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.

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>PRESENTED BY</th>
<th>ESTIMATED TIMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CALL TO ORDER</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>5:30 – 5:31pm</td>
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<tr>
<td>2. ROLL CALL</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>5:31 – 5:32</td>
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<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>5:32 – 5:33</td>
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<tr>
<td>4. CONSENT CALENDAR ITEMS: Any Committee Member or member of the public may pull an item for discussion before a motion is made.</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 5:33 – 5:36</td>
</tr>
<tr>
<td>Approval</td>
<td></td>
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<tr>
<td>a. Minutes of the Open Session of the Quality Committee Meeting (March 5, 2018)</td>
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<tr>
<td>Information</td>
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<tr>
<td>b. FY18 Pacing Plan</td>
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<td>c. Progress Against FY 2018 Committee Goals</td>
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<tr>
<td>5. REPORT ON BOARD ACTIONS ATTACHMENT 5</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Discussion 5:36 – 5:39</td>
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<tr>
<td>6. PATIENT STORY ATTACHMENT 6</td>
<td>Ina Bauman, Quality Committee Member</td>
<td>Discussion 5:39 – 5:59</td>
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<tr>
<td>7. FY18 QUALITY DASHBOARD ATTACHMENT 7</td>
<td>Cheryl Reinking, RN, Chief Nursing Officer</td>
<td>Discussion 5:59 – 6:09</td>
</tr>
<tr>
<td>8. CAUTI DEEP DIVE ATTACHMENT 8</td>
<td>Catherine Carson, RN Sr. Director /Chief Quality Officer</td>
<td>Discussion 6:09 – 6:19</td>
</tr>
<tr>
<td>9. UPDATE ON PATIENT AND FAMILY CENTERED CARE: PATIENT EXPERIENCE ROADMAP ATTACHMENT 9</td>
<td>Cheryl Reinking, RN, Chief Nursing Officer</td>
<td>Discussion 6:19 – 6:29</td>
</tr>
<tr>
<td>10. PROPOSED FY19 COMMITTEE GOALS ATTACHMENT 10</td>
<td>Cindy Murphy, Director of Governance Services</td>
<td>Possible Motion 6:29 – 6:39</td>
</tr>
<tr>
<td>11. PROPOSED FY19 COMMITTEE MEETING DATES ATTACHMENT 11</td>
<td>Cindy Murphy, Director of Governance Services</td>
<td>Possible Motion 6:39 – 6:49</td>
</tr>
<tr>
<td>12. PROPOSED FY19 ORGANIZATIONAL GOALS ATTACHMENT 12</td>
<td>Cheryl Reinking, RN, Chief Nursing Officer</td>
<td>Discussion 6:49 – 6:54</td>
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<tr>
<td>13. VALUE BASE PURCHASING REPORT</td>
<td>Cheryl Reinking, RN,</td>
<td>Discussion</td>
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<td>AGENDA ITEM</td>
<td>PRESENTED BY</td>
<td>ESTIMATED TIMES</td>
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<tr>
<td>ATTACHMENT 13</td>
<td>Chief Nursing Officer</td>
<td>6:54 – 7:09</td>
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<tr>
<td>14. CORE MEASURE ATTACHMENT 14</td>
<td>Cheryl Reinking, RN, Chief Nursing Officer</td>
<td>Discussion 7:09 – 7:14</td>
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<tr>
<td>15. HOSPITAL UPDATE ATTACHMENT 15</td>
<td>Dan Woods, Chief Executive Officer</td>
<td>Discussion 7:14 – 7:19</td>
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<td>16. PUBLIC COMMUNICATION</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Information 7:19 – 7:18</td>
</tr>
<tr>
<td>17. ADJOURN TO CLOSED SESSION</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:18 – 7:19</td>
</tr>
<tr>
<td>18. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>7:19 – 7:20</td>
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<td>19. CONSENT CALENDAR</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:20 – 7:23</td>
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<tr>
<td>Approval</td>
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<td>Gov’t Code Section 54957.2.</td>
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<tr>
<td>a. Minutes of the Closed Session of the Quality Committee Meeting (March 5, 2018)</td>
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<td>Information</td>
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<tr>
<td>b. Quality Council Minutes (February 7, 2018)</td>
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<td>20. Health and Safety Code Section 32155, report related to Medical Staff quality assurance matters:</td>
<td>Shreyas, Mallur, MD, Associate CMO, LG</td>
<td>Discussion 7:23 – 7:28</td>
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<td>- Red/Orange Alert and RCA Updates</td>
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<td>21. ADJOURN TO OPEN SESSION</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:28 – 7:29</td>
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<tr>
<td>22. RECONVENE OPEN SESSION/REPORT OUT</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>7:29 – 7:30</td>
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<td>To report any required disclosures regarding permissible actions taken during Closed Session.</td>
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<tr>
<td>23. ADJOURNMENT</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:30 – 7:31pm</td>
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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

<table>
<thead>
<tr>
<th>Members Present</th>
<th>Members Absent</th>
<th>Members Excused</th>
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<tbody>
<tr>
<td>Dave Reeder,</td>
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<tr>
<td>Peter Fung, MD;</td>
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<tr>
<td>Jeffrey Davis, MD</td>
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* Ina Bauman attended the meeting via teleconference.
* Melora Epperly left the meeting at 6:56 pm.

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 5th of March, 2018 meeting.

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Comments/Discussion</th>
<th>Approvals/Action</th>
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<tbody>
<tr>
<td>1. CALL TO ORDER</td>
<td>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.</td>
<td>None</td>
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<tr>
<td>2. ROLL CALL</td>
<td>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.</td>
<td>None</td>
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<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>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.</td>
<td>None</td>
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<tr>
<td>4. CONSENT CALENDAR ITEMS</td>
<td>Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed.</td>
<td>The open minutes of the February 5, 2018 Quality Committee were approved.</td>
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</table>

Motion: To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (February 5, 2018).

Movant: Fung
Second: Anderson
Noes: None
Abstentions: None
Absent: None
Excused: None
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<tr>
<td><strong>Recused:</strong> None</td>
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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.

### 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
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<tr>
<td><strong>7. FY18 QUALITY DASHBOARD</strong></td>
<td>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.</td>
<td>None</td>
</tr>
</tbody>
</table>
| **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 | |
<p>| <strong>9. CDI DASHBOARD</strong> | 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. | |</p>
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<td>10. CORE MEASURES</td>
<td>Chair Reeder deferred Agenda item 10 to the next quality committee meeting.</td>
<td>Agenda item 10 deferred to 4/2 meeting.</td>
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<tr>
<td>11. JOINT COMMISSION PREPAREDNESS</td>
<td>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.</td>
<td>None</td>
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<tr>
<td>12. PUBLIC COMMUNICATION</td>
<td>None.</td>
<td>None</td>
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</tbody>
</table>
| 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 SESSION REPORT OUT | Open Session was reconvened at 7:24 pm.  
Agenda Items 14 – 16 were addressed in closed session. | None |
| 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

______________________________  
Dave Reeder  
Chair, ECH Quality, Patient Care and  
Patient Experience Committee
QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan

<table>
<thead>
<tr>
<th>FY2018 Q1</th>
<th>FY2018 Q2</th>
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<tr>
<td>JULY 2017</td>
<td>OCTOBER 2, 2017</td>
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</tbody>
</table>
| No Board or Committee Meetings | 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. 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) | OCTOBER 30, 2017 |
| AUGUST 7, 2017 | DECEMBER 4, 2017 |
| AUGUST 28, 2017 (for September’s meeting) | DECEMBER 4, 2017 |
## FY2018 Q3

<table>
<thead>
<tr>
<th>JANUARY 2018</th>
<th>FEBRUARY 5, 2018</th>
<th>MARCH 5, 2018</th>
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</thead>
</table>
| 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 |
|              | FEBRUARY 5, 2018 | MARCH 5, 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  | Standing Agenda Items:  
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2. Consent Calendar  
3. FY18 Quality Dashboard  
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Special Agenda Items:  
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2. Quarterly Quality and Safety Review  
3. Readmission Dashboard  
4. PSI-90 Pt. Safety Indicators  
5. Opioids Usage Discussion  
6. Quality Ratings |
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.

<table>
<thead>
<tr>
<th>GOALS</th>
<th>TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)</th>
<th>METRICS</th>
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<tbody>
<tr>
<td>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.</td>
<td>Q1 FY18 – Goals Q3 FY18 - Metrics</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>Q2 Q4 FY18</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>Q1 – Q2 FY18 – Proposal Q2 FY18 – Implementation Month Q1 – Q4 FY18</td>
<td>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</td>
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<td><strong>4.</strong></td>
<td>Oversee the development of a plan with specific tactics and monitor the HCAHPs scores for Patient and Family Centered Care.</td>
<td><strong>Q2 Q3 FY18</strong></td>
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<td>Review the plan and approve</td>
<td>Committee will review on 4/2 meeting</td>
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<td><strong>5.</strong></td>
<td>Monitor the impact of interventions to reduce hospital-acquired infections.</td>
<td>Quarterly</td>
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<td>Review process toward meeting quality (infection control) organizational goal</td>
<td>1st, 2nd, and 3rd quarter reviewed quality dashboard including standardized infection ratios</td>
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**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*
**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

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.*
<table>
<thead>
<tr>
<th>Item: Patient Story</th>
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<tbody>
<tr>
<td>Quality Committee</td>
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<tr>
<td>Meeting Date: April 2, 2018</td>
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| Responsible party: Ina Bauman, Member, Quality Committee |

| Action requested: For Information |

**Background:**

**Challenges a Patient May (is Likely to) Encounter:**

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.

**Learnings:**

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.
<table>
<thead>
<tr>
<th>2.</th>
<th>El Camino Hospital Senior Management is Dedicated to Improving Patient Stay</th>
</tr>
</thead>
</table>

**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
## Quality and Safety Dashboard (Monthly)

### SAFETY EVENTS

<table>
<thead>
<tr>
<th>Event Description</th>
<th>FY2017 Actual</th>
<th>FY2018 Goal</th>
<th>Trend</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Falls</td>
<td>1.31 (56/42555)</td>
<td>1.49 (Top decile CALNOC)</td>
<td></td>
<td>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 &quot;Get up and go&quot; test within the Fall Risk Assessment tool.</td>
</tr>
<tr>
<td>Hospital Acquired Infection</td>
<td>1.03 (12/11663)</td>
<td>1.09 (SIR Goal: &lt;= 0.75 SIR July-Dec.2017 = 1.459)</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Central Line Associated Blood Stream Infection (CLABSI)</td>
<td>0.28 (4/3116)</td>
<td>0.56 (SIR Goal: &lt;= 0.50 SIR July-Dec.2017 = 0.423)</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Clostridium Difficile Infection (CDI)</td>
<td>0.91 (6/65955)</td>
<td>1.89 (SIR Goal: &lt;= 0.70 SIR July-Dec.2017 = 0.30)</td>
<td></td>
<td>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 request in EPIC to alert nurses to implement contact isolation when C.Diff antigen test Ordered and order to soap and water handwashing.</td>
</tr>
</tbody>
</table>

### Efficiency

<table>
<thead>
<tr>
<th>Event Description</th>
<th>FY2017 Actual</th>
<th>FY2018 Goal</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arithmetic Observed LOS</td>
<td>1.11</td>
<td>1.16</td>
<td>1.11</td>
</tr>
</tbody>
</table>
### Definitions and Additional Information

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Definition Owner</th>
<th>Work Group</th>
<th>FY 2017 Definition</th>
<th>FY 2018 Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Falls</td>
<td>Sheetal Shah; Cheryl Reinking</td>
<td>Falls Committee</td>
<td>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.</td>
<td></td>
<td>QIR Reporting and Staff Validation</td>
</tr>
<tr>
<td>Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)</td>
<td>Catherine Carson/Catherine Nalesnik</td>
<td></td>
<td>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 predicted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)</td>
<td>Catherine Carson/Catherine Nalesnik</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)</td>
<td>Catherine Carson/Catherine Nalesnik</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arithmetic Observed LOS Average over Geometric LOS Expected.</td>
<td>Cheryl Reinking Catherine Carson (Jessica Hatala)</td>
<td></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Sepsis Core Measure
   SEP-1 100% or O%
   Date Period: Jan 2018
   Drop in Sep-1 compliance 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.

8. Mortality Rate
   Observed/Expected
   Premier Standard Risk Calculation Mode
   Date Period: Dec 2017
   January and February data not available yet in Premier Quality Advisor due to data refresh back to Nov. 2015 not complete - delayed with errors to April 10, 2018.

9. HCAHPS Rate Hospital 0-10
   Top Box Rating 9 and 10
   Date Period: Feb 2018
   Slight rebound from January’s result. Average to date July-Feb = 76.8.
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Definition</th>
<th>Owner</th>
<th>Work Group</th>
<th>FY 2017 Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis Core Measure- SEP-1: MONTHLY Compliance Rate ECH vs. All Core Measure Hospitals</td>
<td>New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate &gt; 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.</td>
<td>Catherine Carson/Kelly Nguyen</td>
<td>Sepsis Steering Committee</td>
<td>EPIC Chart Review</td>
<td></td>
</tr>
<tr>
<td>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 &lt;3 excluded)</td>
<td>Percentage of Randomly Sampled ED Patients (LG &amp; MV) who had IVF &gt;=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate &lt;3 Excluded)</td>
<td>Catherine Carson</td>
<td></td>
<td>EPIC Chart Review</td>
<td></td>
</tr>
<tr>
<td>Mortality Rate (Observed/Expected)</td>
<td></td>
<td>Catherine Carson</td>
<td></td>
<td>Premier Quality Advisor</td>
<td></td>
</tr>
<tr>
<td>HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10</td>
<td>“‘9’ or ‘10’ (high)” for the Overall Hospital Rating item</td>
<td>Michelle Gabriel; Ashley Fontenot; Cheryl Reinking</td>
<td>Patient Experience Committee</td>
<td>Press Ganey Tool</td>
<td></td>
</tr>
</tbody>
</table>
### 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 HAIIs 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 😊_

<table>
<thead>
<tr>
<th>HAI</th>
<th>Enterprise Goal NHSN SIR*</th>
<th>No. Of HAI FY 2017</th>
<th>No. Of HAI FY 2018 (To date)</th>
<th>NSHN: Predicted Number of HAI to Meet SIR Goal</th>
<th>FY 2018 1st Q: (July – Sept.) Number of Infections</th>
<th>FY 2018 2nd Q: (Oct. -Dec.) Number Infections</th>
<th>FY 2018 3rd Q: (Jan-March 2018) Number Infections</th>
<th>Number of Infections MV-LG for remaining 2Q to Meet Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAUTI</strong> Catheter Associated Urinary Tract Infection</td>
<td>SIR \leq 0.75&lt;br&gt;SIR Rate Jul-Dec '17 = 1.459</td>
<td>21</td>
<td>14</td>
<td>11&lt;br&gt;MV: 10 / LG:1</td>
<td>4&lt;br&gt;MV: 3&lt;br&gt;LG: 1</td>
<td>6&lt;br&gt;MV: 6&lt;br&gt;LG: 0</td>
<td>4&lt;br&gt;MV: 4 (Jan)&lt;br&gt;LG: 0</td>
<td>0&lt;br&gt;(MV: -3/ LG:0)</td>
</tr>
<tr>
<td><strong>CLABSI</strong> Central Line Associated Bloodstream Infection</td>
<td>SIR \leq 0.5&lt;br&gt;SIR Rate Jul-Dec '17 = 0.423</td>
<td>7</td>
<td>3</td>
<td>4&lt;br&gt;MV:4/ LG: 0</td>
<td>0</td>
<td>2&lt;br&gt;MV: 2&lt;br&gt;LG: 0</td>
<td>1&lt;br&gt;MV: 1&lt;br&gt;LG: 0</td>
<td>1&lt;br&gt;(MV: 1 / LG:0)</td>
</tr>
<tr>
<td><strong>C. Diff Clostridium difficile</strong></td>
<td>SIR \leq 0.7&lt;br&gt;SIR Rate Jul-Dec '17 = 0.30</td>
<td>19</td>
<td>7</td>
<td>25&lt;br&gt;MV: 22/ LG: 3</td>
<td>4&lt;br&gt;MV: 4&lt;br&gt;LG: 0</td>
<td>1&lt;br&gt;MV: 1&lt;br&gt;LG: 0</td>
<td>2&lt;br&gt;MV: 2&lt;br&gt;LG: 0</td>
<td>18&lt;br&gt;(MV: 15 / LG:3)</td>
</tr>
</tbody>
</table>

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_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

• **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

---

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.*
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

   - 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)
- **No code**/comfort care/hospice if external device not option
- **Immobility** 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

After removal of indwelling urinary catheter (IUC), assess for signs and symptoms of bladder retention:

- inability to void 6 hours post removal
- feeling of discomfort even after voiding
- abdominal distention
- frequent voiding with small amounts

Perform bladder scan

- Continue to assess q 2 hours for above signs
- CONSIDER fluid challenge: PO or IV intake

Less than 400mL

May straight catheterize patient

More than 400mL

Is this 1st straight catheter?

- Yes
- No

May straight catheterize a 2nd time

If patient was already straight catheterized twice and continues with signs/symptoms of bladder retention, call MD for Foley insertion order

Document ALL assessments and interventions
**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 Road Map for El Camino Hospital

### Immediate

1-3 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

### Short-Term

3-6 Months

- **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

### Long-Term

6-18 Months

- **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

1. Respect for patients' preferences
2. Coordination and integration of care
3. Information and education
4. Physical comfort
5. Emotional support
6. Involvement of family and friends
7. Continuity and transition
8. Access to care

Picker’s Eight Principles of Patient Centred Care

- MyChart Bedside, PFAC, Listening Carefully Toolkit
- ACP Videos, Education on Adv Care Planning, Bedside Report
- MyChart, Emmi, MyChart Bedside
- Pain Management, Pain Management Pharmacist, Rounding
- Listening Carefully Toolkit, Leader Rounding, Care Team Coaching
- PFAC, Leader Rounding, Care Team Coaching
- Discharge Phone Calls, Bedside Report, OP Pharmacy, Meds to Beds
- MyChart, MyChart Bedside
**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
**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.*

<table>
<thead>
<tr>
<th>GOALS</th>
<th>TIMELINE by Fiscal Year</th>
<th>METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>• Q1 FY19: FY18 Achievement and Metrics for FY19 • Q3 – Q4 FY19: FY20 Goals</td>
<td>• Review Management Proposals, Provide Feedback and Make Recommendations to the Board</td>
</tr>
<tr>
<td>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.</td>
<td>• Q2</td>
<td>• Receive update on implementation of peer review process changes (FY20) • Review Medical Staff Credentialing Process (FY19)</td>
</tr>
<tr>
<td>3. Review Quality, Patient Care, and Patient Experience Committee Reports and Dashboards</td>
<td>• 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</td>
<td>• Review Reports Per the Timeline</td>
</tr>
<tr>
<td>4. Oversee Execution of the Patient and Family Centered Care Plan</td>
<td>• Quarterly</td>
<td>• Review Plan and Progress. Provide Feedback to Management</td>
</tr>
<tr>
<td>5. Monitor the impact of interventions to reduce AMI 30 day mortality, CABG</td>
<td>• Quarterly</td>
<td>• Review process toward meeting quality</td>
</tr>
<tr>
<td>30 day mortality, AMI 30 day readmission, and HF 30 day readmission</td>
<td>organizational goal</td>
<td></td>
</tr>
</tbody>
</table>

**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*
# Quality, Patient Care, Patient Experience

## Committee Meetings

### Proposed FY19 Dates

<table>
<thead>
<tr>
<th>RECOMMENDED QC DATE</th>
<th>CORRESPONDING HOSPITAL BOARD DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, August 6, 2018</td>
<td>Wednesday, August 8 (or 15), 2018</td>
</tr>
<tr>
<td>Monday, September 10, 2018*</td>
<td>Wednesday, September 12 (or Monday 17, 2018)</td>
</tr>
<tr>
<td>Monday, October 1, 2018</td>
<td>Wednesday, October 10, 2018</td>
</tr>
<tr>
<td>Monday, November 5, 2018</td>
<td>Wednesday, November 14, 2018</td>
</tr>
<tr>
<td>Monday, December 3, 2018</td>
<td>Wednesday, January 16, 2019 (or December 12, 2018)</td>
</tr>
<tr>
<td>Monday, February 4, 2019</td>
<td>Wednesday, February 13, 2019</td>
</tr>
<tr>
<td>Monday, March 4, 2019</td>
<td>Wednesday, March 13, 2019</td>
</tr>
<tr>
<td>Monday, April 1, 2019</td>
<td>Wednesday, April 10, 2019</td>
</tr>
<tr>
<td>Monday, May 6, 2019*</td>
<td>Wednesday, May 8, 2019</td>
</tr>
<tr>
<td>Monday, June 3, 2019</td>
<td>Wednesday, June 12, 2019</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Organizational Goals FY19</th>
<th>Benchmark</th>
<th>2018 ECH Baseline</th>
<th>Minimum</th>
<th>Target</th>
<th>Maximum</th>
<th>Weight</th>
<th>Performance Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Throughput</strong></td>
<td>External Benchmark CMS</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>Door to Floor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HCAHPS Service Metric</strong></td>
<td>External Benchmark PG-HCAHPS Adjusted/Received</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Nurse Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Responsiveness</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cleanliness</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Truven Quality Metrics:</strong></td>
<td>External Benchmark Premier</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>AMI 30 day mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CABG 30 day mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI 30 day readmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF 30 day readmission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SP-36</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>- CABG</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- AMI</td>
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</tr>
</tbody>
</table>

### Threshold Goals

<table>
<thead>
<tr>
<th>Budgeted Operating Margin</th>
<th>95% threshold</th>
<th>Achieved Budget</th>
<th>95% of Budgeted</th>
<th>Threshold</th>
<th>FY 19</th>
</tr>
</thead>
</table>

**Notes:**
- TBD indicates 'To Be Determined' for the benchmarks.
<table>
<thead>
<tr>
<th>HAI</th>
<th>Facility – MV</th>
<th># of HAI</th>
<th>Facility- LG</th>
<th># OF HAI</th>
<th>AVE SIR</th>
<th>Target SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI</td>
<td>2016 H2 – 1.817</td>
<td>11</td>
<td>2016 H2 – 0.932</td>
<td>1</td>
<td>1.375</td>
<td></td>
</tr>
<tr>
<td>HX 2015-2016</td>
<td>0.767</td>
<td>20</td>
<td>0.6385</td>
<td>3</td>
<td>0.703</td>
<td>1.039</td>
</tr>
<tr>
<td>CLABS</td>
<td>2016 H2 – 0.492</td>
<td>2</td>
<td>2016 H2 - 0</td>
<td>0</td>
<td>0.246</td>
<td></td>
</tr>
<tr>
<td>HX 2015-2016</td>
<td>0.31</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0.155</td>
<td>0.201</td>
</tr>
<tr>
<td>C.DIFF</td>
<td>2016 Q4-1.185</td>
<td>2016 Q4 - 10</td>
<td>2016 Q4 - 0</td>
<td>0.593</td>
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<tr>
<td>HX 2016</td>
<td>0.753</td>
<td>23</td>
<td>0.331</td>
<td>1</td>
<td>0.542</td>
<td>0.567</td>
</tr>
<tr>
<td>AVE SIR CURRENT</td>
<td>0.738</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AVE SIR HX</td>
<td>0.467</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delta</td>
<td>0.271</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Infection Rate Index:

1/4 if Delta = Min
½ Delta = X
Max = Delta

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th>0.068</th>
<th>0.670</th>
<th>Minium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.136</td>
<td>0.602</td>
<td>Target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.271</td>
<td>0.467</td>
<td>Max</td>
</tr>
</tbody>
</table>
## ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

<table>
<thead>
<tr>
<th>Item:</th>
<th>Value Based Purchasing Result – FY 2019 (Oct. 1, 2018) Quality, Patient Care and Patient Experience Committee April 2, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible party:</td>
<td>Cheryl Reinking, RN Chief Nursing Officer</td>
</tr>
<tr>
<td>Action requested:</td>
<td>For Discussion</td>
</tr>
</tbody>
</table>

### 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)

<table>
<thead>
<tr>
<th>Base Operating DRG Payments</th>
<th>Withhold Amount/ % of revenue -2.00%</th>
<th>Bonus Amount/ +1.71%</th>
<th>Net Impact /-0.30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$79,240,876</td>
<td>$1,584,818</td>
<td>$1,351,057</td>
<td>-233,761</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Threshold</th>
<th>Performance vs Threshold</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter-Associated Urinary Tract Infection</td>
<td>0.464</td>
<td>0.939</td>
<td>0.000</td>
</tr>
<tr>
<td>Central Line-Associated Blood Stream Infection</td>
<td>0.427</td>
<td>0.387</td>
<td>0.000</td>
</tr>
<tr>
<td><em>Clostridium difficile</em> Infection</td>
<td>0.816</td>
<td>0.679</td>
<td>0.013</td>
</tr>
<tr>
<td>Methicillin-Resistant <em>Staphylococcus aureus</em></td>
<td>0.823</td>
<td>0.860</td>
<td>0.000</td>
</tr>
<tr>
<td>Bacteremia : HO LabID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Site Infection Colon</td>
<td>0.832</td>
<td>0.446</td>
<td>0.000</td>
</tr>
<tr>
<td>Abdominal Hysterectomy</td>
<td>0.698</td>
<td>0.732</td>
<td>0.000</td>
</tr>
<tr>
<td>Complication/patient safety for selected indicators (composite)</td>
<td>0.840335</td>
<td>0.541799</td>
<td>0.589462</td>
</tr>
<tr>
<td>Elective Delivery Prior to 39 Completed Weeks Gestation</td>
<td>0.010038</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Description</th>
<th>Performance (%)</th>
<th>Threshold (%)</th>
<th>Benchmark (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>79%</td>
<td>78.69</td>
<td>86.97</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>82%</td>
<td>80.32</td>
<td>88.62</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>64%</td>
<td>65.16</td>
<td>80.15</td>
</tr>
<tr>
<td>Pain Management</td>
<td>76%</td>
<td>70.01</td>
<td>78.53</td>
</tr>
<tr>
<td>Communication about Medicines</td>
<td>66%</td>
<td>63.26</td>
<td>73.53</td>
</tr>
<tr>
<td>Hospital Cleanliness and Quietness</td>
<td>67%</td>
<td>65.58</td>
<td>79.06</td>
</tr>
<tr>
<td>Discharge Information</td>
<td>86%</td>
<td>87.05</td>
<td>91.87</td>
</tr>
<tr>
<td>Care Transitions</td>
<td>54%</td>
<td>51.42</td>
<td>62.77</td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
<td>77%</td>
<td>70.85</td>
<td>84.83</td>
</tr>
</tbody>
</table>

Higher is better for all scores.

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

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description – Survival Rate</th>
<th>Threshold %</th>
<th>Performance vs Threshold</th>
<th>Benchmark %</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-day mortality rate</td>
<td>85.0671</td>
<td>87.7</td>
<td>87.3263</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-day mortality rate</td>
<td>88.3472</td>
<td>88.6</td>
<td>90.8094</td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Pneumonia (PN) 30-day mortality rate</td>
<td>88.2334</td>
<td>83.3</td>
<td>90.7906</td>
</tr>
<tr>
<td>THA/TKA</td>
<td>Primary THA/TKA complication rate</td>
<td>3.2229</td>
<td>2.8</td>
<td>2.3178</td>
</tr>
</tbody>
</table>

Measures expressed as survival rates (higher is better).

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

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description – Medicare Spending per Beneficiary</th>
<th>Threshold</th>
<th>Performance</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPB-1</td>
<td>Medicare Spending per Beneficiary</td>
<td>Median MSPB ratio hospitals during performance period 0.99</td>
<td>1.00</td>
<td>Mean of the lowest decile MSPB ratios for all hospitals during performance period – 0.844</td>
</tr>
</tbody>
</table>

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.
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.
<table>
<thead>
<tr>
<th><strong>Suggested discussion questions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are there any core measures that the committee would like a deeper dive into at another meeting?</td>
</tr>
</tbody>
</table>

**Proposed Committee motion, if any:** None. This is a Discussion item.

**LIST OF ATTACHMENTS:** Core Measure Chart
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Core Measures</th>
<th>Goal</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>Q1</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>CY 2017</th>
<th>Truven 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-SEP</td>
<td>Perfect Care - Severe Septic/Septic Shock</td>
<td>100%</td>
<td>71%</td>
<td>42%</td>
<td>33%</td>
<td>52%</td>
<td>46%</td>
<td>33%</td>
<td>46%</td>
<td>82%</td>
<td>56%</td>
<td>49%</td>
<td>71%</td>
<td>62%</td>
<td>50%</td>
<td>61%</td>
<td>51%</td>
</tr>
<tr>
<td>PC-AMM</td>
<td>Perfect Care - Immunization</td>
<td>100%</td>
<td>57%</td>
<td>57%</td>
<td>100%</td>
<td>98%</td>
<td>92%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>PC-PCG</td>
<td>Perfect Care - PCG (Perinatal Care - Mothers)</td>
<td>PC-01 Elective Delivery</td>
<td>PC-02 Cesarean Section</td>
<td>PC-03 Antenatal Steroids</td>
<td>PC-04 Health Care-Associated Bloodstream Infections in Newborns</td>
<td>PC-05 Exclusive Breast Milk Feeding</td>
<td>100%</td>
<td>66%</td>
<td>78%</td>
<td>84%</td>
<td>76%</td>
<td>53%</td>
<td>80%</td>
<td>73%</td>
<td>75%</td>
<td>76%</td>
<td>54%</td>
</tr>
<tr>
<td>PC-VTE</td>
<td>Perfect Care – Venous Thromboembolism</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>ED-1b</td>
<td>Median Time from ED Arrival to ED Departure for Admitted ED Patients - Reporting Measure</td>
<td>300 min</td>
<td>402</td>
<td>345</td>
<td>371</td>
<td>380</td>
<td>415</td>
<td>302</td>
<td>332</td>
<td>378</td>
<td>315</td>
<td>366</td>
<td>330</td>
<td>321</td>
<td>306</td>
<td>313</td>
<td>365</td>
</tr>
<tr>
<td>ED-2b</td>
<td>Admit Decision Time to ED Departure Time for Admitted Patients - Reporting Measure</td>
<td>120 min</td>
<td>115</td>
<td>95</td>
<td>112</td>
<td>111</td>
<td>217</td>
<td>96</td>
<td>86</td>
<td>74</td>
<td>86</td>
<td>177</td>
<td>81</td>
<td>80</td>
<td>76</td>
<td>81</td>
<td>172</td>
</tr>
<tr>
<td>PC-OF AME</td>
<td>Perfect Care - Out Patient Acute Myocardial Infarction</td>
<td>OP-2 Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival</td>
<td>OP-4 Aspirin at Arrival</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95%</td>
<td>NA</td>
</tr>
<tr>
<td>PC-OF CP</td>
<td>Perfect Care - Out Patient Chest Pain</td>
<td>OP-4 Aspirin at Arrival</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Not data</td>
<td>96%</td>
<td>NA</td>
<td>100%</td>
<td>96%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>OP-18b</td>
<td>Median Time from ED Arrival to ED Departure for Discharged ED Patients</td>
<td>130 min</td>
<td>164</td>
<td>162</td>
<td>205</td>
<td>152</td>
<td>178</td>
<td>170</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>168</td>
<td>166</td>
<td>168</td>
<td>164</td>
<td>161</td>
<td>169</td>
</tr>
<tr>
<td>OP-24</td>
<td>Time to Diagnostic Evaluation by a Qualified Medical Professional</td>
<td>15 min</td>
<td>15</td>
<td>18</td>
<td>13</td>
<td>16</td>
<td>49</td>
<td>15</td>
<td>16</td>
<td>14</td>
<td>15</td>
<td>43</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td>OP-21</td>
<td>Hospital Outpatient Pain Management Population</td>
<td>30 min</td>
<td>60</td>
<td>66</td>
<td>51</td>
<td>55</td>
<td>75</td>
<td>63</td>
<td>55</td>
<td>66</td>
<td>60</td>
<td>69</td>
<td>38</td>
<td>81</td>
<td>57</td>
<td>49</td>
<td>68</td>
</tr>
<tr>
<td>PC-OP STK</td>
<td>Perfect Care - Out Patient Stroke</td>
<td>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</td>
<td>100%</td>
<td>67%</td>
<td>NA</td>
<td>50%</td>
<td>60%</td>
<td>71%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>50%</td>
<td>73%</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>67%</td>
</tr>
<tr>
<td>PC-JIME</td>
<td>Perfect Care - Immunization</td>
<td>6M2 Influenza Immunization/HBIPS</td>
<td>100%</td>
<td>93%</td>
<td>95%</td>
<td>100%</td>
<td>96%</td>
<td>92%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>PC-HBPS</td>
<td>Perfect Care - Hospital Based Inpatient Psychiatric Services</td>
<td>HBIPS-5a Multiple Antipsychotic Medications at Discharge with Appropriate Justification – Overall Rate</td>
<td>100%</td>
<td>90%</td>
<td>87%</td>
<td>90%</td>
<td>85%</td>
<td>87%</td>
<td>87%</td>
<td>86%</td>
<td>77%</td>
<td>78%</td>
<td>87%</td>
<td>100%</td>
<td>100%</td>
<td>60%</td>
<td>87%</td>
</tr>
<tr>
<td>PC-SUB</td>
<td>Perfect Care - Substance Abuse</td>
<td>Sub-1 Alcohol Use Screening</td>
<td>Sub-2 Alcohol Use Brief Intervention Provided or Offered</td>
<td>Sub-3a Alcohol Use Brief Intervention</td>
<td>Sub-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge</td>
<td>Sub-3a Alcohol and Other Drug Use Disorder Treatment at Discharge</td>
<td>100%</td>
<td>82%</td>
<td>85%</td>
<td>95%</td>
<td>87%</td>
<td>69%</td>
<td>94%</td>
<td>84%</td>
<td>95%</td>
<td>91%</td>
<td>72%</td>
</tr>
<tr>
<td>PC-TOB</td>
<td>Perfect Care - Tobacco Use</td>
<td>TOB-1 Tobacco Use Screening</td>
<td>TOB-2 Tobacco Use Treatment Provided or Offered</td>
<td>TOB-3 Tobacco Use Treatment Provided or Offered at Discharge</td>
<td>TOB-3a Tobacco Use Treatment at Discharge</td>
<td>100%</td>
<td>87%</td>
<td>79%</td>
<td>86%</td>
<td>84%</td>
<td>70%</td>
<td>90%</td>
<td>81%</td>
<td>50%</td>
<td>90%</td>
<td>69%</td>
<td>78%</td>
</tr>
</tbody>
</table>

**Legend:**
- **G**: 95% - 100%
- **R**: <90%
- **Y**: 20% - 49%
- **Not Available**: Not Available
- **Color Indicator**
  - **G**: Green
  - **R**: Red
  - **Y**: Yellow
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.