues facing the Committee in FY19? 3. Are the proposed Committee goals "SMART" (Specific, Measurable, Relevant, Attainable, Time Bound)?	
	Proposed Committee motion, if any: To recommend that the Board approve the Proposed FY19 Quality, Patient Care and Patient Experience Committee Goals.	
	LIST OF ATTACHMENTS: 1. Draft FY19 Quality, Patient Care and Patient Experience Committee Goals	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

PROPOSED FY19 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: 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 FY19: FY18 Achievement and Metrics for FY19 • Q3 – Q4 FY19: FY20 Goals	• Review Management Proposals, Provide Feedback and Make Recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the recommendations made through the Greeley peer review process.	• Q2	• Receive update on implementation of peer review process changes (FY20) • Review Medical Staff Credentialing Process (FY19)
3. Review Quality, Patient Care, and Patient Experience Committee Reports and Dashboards	• Monthly: FY 19 Quality dashboardQ1 – Q2 FY18 – Proposal • Three Times Per Year: CDI, Core Measures, PSI-90, Readmissions, Pt. Experience (HCAHPS), ED Pt. Satisfaction • Annually: Leapfrog Survey Results and VBP Calculation Reports	• Review Reports Per the Timeline
4. Oversee Execution of the Patient and Family Centered Care Plan	• Quarterly	• Review Plan and Progress. Provide Feedback to Management
5. Monitor the impact of interventions to reduce AMI 30 day mortality, CABG	• Quarterly	• Review process toward meeting quality

30 day mortality, AMI 30 day readmission, and HF 30 day readmission		organizational goal

SUBMITTED BY:

David Reeder **Chair**, Quality Committee

Cheryl Reinking, RN **Interim Executive Sponsor**, Quality Committee

Submitted to the Quality Committee For Discussion on April 2, 2018

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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Quality, Patient Care, Patient Experience

Committee Meetings
Proposed FY19 Dates

RECOMMENDED QC DATE FIRST MONDAY	CORRESPONDING HOSPITAL BOARD DATE
Monday, August 6, 2018	Wednesday, August 8 (or 15), 2018
Monday, September 10, 2018*	Wednesday, September 12 (or Monday 17, 2018
Monday, October 1, 2018	Wednesday, October 10, 2018
Monday, November 5, 2018	Wednesday, November 14, 2018
Monday, December 3, 2018	Wednesday, January 16, 2019 (or December 12, 2018)
Monday, February 4, 2019	Wednesday, February 13, 2019
Monday, March 4, 2019	Wednesday, March 13, 2019
Monday, April 1, 2019	Wednesday, April 10, 2019
Monday, May 6, 2019*	Wednesday, May 8, 2019
Monday, June 3, 2019	Wednesday, June 12, 2019

*Quality Committee Report will be late getting into the Board packet, but the packet can be supplemented.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Proposed FY 19 Organizational Goals Patient Care and Patient Experience Committee April 2, 2018
	Responsible party:	Cheryl Reinking, RN Chief Nursing Officer
	Action requested:	For Discussion
	Background: Each new fiscal year ECH leaders develop organizational goals that cascade to all levels of the organization. Incentive compensation is based on achievement of the organizational goals. The goals should align with the strategic objectives of the organization. The goals for FY 19 align directly with the strategic objectives in consumer alignment (quality and patient experience goals), and high performing organization (affordability/efficiency goal). These goals relate directly to several of the Truven Top 100 measures that the organization is not performing as well as expected. The metrics have not yet been established because the baseline data is not yet ready.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide an overview of the FY 19 proposed organizational goals • Receive feedback from the board members on strategic alignment and appropriateness of the goals.	
	Suggested discussion questions: 1. Are the goals aligned with the strategic goals and objectives?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: 1. Propose FY 19 Proposed Organizational Goals	

DRAFT FY19 Organizational Goals

Organizational Goals FY19	Benchmark	2018 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe
Organizational Goals							
Patient Throughput Door to Floor	External Benchmark *CMS*	*TBD*	*TBD*	*TBD*	*TBD*	34%	
HCAHPS Service Metric Nurse Communication Responsiveness Cleanliness	External Benchmark *PG-HCAHPS Adjusted/Receiv*	*TBD*	*TBD*	*TBD*	*TBD*	33%	
Truven Quality Metrics: AMI 30 day mortality CABG 30 day mortality AMI 30 day readmission HF 30 day readmission SP-36 - CABG - AMI	External Benchmark *Premier*	*TBD*	*TBD*	*TBD*	*TBD*	33%	
Threshold Goals							
Budgeted Operating Margin	95% threshold	Achieved Budget	95% of Budgeted			Threshold	FY 19

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:	
1/4 if Delta = Min					0.068	0.670	Minium
½ Delta = X					0.136	0.602	Target
Max = Delta					0.271	0.467	Max

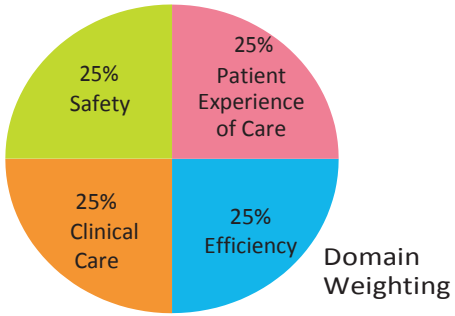
ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Value Based Purchasing Result – FY 2019 (Oct. 1, 2018) Quality, Patient Care and Patient Experience Committee April 2, 2018
	Responsible party:	Cheryl Reinking, RN Chief Nursing Officer
	Action requested:	For Discussion
	Background: Value Based Purchasing is CMS' effort at Pay for Performance. In its 6th year, VBP adjusts Medicare inpatient reimbursement based on hospital's performance on quality and patient experience measures. In FY 2018, 1600 hospitals received bonus payments. Medicare withholds 2% of a hospital's anticipated DRG payments. Hospitals can earn back all of the 2% and more if it performs well, or lose some if it does not.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide education on how ECH performed on the most recent VBP • Identify metrics that if improved, would increase the dollars earned back	
	Suggested discussion questions: 1. ECH will have $1,584,818 withheld in October 2018 and based on these metrics, is predicted to earn back $1,351,057. Net impact is a loss of $233,761 or 0.31% 2. The Efficiency quadrant is valued at 25% of the total VBP and ECH's score is 0.00. 3. Most of the 30% loss is due to MSPB-1 (Medicare Spend per Beneficiary) : totals dollars spent per Medicare pt. from 3 days prior to admission to 30 days after discharge (for all tests, meds, procedures, consults, MD visits, Home Health, SNF, etc.)	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: Value Based Purchasing Chart	

FY 2019 Hospital Value-Based Purchasing: El Camino Hospital

FFY 2019 (10/1/2018)

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



Safety (25% of Total Performance Score) Domain Score = 36.67

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

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

Patient Experience of Care (25% of Total Score) Domain Score = 37.00

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

Higher is better for all scores.

Clinical Care (25% of Total Performance Score) Domain Score = 40.00

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

Measures expressed as survival rates (higher is better).

Efficiency (25% of Total Performance Score) Domain Score = 0.00

Baseline period			Performance period	
CY 2015			CY 2017	
Measure ID	Description	Threshold	Performance	Benchmark
MSPB-1	Medicare Spending per Beneficiary	Median MSPB ratio hospitals during performance period 0.99	1.00	Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.844

Lower is better for all scores.

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

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item: Core Measure Status Report	Core Measure Status Report Patient Care and Patient Experience Committee April 2, 2018
	Responsible party:	Cheryl Reinking, RN Chief Nursing Officer
	Action requested:	For Discussion

Background:

As required by CMS, ECH must gather and submit data to CMS on the core measures determined by CMS.

Regarding measures to focus on improvement:

- PC-PCM Perinatal Perfect Care Mothers; PC-02 Primary C/Section rate at Mountain View :
  - The MCH team is part of the CMQCC Collaborative to reduce C/S rate with limited improvement thus far. Medical Director does share MD specific data to drive physician behavior change. In addition, a multidisciplinary group meets monthly with development of protocols to change practice to promote vaginal birth.
- ED 1b: ED arrival to Departure for Admitted Pts. – this measure involves the entire process from patient presentation to the ED to disposition on an inpatient unit. There are many factors affecting this measure.
  - Teams have been working on improvement efforts, but this effort needs a broader focus throughout the organization and proposing this effort be an organizational goal for FY 19.
- PC-OP Stroke: CT/MRE results within 45 min. of ED arrival.
  - Improvement to meet the 45 min time to CT/MRI. 100% achieved for 6 months, but one failure can greatly affect performance.
- PC-HBIPS: In-patient Psychiatric Services. Improvement in justification for more than 1 anti-psychotic meds at discharge.
  - Developing a plan with iCare to develop a hard stop when anti-psychotic medications are ordered at discharge without a justification.

Other Board Advisory Committees that reviewed the issue and recommendation, if any:

None.

Summary and session objectives :

- Provide an overview of Core Measure Performance at ECH and areas for improvement with identified efforts to improve.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Suggested discussion questions: 1. Are there any core measures that the committee would like a deeper dive into at another meeting?
	Proposed Committee motion, if any: None. This is a Discussion item.
	LIST OF ATTACHMENTS: Core Measure Chart

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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	Not data	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

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Hospital Update
Quality, Patient Care and Patient Experience Committee:

April 2, 2018
Dan Woods, CEO

Quality and Safety

The Joint Commission (TJC) Survey Preparation: Leadership expects the next triennial survey of both hospitals to take place sometime between August 2018 and January 2019. A mock joint commission survey was conducted at both campuses February 6th, 7th, and 8th. A governance structure is in place to provide executive support to the managers, directors and front line staff. Action plans are being executed by members of the Continuous Readiness Team.

A new tele-psychiatry vendor will be used to provide psychiatric consultations in the Emergency Departments at both MV and LG beginning April 1, 2018. ECH has been using a different vendor for tele-psychiatry in the MV ER for a number of years, but the service was not as prompt as we expect, thus a move to a new vendor. In addition, the service will extend to the ECH LG Emergency Department.

Patient Experience

The patient experience roadmap for the final 6 months of FY 18 is being executed. Leader rounding refresher training is occurring the week of March 13 and Nursing Communication Training is kicking of March 1st. The Patient and Family Advisory Council is being re-booted as well to engage more patients and families in the improvement work throughout the organization. As well, performance improvement management initiatives are making a difference with improving patient flow and overall satisfaction in several areas as appropriate, including ongoing average length of stay (ALOS) reductions, reducing the door-to-treatment time in the Emergency Department, reducing 30-day readmission rates in urology and heart failure, and improving pain management and timely intervention in the behavioral medicine department.

We have added some new language to our patient statements to (1) include the new feature in myChart for patients to review their detailed bill and (2) provide information about our new online Patient Tools as well as Pay-by-phone. We have started to assist patients with enrollment in myChart during the scheduling and registration process in main registration; we will expand this to all registration sites in March. Our implementation plan for MyChart Bedside includes having patients using Apple iPads to access it in their patient rooms by end of 2018.

Facilities

We have several major construction projects underway and one in the planning phase at the Mountain View Campus.

- **Behavioral Health Services (BHS) Building:** Construction of a new 2-Story BHS Building with 36 Beds & Outpatient Services & Support is progressing on schedule with a target completion date of March 2019. The Final GMP Proposal has been accepted and is within the revised budget of $96,100,000. The forecasted cost as of March 19th is $92,787,000.

- **Integrated Medical Office (IMOB) Building:** Construction of a new 7-Story Structure housing hospital services on floors G,1 and 2, leased medical office space on floors 3-6, and a 360 Car Parking Structure adjacent. The structure will be connected to the new main hospital on 3 levels. The project is progressing on schedule with a target completion date for construction of May 2019. Acceptance of the Final GMP proposal is within the revised budget of $302,100,000 and will be finalized by the end of the month. The forecasted cost as of March 19th is $296,864,000.

- **Central Utility Plant Upgrades:** Construction and equipment installation of utility systems upgrades designed to serve the new BHS and IMOB projects continues on schedule and we expect it be completed slightly under the $9,000,000 budget.

- **Women's Hospital Expansion:** Currently in the initial planning and study phase. The "expansion" is to the 2nd & 3rd floors that are currently occupied by medical offices, to provide private as opposed to the current semi-private rooms for post-partum mothers. There is no addition to the building footprint contemplated. Various options for sequencing the construction have been evaluated and contractors are working to forecast schedules and costs associated with each option.

- **North Drive Parking Structure Expansion:** Project is essentially complete and we forecast it will be under budget.

Operations

The FY19 planning and budgeting process is in full swing as the management team works through department planning, volume projections, revenue and expense estimates, and other resource allocation needs. The service line leaders recently reported on operations from the first half of the fiscal year and plans for the second half of FY18. Leadership efforts have focused on strengthening physician relations, growing market share, and improving efficiency (i.e. removing barriers to timely scheduling of diagnostic testing and surgical procedures) at both the Mountain View and Los Gatos hospital campuses. Los Gatos surgical volumes have increased by 9 percent and Mountain View surgical volumes have increased by nearly 3 percent.

The College of American Pathologist (CAP) survey in the Laboratory in Los Gatos occurred on February 28th. There were several findings. CAP is a very detailed survey with 3000 items on their checklist. The laboratory leadership will await the final report and develop action plans to address the findings.

Financial Services

Cash collections for February were $71,334,693 million and $7,560,245 over goal. Our front end (self-pay) collections are on track to achieve $1million above our goal for the year. Denial Recoveries midyear were $9.8 Million compared to our goal of $7 Million in recoveries. Our cost initiative reduction goal is proceeding well. As of March 1, 2018, we have implemented $4,445,671 of our $4.8 M savings challenge.

Information Services

Four physicians are now live on Community Connect with a 5 physician practice expected to go live by the end of FY18 for a total of 9 physicians using the El Camino Community Connect Epic system in their office by July 2018.

Dashboards (Service Line, Departmental, and Executive) will be activated this week to enable real time operational metrics, including a dashboard for the Nursing Department to track key metrics.

Philanthropy

During period 7 of FY18, the Foundation secured $436,942. The total revenue received for the annual El Camino Heritage Golf Tournament, held in October 2017, was $333,650, which is 111% of goal. Proceeds benefited the Taft Center for Clinical Research. The total revenue received for the 6th annual Norma's Literary Luncheon (held on 8th February) by end of period 7 was $162,770, which exceeds the fundraising goal. Thanks to a generous gift from the Melchor family to underwrite all expenses, all ticket sales, sponsorships, and donations have been earmarked for a proposed new patient family residence on the Mountain View campus.

Auxiliary

Our very dedicated Auxiliary contributed 7,154 volunteer hours in January 2018.