AGENDA

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

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

Jeffrey Davis will be participating via teleconference from 2000 W Westcourt way, Tempe, AZ 85282
Melora Simon will be participating via teleconference from 107 Crescent Ave, Portola Valley, CA 94028

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER**	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 (April 2, 2018) ***Information*** b. Research Article c. Patient Story d. FY18 Pacing Plan e. Progress Against FY 2018 Committee Goals			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion** **5:36 – 5:39**
6.	**SEPSIS UPDATE** **ATTACHMENT 6**	Kelly Nguyen Manager Sepsis Quality		**Discussion** **5:39 – 5:59**
7.	**FY18 QUALITY DASHBOARD** **ATTACHMENT 7**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **5:59 – 6:09**
8.	**REVIEW COMMITTEE CHARTER** **ATTACHMENT 8**	Cindy Murphy Director of Governance Services		**Discussion** **6:09 – 6:14**
9.	**PROPOSED FY19 COMMITTEE GOALS** **ATTACHMENT 9**	Cindy Murphy Director of Governance Services		**Possible Motion** **6:14 – 6:24**
10.	**PROPOSED FY19 ORGANIZATIONAL GOALS** **ATTACHMENT 10**	Cheryl Reinking, RN, Chief Nursing Officer		**Possible Motion** **6:24 – 6:34**
11.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE** **ATTACHMENT 11**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:34 – 6:39**

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
12.	**QUARTERLY QUALITY AND SAFETY REVIEW**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:39 – 6:49**
13.	**PT. EXPERIENCE (HCAHPS) AND ED PT. SATISFACTION (PRESS GANEY)** **ATTACHMENT 13**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:49 – 6:59**
14.	**HOSPITAL UPDATE** **ATTACHMENT 14**	Mark Adams, MD Interim Chief Medical Officer		**Discussion** **6:59 – 7:04**
15.	**PUBLIC COMMUNICATION**	Dave Reeder, Quality Committee Chair		**Information** **7:04 – 7:07**
16.	**ADJOURN TO CLOSED SESSION**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:07 – 7:08**
17.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**7:08 – 7:09**
18.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required** **7:09 – 7:12**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (April 2, 2018) ***Information*** b. Quality Council Minutes (March 7, 2018)			
19.	*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** **7:12 – 7:17**
20.	**ADJOURN TO OPEN SESSION**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:17 – 7:18**
21.	**RECONVENE OPEN SESSION/REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Dave Reeder, Quality Committee Chair		**7:18 – 7:19**
22.	**ADJOURNMENT**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:19 – 7:20pm**

Upcoming FY18 Meetings
June 4, 2018

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, April 2, 2018
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

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

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 2nd of April, 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 5:34 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Dr. Peter Fung, Katie Anderson, Nancy Carragee, and Mikele Epperly are absent.	***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 (March 5, 2018). **Movant:** Ron **Second:** Simon **Ayes:** Bauman, Davis, Kliger, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** Anderson, Carragee, Epperly, Fung **Excused:** None **Recused:** None Chair Reeder reviewed over the results of the questionnaire that was given to the members at the last meeting for rating the value and importance of agenda items. He also noted that there won't be a clinical program reporting for a while since the committee would rather have more discussion and less presentation during the meeting.	***The open minutes of the March 5, 2018 Quality Committee were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee. He highlighted the Periodic Review of the District's Bylaws was completed with minor changes, FY18 YTD Financial Report is doing quite well, and the Community Benefit Mid-year Metrics were reviewed and approved.	***None***
6. PATIENT STORY	Committee member Ina Bauman shared her patient experience with the Committee as an overall positive experience with some learning opportunities within her 3 hospital visits. She noted some communication problems between the staff, patient and family. She also highlighted a major factor of receiving delayed pain medication after 2.5 hours from surgery. Mrs. Bauman asked for feedback and questions from the Committee and a brief discussion ensued.	***Ashlee F to follow up if there is a data limit when filing an online compliant***
7. FY18 QUALITY DASHBOARD	Mrs. Reinking reported that ECH has zero new HAI's for February in CAUTI, CLABSI, and C. Diff, Falls have declined over 3 months, Average LOS recovered after increase in pt. volume and acuity in January, and mortality data not available yet in Quality Advisor due to delayed data refresh. The Committee discussed Sepsis Core Measure and it was requested to bring back the mortality rate/ratio into the data being provided. Catherine Carson explained to The Committee that our mortality rate is low between 10-12%. The Committee inquired about IVF Bolus admin time target and Mrs. Carson stated that admin time target varies case by case. She furthered explained how there are no changes in CMS regarding patient physiology which can help with our data. *The Committee requested to review a spreadsheet with percentage data of QRRs reported and the categories sorted by compliant.*	***Committee requested to review a spreadsheet with percentage data of QRRs reported and the categories sorted by compliant.***
8. CAUTI DEEP DIVE	Mrs. Carson reported on the work of the HAI Teams to address each HAI in the Quality Goal and the results to date. Highlighting some key accomplishments taken in FY2018 by the HAI CAUTI Team: • Daily monitoring of Foley catheter justification • CAUTI Event reviews • Staff Education on CAUTI prevention measures • Foley usage including urine culture ordering • Nurse Driven Protocol for Foley removal (2017-2018) She provided information regarding CAUTI and best practices for reduction of these infections. Mrs. Carson asked for feedback and questions from the Committee and a brief discussion ensued	

Agenda Item	Comments/Discussion	Approvals/Action
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Mrs. Reinking provided an overview of the patient care experience roadmap for the next 18 months. She explained the crosswalk of the patient care experience roadmap to the eight principles of Patient Centered Care: • Respect for patient's preference • Coordination and integration of care • Information and education • Physical comfort • Emotional Support • Involvement of family and friends • Continuity and transition • Access to care Mrs. Reinking asked for feedback from the Committee and a brief discussion ensued. *The Committee requested a spreadsheet to be presented at a later meeting to include the amount of grievance letters received and sorted by type of compliant.*	***The Committee requested a spreadsheet to be presented at a later meeting to include the amount of grievance letters received and sorted by type of compliant.***
10. PROPOSED FY19 COMMITTEE GOALS	Cindy Murphy, Director of Governance Services, reviewed over the Proposed FY19 Committee Goals stating they are very similar to the ones for FY18. She reminded the members that the goals would need to be approved by the next meeting on April 30th, so it can go to the Board. Dave Reeder asked the Committee to review and address any concerns before the next meeting.	
11. PROPOSED FY19 COMMITTEE MEETING DATES	Cindy Murphy, Director of Governance Services reviewed the proposed FY19 meeting dates and asked if there were any conflicts. One was noted for September 10, 2018 because it is Rosh Hashanah. The Committee decided to adjust the date to September 5th, 2018.	
12. PROPOSED FY19 ORGANIZATIONAL GOAL	Mrs. Reinking provided an overview of the proposed FY19 organizational goals to the Committee. She explained how the goals are aligned directly with the strategic objectives in consumer alignment (quality and patient experience goals), and high performing organization (affordability/efficiency goal). The metrics have not yet been established because the baseline data is not yet ready. Mrs. Reinking asked for feedback and questions from the Committee and a brief discussion ensued.	
13. VALUE BASE PURCHASING	Mrs. Reinking reviewed on how ECH is performing on the most recent Value Based Purchasing. She explained that 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%. She further explained that 30% loss is due to MSPB-1 (Medicare Spend per Beneficiary): totals dollars spent per Medicare pt. from 3 days	

Agenda Item	Comments/Discussion	Approvals/Action
	prior to admission to 30 days after discharge. Mrs. Reinking asked for feedback and questions from the Committee and a brief discussion ensued.	
14. CORE MEASURE	Mrs. Reinking discussed the Core Measure Status Report which is data submitted to CMS on the cores measures determined by CMS. She provided an overview of Core Measure Performance at ECH and areas for improvement with identified efforts to improve highlighted these areas: • PC-PCM Perinatal Perfect Care Mothers; PC-02 Primary C/Section rate at Mountain View • 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. • PC-OP Stroke: CT/MRE results within 45 min. of ED arrival. • PC-HBIPS: In-patient Psychiatric Services. Improvement in justification for more than 1 anti-psychotic meds at discharge. Mrs. Reinking asked for feedback from the Committee and a brief discussion ensued.	
15. HOSPITAL UPDATE	Dan Woods, Chief Executive Officer provided a brief hospital update to the committee members highlighted the following areas in Quality and Safety, Patient Experience, Facilities, and Auxiliary. • The Joint Commission (TJC) new safer matrix of "see one cite one" that began January 2017. • Encouraging staff to have patient download MyChart and MyChart Bedside to their mobile phone. • Behavioral Health Services (BHS) building with 36 beds is underway along with the Integrated Medical Office (IMOB) building which laid down their steel base. • Acknowledging the contributed 7,154 volunteer hours provided by the Auxiliary staff.	
16. PUBLIC COMMUNICATION	None.	***None***
17. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:28 pm. **Movant:** Simon **Second:** Ron **Ayes:** Bauman, Davis, Kliger, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None	***Adjourned to closed session at 7:28 pm.***

Agenda Item	Comments/Discussion	Approvals/Action
	Absent: Anderson, Carragee, Epperly, Fung **Excused:** None **Recused:** None	
18. AGENDA ITEM 22: RECONVENE OPEN SESSION/REPORT OUT	Open Session was reconvened at 7:30 pm. *Agenda Items 18 – 20 were addressed in closed session.*	
19. AGENDA ITEM 23: ADJOURNMENT	The meeting was adjourned at 7:30pm. **Motion:** To adjourn at 7:30 pm. **Movant:** Ron **Second:** Simon **Ayes:** Bauman, Davis, Kliger, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** Anderson, Carragee, Epperly, Fung **Excused:** None **Recused:** None	***Meeting adjourned at 7:30 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

What are septic shock and sepsis? The facts behind these deadly conditions

www.sciencerocksmyworld.com/what-are-septic-shock-and-sepsis-the-facts-behind-these-deadly-conditions/

June 11, 2016

By Hallie Prescott, *University of Michigan* and Theodore Iwashyna, *University of Michigan*.

Most Americans have never heard of it, but according to recent federal data, sepsis is the most expensive cause of hospitalization in the U.S., and is now the most common cause of ICU admission among older Americans.

Sepsis is a complication of infection that leads to organ failure. More than one million patients are hospitalized for sepsis each year. This is more than the number of hospitalizations for heart attack and stroke combined. People with chronic medical conditions, such as neurological disease, cancer, chronic lung disease and kidney disease, are at particular risk for developing sepsis.

And it is deadly. Between one in eight and one in four patients with sepsis will die during hospitalization – as most notably Muhammad Ali did in June 2016. In fact sepsis contributes to one-third to one-half of all in-hospital deaths. Despite these grave consequences, fewer than half of Americans know what the word sepsis means.

What is sepsis and why is it so dangerous?

Sepsis a severe health problem sparked by your body's reaction to infection. When you get an infection, your body fights back, releasing chemicals into the bloodstream to kill the harmful bacteria or viruses. When this process works the way it is supposed to, your body takes care of the infection and you get better. With sepsis, the chemicals from your body's own defenses trigger inflammatory responses, which can impair blood flow to organs, like the brain, heart or kidneys. This in turn can lead to organ failure and tissue damage.

At its most severe, the body's response to infection can cause dangerously low blood pressure. This is called septic shock.

Sepsis can result from any type of infection. Most commonly, it starts as a pneumonia, urinary tract infection or intra-abdominal infection such as appendicitis. It is sometimes referred to as "blood poisoning," but this is an outdated term. Blood poisoning is an infection present in the blood, while sepsis refers to the body's response to any infection, wherever it is.

Once a person is diagnosed with sepsis, she will be treated with antibiotics, IV fluids and support for failing organs, such as dialysis or mechanical ventilation. This usually means a person needs to be hospitalized, often in an ICU. Sometimes the source of the infection must be removed, as with appendicitis or an infected medical device.

It can be difficult to distinguish sepsis from other diseases that can make one very sick, and there is no lab test that can confirm sepsis. Many conditions can mimic sepsis, including severe allergic reactions, bleeding, heart attacks, blood clots and medication overdoses. Sepsis requires particular prompt treatments, so getting the diagnosis right matters.

Back so soon?
Hospital hallway image via www.shutterstock.com.

The revolving door of sepsis care

As recently as a decade ago, doctors believed that sepsis patients were out of the woods if they could just survive to hospital discharge. But that isn't the case – 40 percent of sepsis patients go back into the hospital within just three months of heading home, creating a "revolving door" that gets costlier and riskier each time, as patients get weaker and weaker with each hospital stay. Sepsis survivors also have an increased risk of dying for months to years after the acute infection is cured.

If sepsis wasn't bad enough, it can lead to another health problem: Post-Intensive Care Syndrome (PICS), a chronic health condition that arises from critical illness. Common symptoms include weakness, forgetfulness, anxiety and depression.

Post-Intensive Care Syndrome and frequent hospital readmissions mean that we have dramatically underestimated how much sepsis care costs. On top of the US$5.5 billion we now spend on initial hospitalization for sepsis, we must add untold billions in rehospitalizations, nursing home and professional in-home care, and unpaid care provided by devoted spouses and families at home.

Unfortunately, progress in improving sepsis care has lagged behind improvements in cancer and heart care, as attention has shifted to the treatment of chronic diseases. However, sepsis remains a common cause of death in patients with chronic diseases. One way to help reduce the death toll of these chronic diseases may be to improve our treatment of sepsis.

Rethinking sepsis identification

Raising public awareness increases the likelihood that patients will get to the hospital quickly when they are developing sepsis. This in turn allows prompt treatment, which lowers the risk of long-term problems.

Beyond increasing public awareness, doctors and policymakers are also working to improve the care of sepsis patients in the hospital.

For instance, a new sepsis definition was released by several physician groups in February 2016. The goal of this new definition is to better distinguish people with a healthy response to infection from those who are being harmed by their body's response to infection.

As part of the sepsis redefinition process, the physician groups also developed a new prediction tool called qSOFA. This instrument identifies patients with infection who are at high risk of death or prolonged intensive care. The tools uses just three factors: thinking much less clearly than usual, quick breathing and low blood pressure. Patients with infection and two or more of these factors are at high risk of sepsis. In contrast to prior methods of screening patients at high risk of sepsis, the new qSOFA tool was developed through examining millions of patient records.

Life after sepsis

Even with great inpatient care, some survivors will still have problems after sepsis, such as memory loss and weakness.

Doctors are wrestling with how to best care for the growing number of sepsis survivors in the short and long term. This is no easy task, but there are several exciting developments in this area.

The Society of Critical Care Medicine's THRIVE initiative is now building a network of support groups for patients and families after critical illness. THRIVE will forge new ways for survivors to work with each other, like how cancer patients provide each other advice and support.

As medical care is increasingly complex, many doctors contribute to a patient's care for just a week or two.

Electronic health records let doctors see how the sepsis hospitalization fits into the broader picture – which in turn helps doctors counsel patients and family members on what to expect going forward.

The high number of repeat hospitalizations after sepsis suggests another opportunity for improving care. We could analyze data about patients with sepsis to target the right interventions to each individual patient.

Better care.
Intensive care image via www.shutterstock.com.

Better care through better policy

In 2012, New York state passed regulations to require every hospital to have a formal plan for identifying sepsis and providing prompt treatment. It is too early to tell if this is a strong enough intervention to make things better. However, it serves as a clarion call for hospitals to end the neglect of sepsis.

The Centers for Medicare & Medicaid Services (CMS are also working to improve sepsis care. Starting in 2017, CMS will adjust hospital payments by quality of sepsis treatment. Hospitals with good report cards will be paid more, while hospitals with poor marks will be paid less.

To judge the quality of sepsis care, CMS will require hospitals to publicly report compliance with National Quality Forum's "Sepsis Management Bundle." This includes a handful of proven practices such as heavy-duty antibiotics and intravenous fluids.

While policy fixes are notorious for producing unintended consequences, the reporting mandate is certainly a step in the right direction. It would be even better if the mandate focused on helping hospitals work collaboratively to improve their detection and treatment of sepsis.

Right now, sepsis care varies greatly from hospital to hospital, and patient to patient. But as data, dollars and awareness converge, we may be at a tipping point that will help patients get the best care, while making the best use of our health care dollars.

This is an updated version of an article originally published on July 1, 2015. You can read the original version here.

Hallie Prescott, Assistant Professor in Internal Medicine, University of Michigan and Theodore Iwashyna, Associate Professor, University of Michigan

This article was originally published on The Conversation. Read the original article.

Now, Check Out:

- **Here's the Scientifically #1 Way to Prevent Dementia**
- **How nanotechnology can help us grow more food using less energy and water**
- **Catching metastatic cancer cells before they grow into tumors: a new implant shows promise**
- **Fruit-Derived Pills May Lower Blood Sugar for Obese People**
- **[Video] Watch this Angry Squirrel Go Nuts and Flick its Tail**

Sharing

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[redacted]

Patient Experience Dept
Los Gatos Community Hospital,
815 Pollard Road,
Los Gatos Ca 95023

Unfortunately a week ago I experienced a sudden onset of sweating, dragging my feet, feeling very heavy, needing to sit down, with shortness of breath and a pain in my chest which went round to my back and up into my neck and definitely generally not feeling right.

Fortunately I was taken to Los Gatos Community hospital Emergency Department, where in my alarmed state, Evelyn and Wylie without hesitation initiated a barrage of

tests - as I recall B.P. Blood Samples, EKG, X-Ray (bringing the machine to me!) whilst being most supportive and encouraging.

A CAT Scan was then organised and I was terrified. I was given a 'calming' tablet but was still so fearful I was unable to do the test. Rose was most understanding and sympathetic and it was only through her actions of accommodating and organising the situation to alleviate my fears (along with help from Dee Dee) that made the scan possible.

I was then admitted for overnight in order for the cardiologist to monitor a stress test the next day. Sandrine, Kevin and especially Brianna gave me consistently, kind and thoughtful attention - treating me as they would a family member or friend. Gloria in the stress test department was as warm and welcoming as well.

x x x

I was then set up for a nuclear stress test in Dr. Felix hee's office. I was very scared. Dr. Lee had explained the procedure to me during my treadmill stress test, however having been told in the abstract and in my somewhat debilitated state I had not really taken it in. So I went the day before the test to find the location, and find out more.

There I met Lisa, who realising my distress and concern, kindly took time out of her busy day to talk me through the procedure and show me the equipment to allay my fears. She even checked in on me on the test day when Tim seamlessly chatted me through the two hour session and happily answered all my questions. Mention must also be made of Chris with her very approachable way and lovely telephone manner.

So all in all, Los Gatos displays a shining example of what human kindness is all about. I applaud you all.

Warmly

[redacted]

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. Serious Safety/Red Alert Event as needed 5. 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. Proposed FY 19 Organizational Goals 5. Value Base Purchasing Report 6. Core Measure 7. 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. Hospital Update 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. Leapfrog Survey Results 8. 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. Approve FY19 Pacing Plan 2. Readmission Dashboard 3. PSI-90 Pt. Safety Indicators 4. Update on Patient and Family Centered Care

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.	• 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.	• 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 Board Actions Quality, Patient Care and Patient Experience Committee April 30, 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 Board Actions	

April 2018 ECH Board Actions*

1. Approved the FY 18 Period 7and 8 Financials
2. Approved a Resolution Delegating Authority to the Executive Compensation Committee to Approve Annual Salary Ranges, Annual Base Pay Adjustments, Individual Incentive Goals and Incentive Payments for Executives other than the CEO.
3. Approved a Resolution Approving the Winding Up and Dissolution of Pathways Continuous Care (Private Duty Services).
4. Approved Revised ECH Bylaws Sections 5.1 1nd 5.2.

*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:	Sepsis Report Quality Committee of the Board Meeting Date: April 30, 2018
	Responsible party:	Kelly Nguyen, MSN, RN Manager, Sepsis Quality
	Action requested:	For Discussion
	Background: The last time a Sepsis report was presented to the Quality Committee of the Board was August 2016. At that time, the Committee requested a quality metric to be reported on whether the IVF Bolus was ordered within 2 hours of time of presentation for Severe Sepsis or Septic Shock patients. After discussion regarding Sepsis at the April 2nd meeting, an update on Sepsis was requested.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide an update on the Sepsis program at ECH expanding on the metrics included in the monthly Quality Dashboard	
	Suggested discussion questions: 1. The incidence of sepsis continues to increase due to increase of age and co-morbidity in the community. Most sepsis case are admitted through the ED with few cases identified within the hospital 2. The administration of IV Fluids within the 3 hour window for compliance is at 72.3% 3. The sepsis mortality rate is 13%, and for patients not with a DNR order is 5%.	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: Annual Sepsis Report	

El Camino Hospital®
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Annual Sepsis Report
Sepsis Program

April 30, 2018

Kelly Nguyen, MSN, RN
Manager, Sepsis Quality

Sepsis Statistics

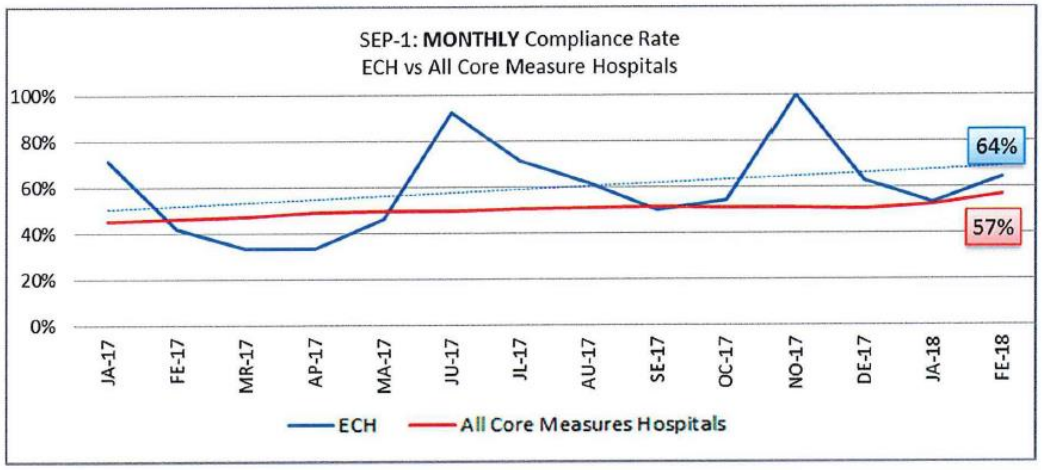
Enterprise data: 4/17-3/18

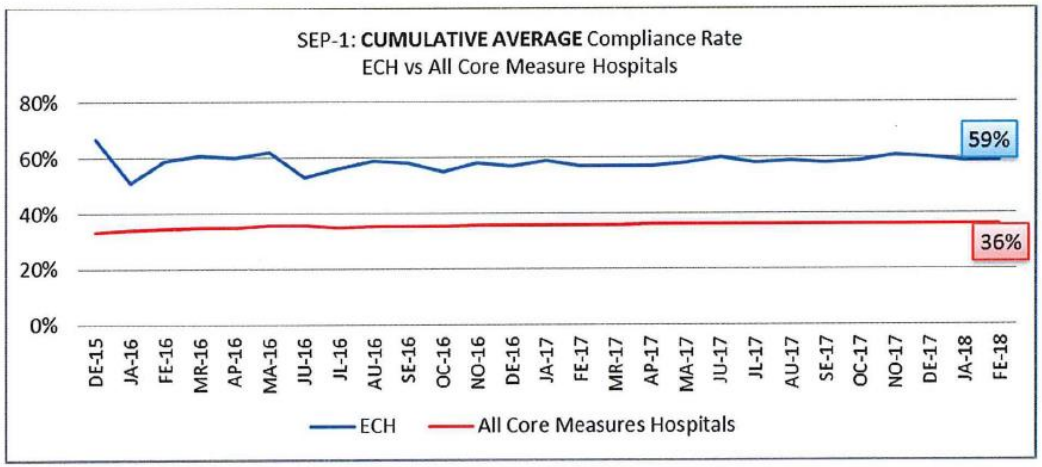
- Treated 1,623 cases
  - 163 in February
  - 283 admissions to CCU/ICU
- 74 inpatient sepsis alerts

- Sepsis is the leading cause of death in U.S. hospitals.[1]
- Sepsis is the leading cause of readmissions to the hospital with 19% of people hospitalized with sepsis needing to be re-hospitalized within 30 days.[2]
- As many as 87% of sepsis cases originate in the community.[3]
- Mortality from sepsis increases by as much as 8% for every hour that treatment is delayed. As many as 80% of sepsis deaths could be prevented with rapid diagnosis and treatment.[4]
- Approximately 6% of all hospitalizations are due to sepsis and 35% of all deaths in-hospital are due to sepsis. [3]

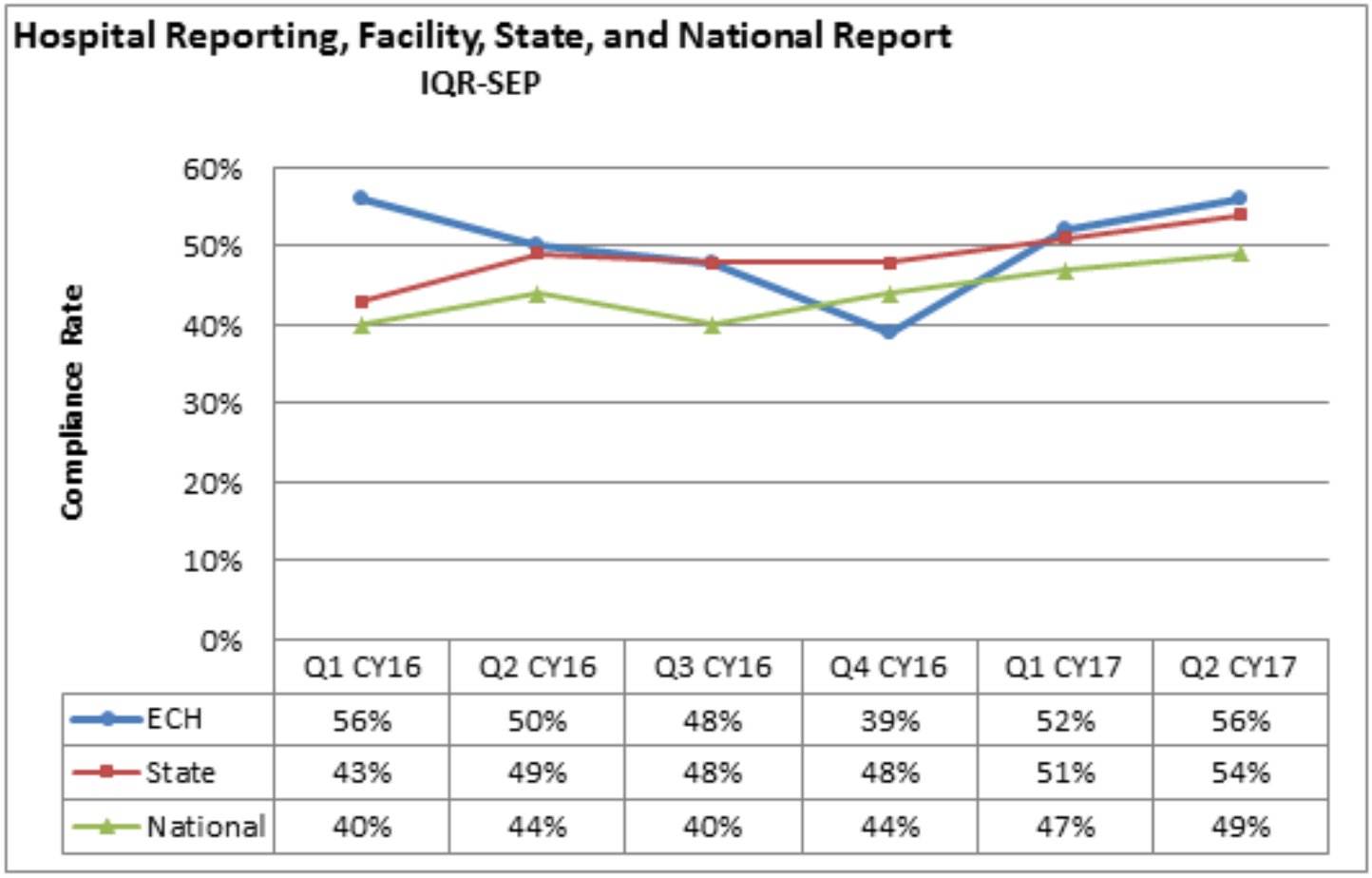
www.sepsis.org

Sepsis (SEP-1) Core Measure Compliance



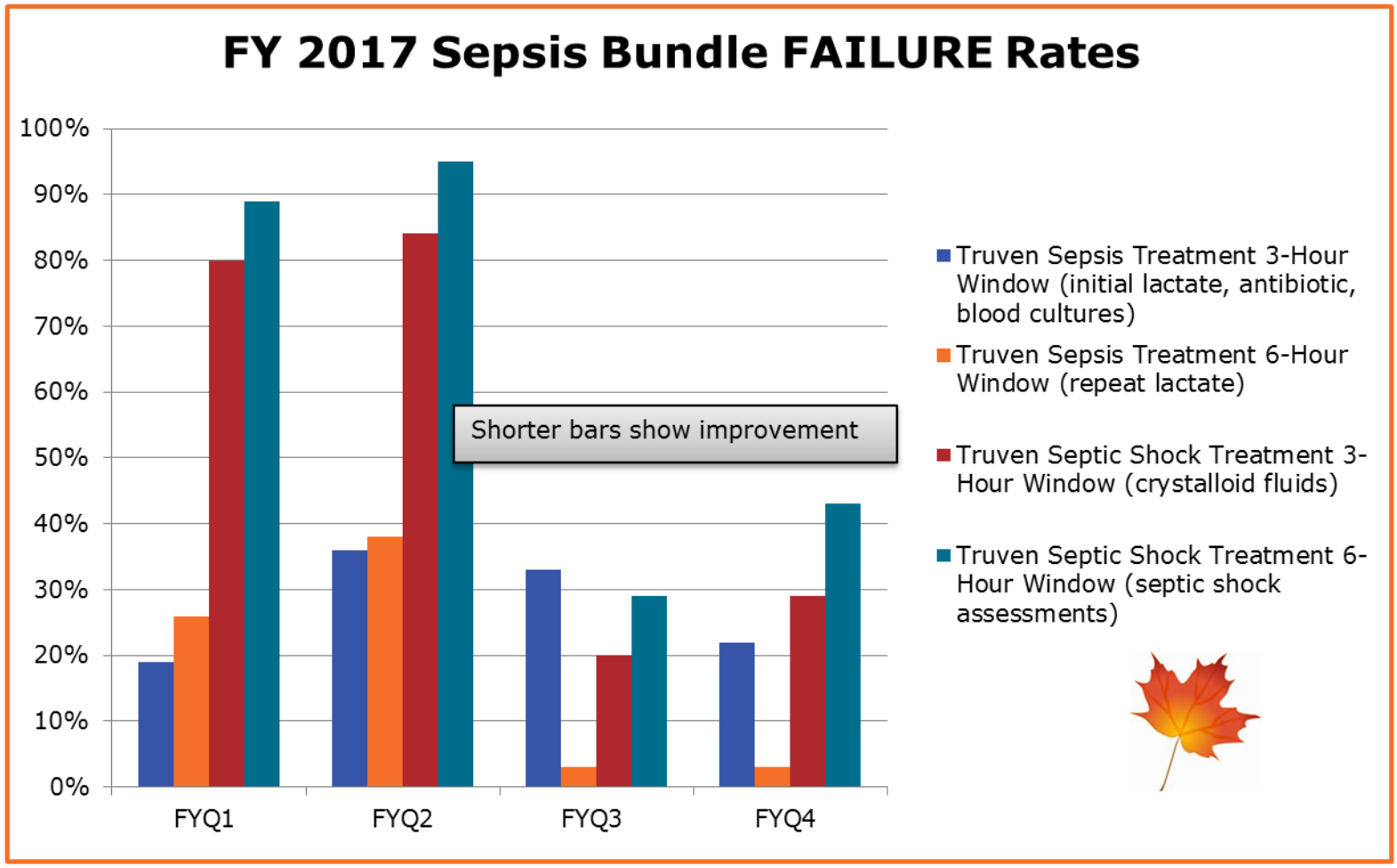


IQR SEP-1 Compliance

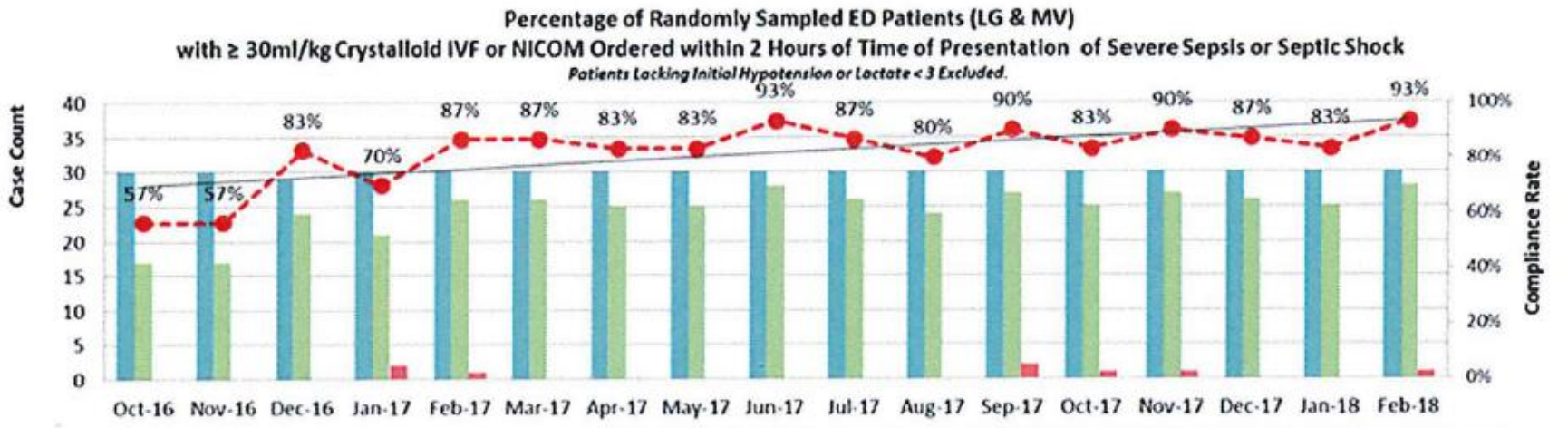


	Q1 CY16	Q2 CY16	Q3 CY16	Q4 CY16	Q1 CY17	Q2 CY17
ECH	56%	50%	48%	39%	52%	56%
State	43%	49%	48%	48%	51%	54%
National	40%	44%	40%	44%	47%	49%

SEP-1 Semi-Annual Compliance Report



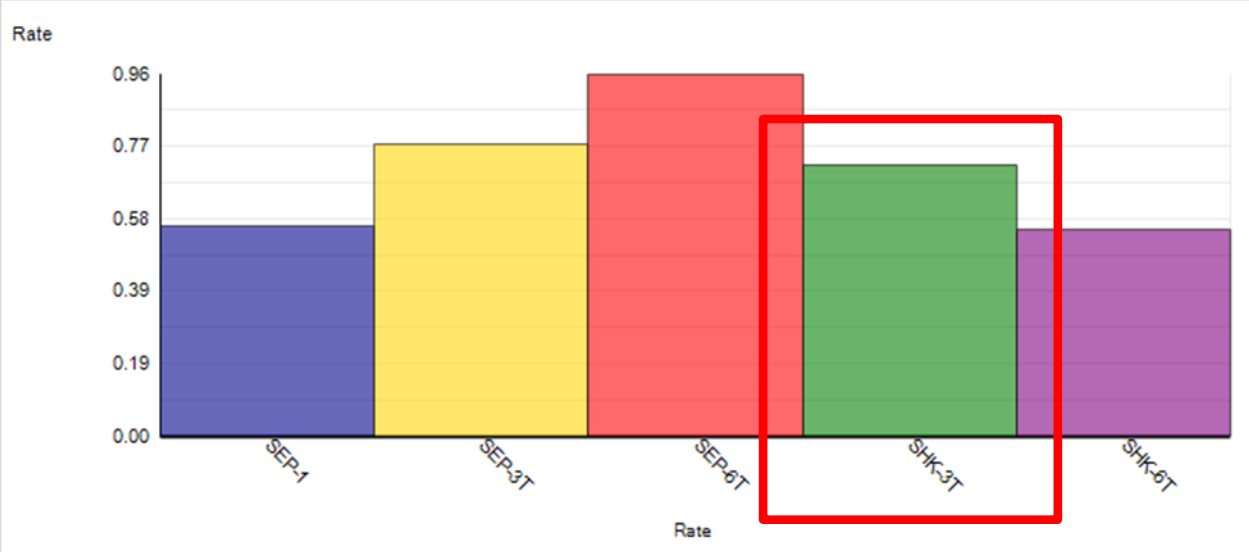
Internal Goal: Increased IVF/NICOM Ordering in the Emergency Departments



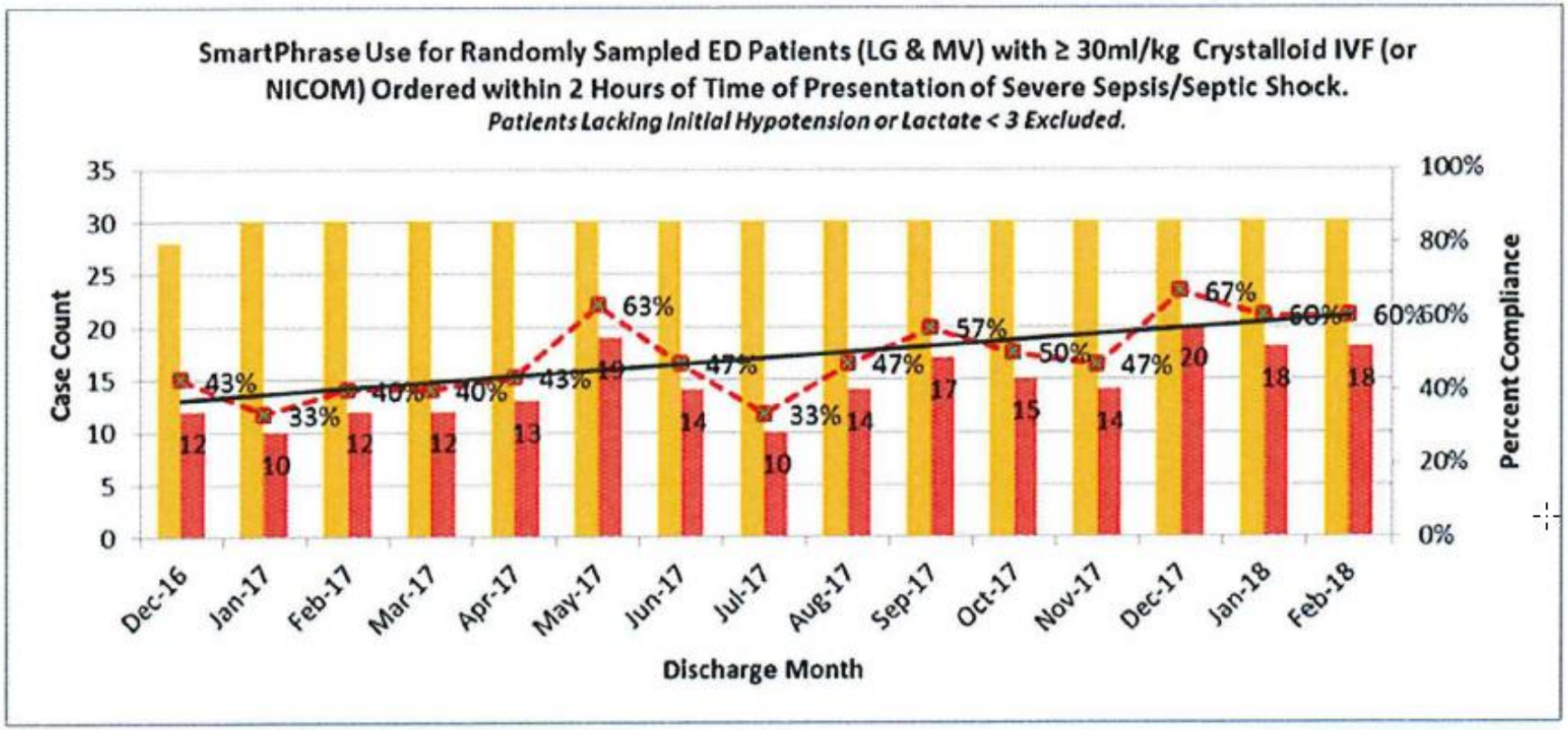
	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Number of Sampled Cases	30	30	29	30	30	30	30	30	30	30	30	30	30	30	30	30	30
Cases with 30ml/kg or NICOM ordered within 2h TOP	17	17	24	21	26	26	25	25	28	26	24	27	25	27	26	25	28
Cases 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	1
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%	83%	93%

Fluid Administration Compliance, SEP-1

Indicator Description	Denominator Count	Measure Failure Case Count	% of Measure Failure Cases	Measure Success Case Count	% of Measure Success Cases
Early Management Bundle	177	78	44.07%	99	55.93%
Sepsis Treatment 3-Hour Window	177	39	22.03%	138	77.97%
Sepsis Treatment 6-Hour Window	138	5	3.62%	133	96.38%
Septic Shock Treatment 3-Hour Window	76	21	27.63%	55	72.37%
Septic Shock Treatment 6-Hour Window	29	13	44.83%	16	55.17%



ED Provider Documentation



Internal Accomplishments

- **Policies & Procedures:** Updated, expanded, approved by 11 committees
- **Sepsis Alert Rollout:** Expanded to include: ED, CCU/ICU, palliative
- **Epic Requests:** Reports, order sets (alert/OB/chorio, ED, CCU/ICU revisions), documentation, etc. Cognitive Computing/Clinical Analytics activated 4/2018
- **Perioperative Rollout:** Pre-op, PACU, Endo, Rad.
- **Grand Rounds** (2)
- **Created 1.0 FTE (Nov.), hired 0.5 FTE (Feb.)**
- **Disease Specific Certification:** Application accepted!

Obstetric Sepsis Rollout

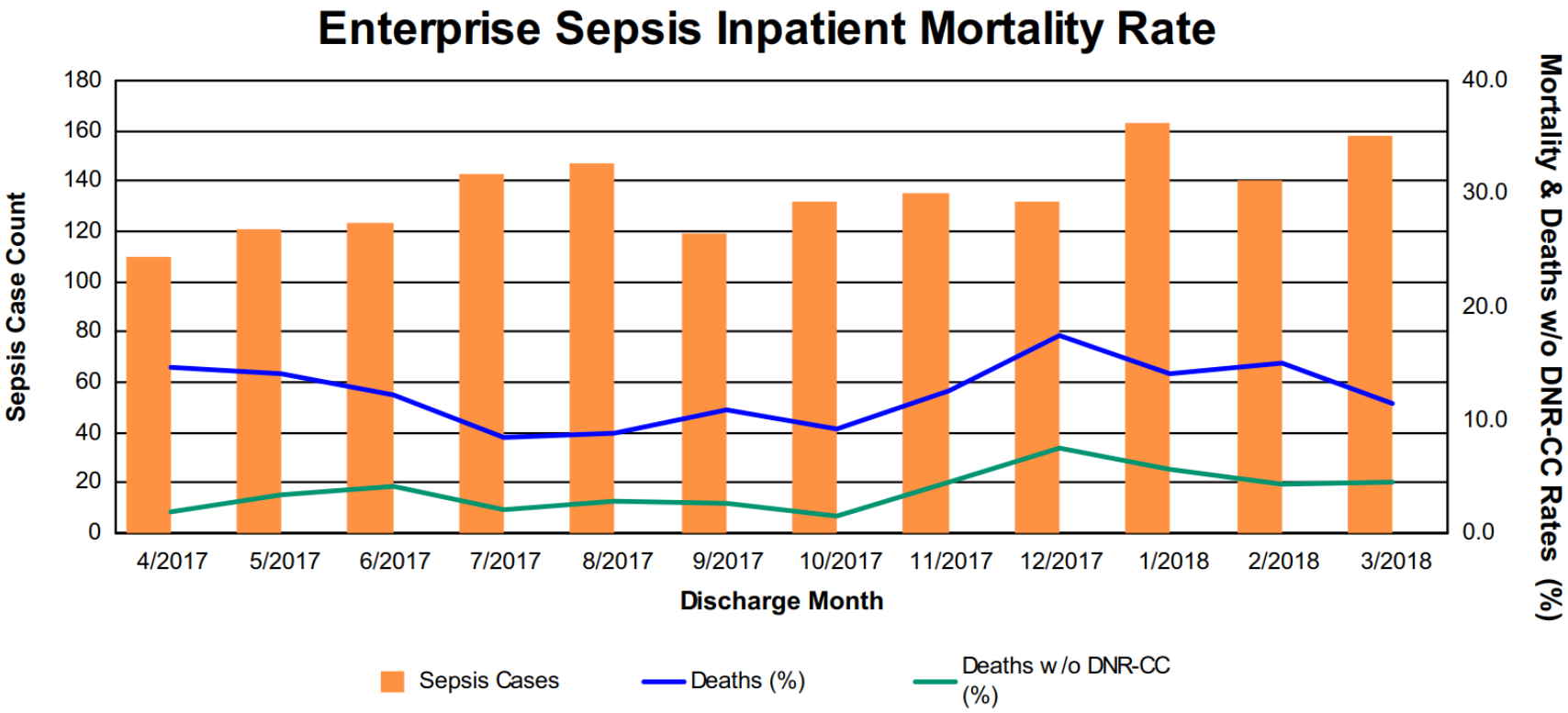
Category	Sub-project	Status	Action Item(s)	Risk/Gap	Status	Timeline – Tentative
Clinical Mgmt.	Develop OB Sepsis Management Policies/Procedures		✓ Develop OB Sepsis Policy ✓ Develop OB Sepsis Standardized Procedure ✓ Determine if Sepsis Alert should be called as "OB Sepsis Alert" (procedure will be written as such)		Content of all 3 policies/procedures modified. Approvals from following needed: Sepsis Committee, Sepsis Exec ED, Critical Care, Dept. Surgery, Dept. Medicine, Dept. OB, ePolicy, P&T, MEC, BOD (for standardized procedure only).	COMPLETE and LIVE
	Develop OB Sepsis Orderset(s)		✓ Modify existing & build in epic		Orderset mocked up, RFS submitted	COMPLETE and LIVE
	Develop OB Sepsis Smartphrases		✓ Modify existing & build into epic		Need to modify existing	3/2018 Built by ACG/ pending OB review
	Screening Tool		✓ Select tool ✓ Determine expectation for screening frequency/location w/in EMR ✓ Build tool □ **Build corresponding BPA**	✓ BPA build might be put on hold.	OB RCA committee reviewed locations/workflows with end user feedback. RFS in process. P&P approvals, education for staff needed before go-live.	11/28/17 OB RCA Workgroup sign-off 12/2018 Epic build begins **4/10/18 Go-live confirmed**
Education	Immediate Need		✓ Educate RNs on basics of sepsis		Simulation courses taught by Women's Hospital educator.	COMPLETE
	Grand Rounds		✓ Identify speaker ✓ Select dates ✓ Create content ✓ Funding		Catherine Albright, MD presenting	**4/17/18 Confirmed Rounds** COMPLETE, Presentation Pending
	In-service		✓ Compile content ✓ Select dates ✓ Schedule RNs (L&D, MBU, ED)		Scheduled, distributed, sign-ups in progress	**4/9/18 First of 17 classes**
	Modules		✓ Standardized Procedure Module (L&Ds) ✓ Sepsis Alert & Mgmt Module (All Women's) ✓ Perinatal Sepsis (All RNs)		Need to modify existing modules for perinatal content.	**4/1/18 Live in Healthstream for 30 days** • Standardized procedure annual for L&D/ED/Flex. • Assigned on hire for new hires.
	Reference Materials		✓ Create badge buddies for RNs & Providers □ **Create pocket cards**	Need pocket card?	Badge buddies for providers & RNs submitted for printing 3/20	
Sustainment	Sepsis Committee		✓ Add MFM to committee ✓ Add Women's Hospital educator to committee □ **Add frontline RN(s) to committee** ✓ Include OB Workgroup as ongoing agenda item □ **Create unit education boards**	Need bedside RN champions Need unit boards		Ongoing
	Monitoring		□ **Conduct monthly audits of screening tool**	Need bedside RN champions to assist with this	Report being built.	4/10/18 Target report start date

External Accomplishments

- **Community lectures:**
  - Sons in Retirement (3)
  - Gamma Kappa ADK (1)
  - Nursing Schools (3)
  - Med-Surg Nursing Conference, South S.F. (podium presenter)
- **Sepsis Alliance:**
  - Sepsis Coordinator Network Advisor
- **SCCo Sepsis Collaborative:**
  - HSAG partnership. Presentation 6/8
  - Farmers Markets (plan decided, rollout July)
  - SEP-1 core measure & mortality sharing
- **Apex Innovations:** beta site for sepsis education series
- **Elder Summit**
- **HQI Sepsis Roundtable participant**
- **Fire Fighter Education:** Commitment from Gilroy FD.

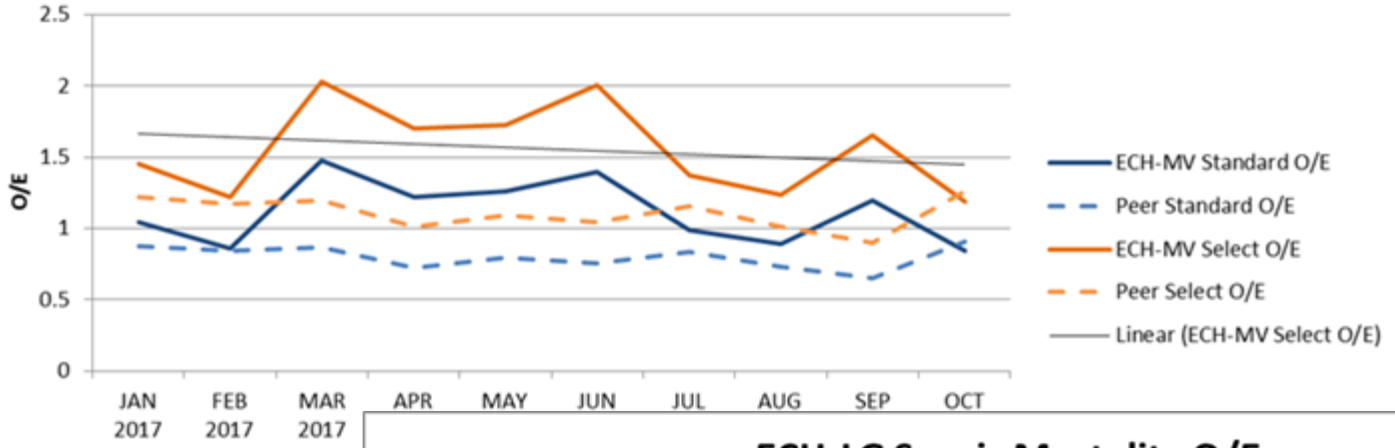
Enterprise Sepsis Inpatient Mortality Rate

Not risk-adjusted. All SEP-1 ICD-10s, patients ≥ 18 years



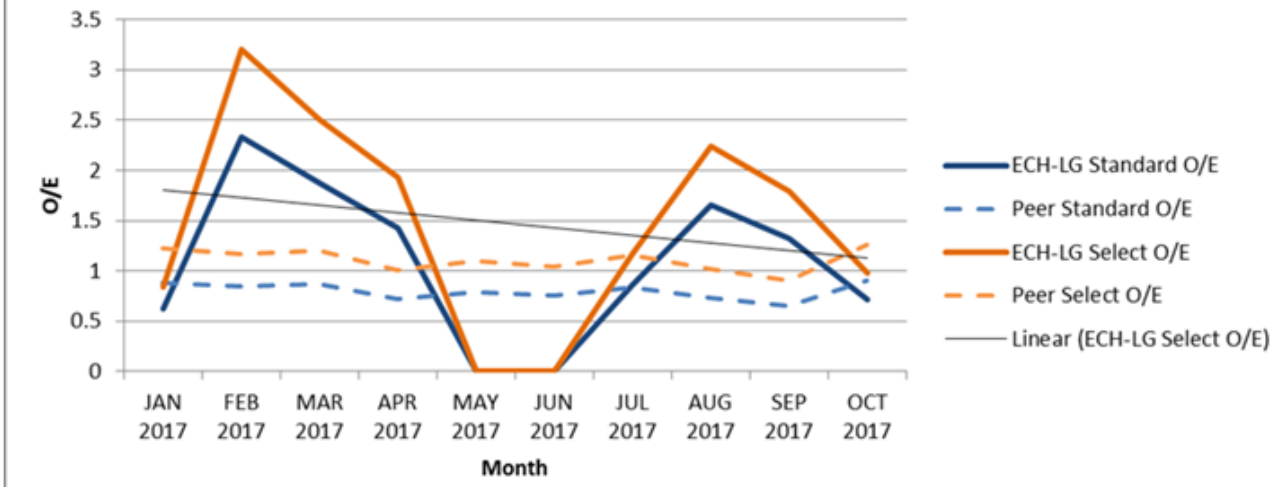
ECH-MV Sepsis Mortality O/E

Source: Premier. Denominator: SEP-1 core measure population.
Select: Top performers (non-academic) west of the Mississippi.



ECH-LG Sepsis Mortality O/E

Source: Premier. Denominator: SEP-1 core measure population. Select: Top performers (non-academic) west of the Mississippi.





















Circular photos from sepsis.org

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Quality Dashboard Quality Committee of the Board Meeting Date: April 30, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director/Chief Quality 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 continued to decline over 4 months 3. Average LOS increased in March to over goal of 1.11 4. Mortality data available and reported for Dec – Jan with increase related to severe flu season	
	Proposed Committee motion, if any: None. This is a Discussion item. (OR, insert motion)	
	LIST OF ATTACHMENTS: March Quality Dashboard results	

El Camino Hospital
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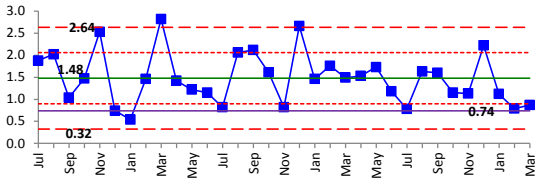
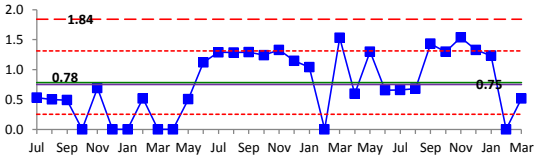
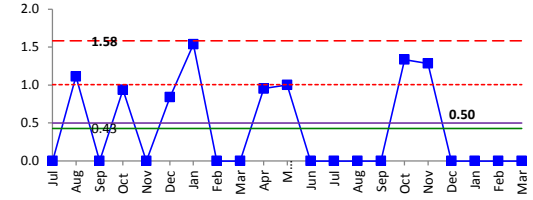
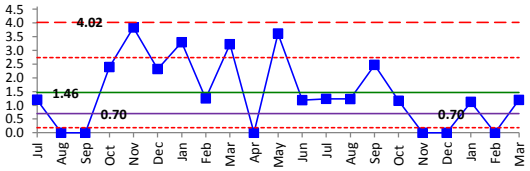
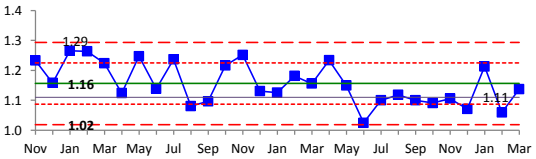
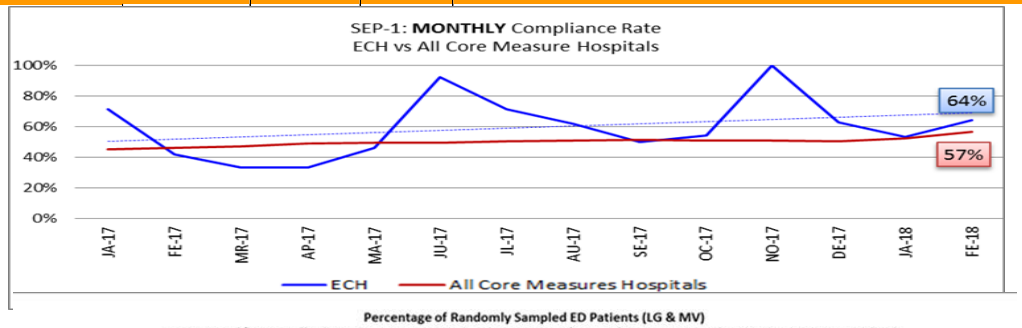
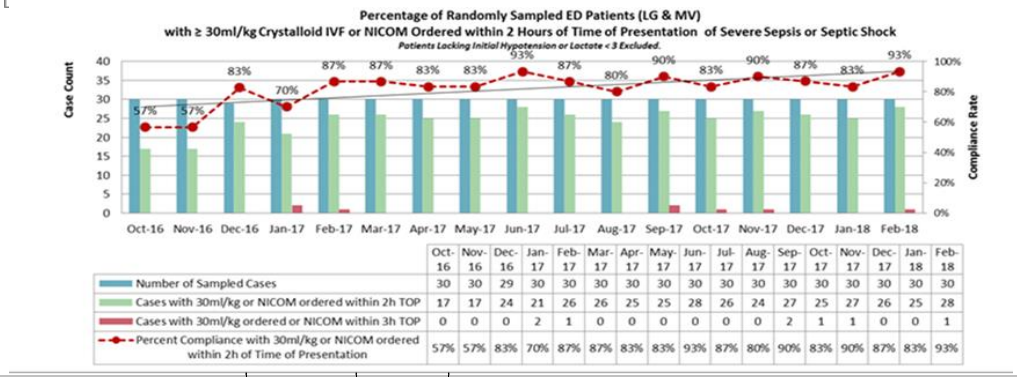
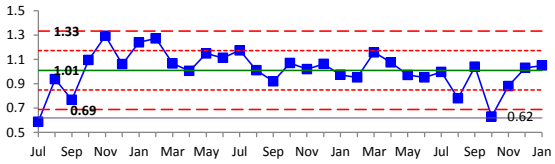
Quality and Safety Dashboard (Monthly)

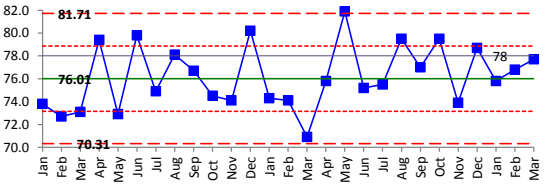
		Performance		Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS		Month	FYTD	FY2017 Actual	FY2018 Goal		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: March 2018*	0.87 (5/5745)	1.26 (61/48400)	1.49	0.74 (Top decile CALNOC)		In March, # of falls increased slightly to 5, and slightly above goal. In qtr 3 FY 18, 1 fall with moderate injury and 4 instances of mild harm (an xray is considered mild harm by CALNOC). Of 16 falls in qtr 3, 5 were considered as preventable. USF students producing videos for ECH nursing staff on the Hendrich II Falls Risk Assessment and the Get Up and go portion of the risk assessment.
2	*Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: March 2018* *SIR Goal: <= 0.75*	0.51 (1/1947)	0.95 (13/13610)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		No new CAUTIs in February, 1 new CAUTI in March, for a total of 5 in qtr 3 fy18. This HAI was discovered on admission to Acute Rehab with admission surveillance screening, pt had fever for 2 days and opportunity for foley removal before transfer. Nursing badge buddy for Houdini foley removal algrithim in printing process and iCare changes for nursing orders and documentation for foley removal protocol in process.
3	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: March 2018* *SIR Goal: <= 0.50*	0.0 (0/780)	0.25 (2/7896)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		No new CLABSI HAI since December 2017. Peer support education beginning new Central line dressing kit. Standardized Sage warmers for CHG bathing installed with new procedure. iCare requests for standarized CVL documentation across all types of lines. Planning started for nursing competency for blood culture draw from central lines (to reduce contamination of specimens).
4	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: March 2018* *SIR Goal: <= 0.70*	1.19 (1/8376)	0.94 (7/74331)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		No new C.Diff HAI in February, one noted in March. 66 y/o maile on many units, no in hospital transfer noted after review. Pt. colonized on admission. On 5 Antibiotics for peritonitis, protonix w/hx of gastric ulcer, anemia & renal failure, on bowel regimen for constipation, no loose stools. C.Diff toxin/antigen discovered with order at discharge after 28 days. Quality Dir. to follw up with hospitalist
Efficiency		Month	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: March 2018*	1.14	1.11	1.16	1.11		ALOS increased to 4.64 from 4.28 in February, and the expected LOS increased also (GMLOS), resulting in the ration of 1.14.

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: Feb 2018*				5 failures of sampled cases; 3 due to not giving enough crysalloid fluids, 1 septic shock focused exam not completed in the time frame, 1 vassopressor not given.
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: Feb 2018*				ED physicians are sustaining and continuing to improve regarding ordering of fluids.

Mortality	Performance Month	Performance FYTD	FY 2017	FY 2018 Goal	Trend	Comments
8 **Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Jan 2018*	1.05 (2.09%/1.99%)	0.93 (1.61%/1.73%)	1.02 (1.88%/1.83%)	0.62		Re-publish of EPIC data from Nov. 2015 completed March 27th. Mortaity rate data available from December 2017. Increases noted since Dec. related to severity of flu season.

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: March 2018*	77.1 (209/269)	77.1 (1661/2153)	76.30	78.0%		Rating increased 2 percentage points since January, near to goal in March. Improvements due to Nursing Communication weekly focus such as actively listening (sit at pt. eye level, and repeat back), and leader rounding training.

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	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:	Biennial Committee Charter Review Quality, Patient Care, and Patient Experience Committee April 30, 2018
	Responsible party:	Cindy Murphy, Director of Governance Services
	Action requested:	Possible Motion
	Background: The Governance Committee's charter provides that it will ensure that each Board Advisory Committee reviews its Charter every other year. The Quality Committee last reviewed its Charter in 2016. The Governance Committee will review any proposed revisions and make a recommendation to the Board. Staff does not have any specific recommendations to revise the Charter at this time. However, there may be some proposed revisions as a result of the work being done at the April 25th Joint Board and Committee Educational Session.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
	Summary and session objectives: For the Committee to review its Charter and discuss whether (1) it is meeting the mandates of its Charter and (2) any desired changes.	
	Suggested discussion questions: 1. Are there any activities provided in the Charter that the Committee is not performing? 2. Are there any activities the Quality Committee should be engaging in that are not provided in the Charter?	
	Proposed Committee motion, if any: None proposed. At the discretion of the Committee.	
	LIST OF ATTACHMENTS: 1. Current Committee Charter (A Proposed Revised Draft will be provided following the April 25th education session as appropriate.)	

Quality, Patient Care and Patient Experience Committee Charter

Purpose

The purpose of the Quality, Patient Care and Patient Experience ("Quality Committee") committee is to advise and assist the El Camino Hospital Board of directors in constantly enhancing and enabling a culture of quality and safety at ECH. The committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the El Camino strategic plan related to delivering high quality healthcare to the patients that we serve. High quality care is defined as care that is:

- Culture of safety that mitigates risk and utilizes best practice risk prevention strategies
- Patient-centered
- Delivered in an efficient and effective manner
- Timely
- Delivered in an equitable, unbiased manner

The organization will measure the degree to which we have achieved high quality healthcare using the CMS value based purchasing program among other measures.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. In addition, the Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management and quality improvement.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

The Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Quality Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Quality Committee may also include (A) no more than nine (9) external (non-director) members who possess knowledge and expertise in assessing quality indicators, quality processes (e.g., LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff matters, and members who have previously held executive positions in other hospital institutions (e.g., CNO, CMO, HR); and (B) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine external members are recommended to serve on this committee.
- All Committee members shall be appointed by the Board Chair, subject to approval by the Board, for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair of the Committee shall be a Hospital Board member.

Staff Support and Participation

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as senior members of the ECH staff may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff.

General Responsibilities

The Committee's primary role is to develop a deep understanding of the organizational strategic plan, the quality plan and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and

with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for:

- Ensuring that performance metrics meet the Board's expectations
- Align those metrics and associated process improvements to the strategic plan and organizational goals and quality plan
- Ensuring that communication to the board and external constituents is well executed.

Specific Duties

The specific duties of the Quality Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT) to benchmark progress using a dashboard
- Oversee management's development of Hospital's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services
- Review reports related to ECH-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    a. ECH-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan
    b. ECH-wide patient safety goals and hospital performance relative to patient safety targets
    c. ECH-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports and risk management reports
    d. ECH-wide LEAN management activities and cultural transformation work
    e. ECH-wide patient satisfaction and patient experience surveys
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to include, but not be limited to, The Joint Commission (TJC), Department of Health and Human Services, and Office of Civil Rights
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements
- Review sentinel events and red alerts as per the hospital and board policy
- Oversee organizational performance improvement for both hospital and medical staff activities and ensure that tactics and plans, including large-scale IT projects that target clinical needs, are appropriate and move the organization forward with respect to objectives described in the strategic plan
- Ensure that ECH scope of service and community activities and resources are responsive to community need.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans. Annually, the committee should do a self-evaluation to determine the degree to which we have achieved our specific objectives related to quality of care.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for review and approval.

Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board and the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

Approved as Revised: 11/12/14; 4/8/15

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Proposed FY19 Committee Goals Quality, Patient Care and Patient Experience Committee April 30, 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. At its meeting on April 2, 2018 the Committee discussed the Proposed FY19 Committee Goals and gave some consideration to reducing the frequency of review of: CDI, Core Measures, PSI-90, Readmissions, Pt. Experience (HCAHPS), and ED Pt. Satisfaction metrics and trends. The revised proposal provides for review of each twice per year instead of the three times.	
	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
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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 Dashboard Q1 – Q2 FY18 – Proposal • Three (Or Two?) 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 30, 2018

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Propose FY 19 Proposed Organizational Goals Patient Care and Patient Experience Committee April 30, 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? 2. See Added Goal for Employee Engagement.	
	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 ED Door to Patient Floor	External Benchmark *CMS*	*TBD*	*TBD*	*TBD*	*TBD*	30%	Q4
HCAHPS Service Metric Nurse Communication Responsiveness Cleanliness	External Benchmark *PG-HCAHPS Adjusted/Received*	*TBD*	*TBD*	*TBD*	*TBD*	30%	Q4
Truven Quality Metrics AMI 30 day mortality 5% CABG 30 day mortality 5% AMI 30 day readmission 5% HF 30 day readmission 5%	External Benchmark *Premier*	*TBD*	*TBD*	*TBD*	*TBD*	20%	FY
People Employee Engagement	External Benchmark *Press Ganey*	FY18 Press Ganey Overall Engagement Indicator Score 4.09 - (40th percentile)	*TBD*	*TBD*	*TBD*	20%	FY
Threshold Goals							
Budgeted Operating Margin	95% threshold	Achieved Budget	95% of Budgeted			Threshold	FY 19

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Patient and Family Centered Care: Grievance Update Quality, Patient Care and Patient Experience Committee April 30, 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 number grievances FYD as it relates to total patients served. • Provide an overview of the nature of the grievances received from the patients served.	
	Suggested discussion questions: 1. Are there more or less grievances than you assumed? 2. Are the nature of the grievances what you assumed? 3. What does the grievance committee do when there is a trend?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: 1. Update on Patient and Family Centered Care: Grievance Presentation with metrics	

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Grievances Update

Cheryl Reinking, CNO

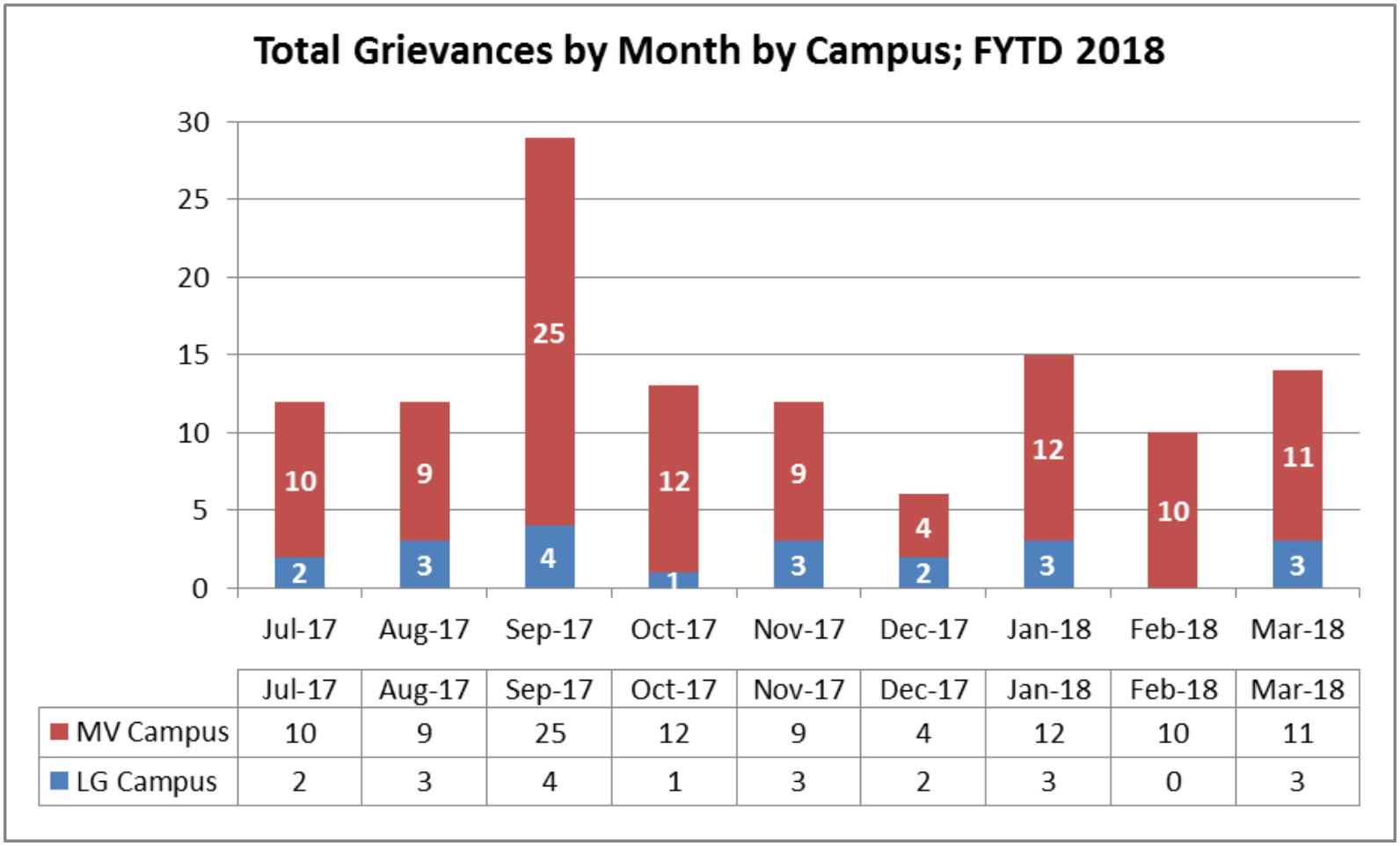
Grievances – July 1 – March 30

Category	Total Number
FYTD total number of patient grievances	123
FYTD total discharges	18,235
FYTD ED visits	47,645
Total ED & Discharges	65,880
% grievances per total ED & discharges	0.19%

Grievances compared to Discharges & ED Visits

	# of Grievances	Total # of Discharges	Total # ED Visits
Jul-17	12	2017	4518
Aug-17	12	1990	5099
Sep-17	29	1930	4935
Oct-17	13	2077	5216
Nov-17	12	2065	4741
Dec-17	6	2160	5287
Jan-18	15	2124	6759
Feb-18	10	1841	5488
Mar-18	14	2031	5602

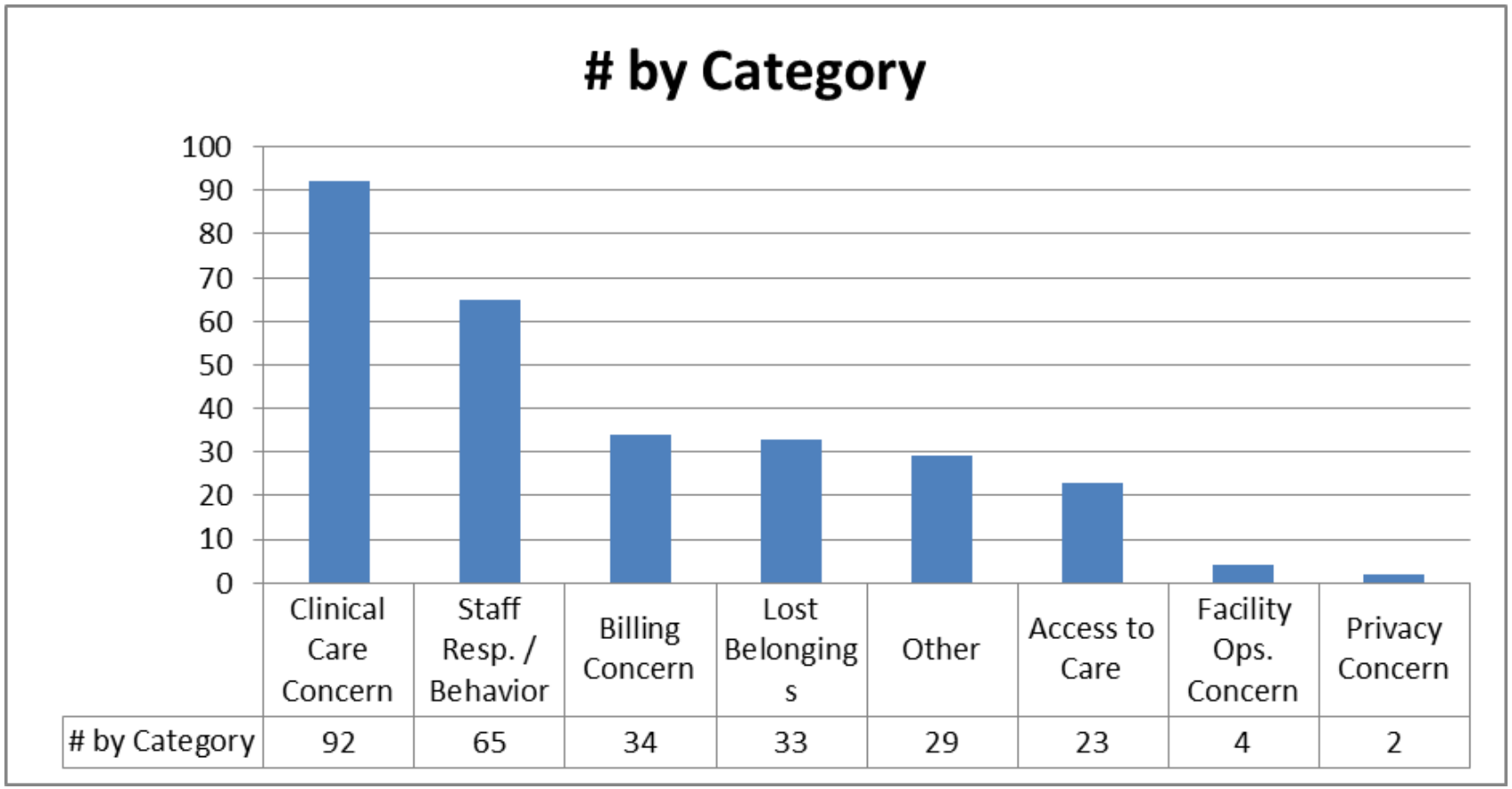
Grievances by Month



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
MV Campus	10	9	25	12	9	4	12	10	11
LG Campus	2	3	4	1	3	2	3	0	3

Grievances by Category FYTD

note: one patient grievance can have multiple concerns



	Clinical Care Concern	Staff Resp. / Behavior	Billing Concern	Lost Belongings	Other	Access to Care	Facility Ops. Concern	Privacy Concern
# by Category	92	65	34	33	29	23	4	2

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Patient Care Experience Score Dashboard Updates: Inpatient (HCHAPS) and ED pt. Satisfaction Quality, Patient Care and Patient Experience Committee April 30, 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 update on the most recent HCAHPS and ED patient experience survey scores from Press Ganey.	
	Suggested discussion questions: 1. Are the scores trending in the right direction? 2. What are the reasons for either the trends up or down?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: 1. Pt. Experience(HCAHPS) and ED Pt. Satisfaction (Press Ganey)	

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Pt. Experience (HCAHPS) and ED Pt. Satisfaction (Press Ganey)

Quality Committee

April 30, 2018

Cheryl Reinking, RN
Chief Nursing Officer

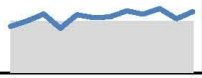
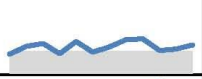
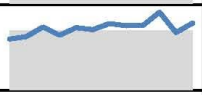
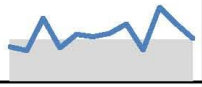
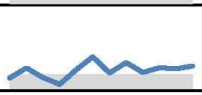
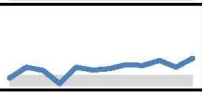
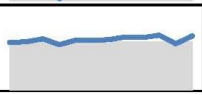
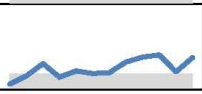
FY18 Inpatient HCAHPS Monthly Report

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

	Baseline & Rolling 12 Months Top Box	Top Box				%Tile Rank All PG	%Tile Rank Bay Area	50th Percentile from Hospital VBP Perf. Standards	Mean of Top Decile from Hospital VBP Perf. Standards
		Baseline	Feb-18	Mar-18	Target	Mar-18	Mar-18		
Rate Hospital 0-10		76	76.8	77.7	78	74	73	70.23	84.58
Recommend the hospital		82.3	83.7	86.2	79.8	93	95	n/a	n/a
Comm w/ Nurses		79.9	80.4	81.6	79.9	64	80	78.52	86.68
Response of Hosp Staff		66.7	60.3	70.8	66.7	71	98	65.08	80.35
Comm w/ Doctors		84.5	84.2	87.3	80.8	89	99	80.44	88.51
Hospital Environment		67.2	64.7	70.1	66.3	71	99	65.6	79
Pain Management		74.9	75	70.8	70.8	58	38	70.2	78.46
Communication about Pain* **(new as of January '18)**			72.5	67.6		62	47		
Comm About Medicines		68.6	61.3	68.2	63.8	78	93	63.37	73.66
Discharge Information		87.4	86.6	88.8	87.6	62	73	86.6	91.63
Care Transitions		56.8	55.2	56.3	53.3	68	62	51.45	62.44

ED Pt. Satisfaction (Press Ganey)

ECH Enterprise FY 18 ER PG Monthly Report
Measure by: Top Box & Receive Date | Desired Direction: Up | Baseline: FY 17 | Results Through March 2018

	Baseline & Rolling 12 Months Top Box	Top Box			%Tile Rank All PG	%Tile Rank CA Center		
		Baseline	Feb-18	Mar-18	Mar-18	Mar-18	50% PG	75% PG
Overall Rating ER Care		64.5	65.2	74	77	97	86.1	89.5
Likelihood of recommending		68.4	69.3	74	75	96	85.1	88.9
Overall		64	65.1	68.4	58	92	86.8	89.6
Arrival Overall		56.3	57.5	60.4	47	92	85.5	89.5
Nurses Overall		67.8	66.8	71.2	54	90	88.9	91.5
Doctors Overall		69.8	73.4	70	59	83	86.8	83
Tests Overall		67	69.7	71	57	89	89.4	91.3
Family or Friends Overall		67.7	68.7	70.5	54	87	89.3	91.7
Personal/Insurance Info Overall		65.5	69.1	73.5	65	95	90.3	92.3
Personal Issues Overall		55.8	53.9	62.9	66	97	82.6	83
Overall Assessment Overall		66.4	67.3	74	76	96	85.4	89

El Camino Hospital®
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Hospital Update
Date April 18, 2018
Mark Adams, MD, Interim CMO

Organizational Goal Update – February (SIR) and March (Others) 2018

Organizational Goals FY18	Benchmark	2017 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY18 through March	
Quality, Patient Safety & iCare									
Arithmetic Observed LOS Average / Geometric LOS Expected for Medicare Population (ALOS /GMLOS)	External: Expected via Epic Methodology	FY 2016: 1.21 (ALOS 4.86/GMLOS 4.00) FY 2017 YTD April: **1.18** (4.81/4.08)	1.12	1.11	1.09	34%	4Q FY18		1.11
HCHAPS Service Metric: Rate Hospital	External Benchmark	HCAHPs Baseline: 10/2016-12/2016: **75.5%** 1/2017-3/2017: **75.1%**	77%	78%	79%	33%	4Q FY18		77%
Standarized Infection Ratio (SIR)* Observed HAIs/Predicted HAIs (Hospital Acquired Infections)	External Benchmark	July- Dec 2016L CAUTI 1.37, CLABSI 0.25, C.DIFF 0.59 Avg: **0.738**	0.670	0.602	0.534	33%	FY18		CAUTI: 1.459 CLABSI: 0.423 C.Diff: 0.30 Avg: 0.525
Threshold Goals									
Budgeted Operating Margin	95% Threshold	Achieved Budget	95% of Budgeted			Threshold	FY 18		Met

* These metrics are available through February 2018 only- Updated Infection Data will not be available until the end of the Fiscal Year

Quality and Safety

Many ECH leaders participated in a refresher course on Leadership Rounding and learned of this significant, hands-on management tool that builds a highly engaged workforce that is focused on patient safety, quality, and efficiency. We have implemented a predictive analytics model to detect sepsis and a tool to assess best practice alerts for assisting with clinical variation in Epic to promote cognitive computing capabilities.

Patient Experience

One of our Schegistrars in the BH Department received a wonderful recognition from a patient stating "You are the major compelling reason I've chosen this facility as the one for me, I tend to trust my instincts, and this feels right, you are a big part of that. I've looked into a lot of different treatment facilities and so many of the schegistrars I've spoken with were unfeeling, blunt, and just generally unwelcoming. You are the exact opposite of that. You are personable, sensitive, happy and wonderful".

Finance

As part of the FY19 operating budget process, El Camino Hospital leaders have been projecting patient volumes and calculating projected operating expenses, which is very challenging during a period of healthcare industry transformation. Senior leadership has been meeting with key service line directors and hospital administration from both campuses to review year-to-date key performance indicators (KPIs), update business plans with an emphasis on growth, challenge operating assumptions, and anticipate continued challenges and opportunities associated with reducing operating costs without compromising quality and service.

February cash collections were outstanding for a short month, collecting $71,334,693: $7,560,245 over goal for the month and ahead $48,151,719 through February. We have

achieved $9 million in denial recoveries, already $2 million over our FY18 goal. We have implemented $4,711,377 of our $4.8 million savings challenge and cost avoidance of $326,312.

Silicon Valley Medical Development, LLC

The following physicians are now employed by and began practicing at El Camino Health Primary Care:

Charlyne Julao, DO - Family Medicine (3/1/18)
Mathilde Moazazi, MD - Family Medicine (4/2/18)
Vijaya Dudyala, MD - Internal Medicine (4/16/18)

Marketing and Communications

Many media opportunities were optimized this month with coverage of the NICU (Jasmine's story and a mother of triplets' marathon world record); female surgeons practicing at El Camino Hospital, the South Asian Heart Center Scarlet Ball, and the Foundation's Norma's Literary Luncheon. Additionally, support was provided for a reality TV show filming a family delivery in Los Gatos.

Information Services

Independent physicians continue to express interest in implementing Epic in their practices as part of the Community Connect program. The Interventional Radiology procedural area is converting to the Epic Cupid platform to improve physician and patient workflows. Physician experts in the Epic system have completed 30% of the planned individualized training and personalization sessions for physicians. Positive feedback has been received from physician participants with improvements implemented in the Epic system to improve physician efficiency.

Corporate and Community Health (CONCERN and Community Benefit)

CONCERN:EAP implemented its new online appointment scheduling program for onsite counseling at large customer and finalized all the details for our Digital Transformation Project, including meetings with large customers to test concepts.

Community Benefit staff presented our ECH Community Benefit program to the ECH Auxiliary and conducted a statewide webinar for the Association of California Healthcare Districts on the ECHD Community Benefit grants program. We also sponsored the 2018 Kids in Common Santa Clara County Children's Summit which focuses on developmental assets which are used in many school based programs.

The Chinese Health Initiative ("CHI") participated in providing a CME/CE program on culturally sensitive end-of-life care for Chinese patients. 108 healthcare professionals and trained volunteers completed the training. CHI also (1) collaborated with the Cancer Center to hold a colon cancer prevention workshop, attended by over 50 community members, to raise awareness about colon cancer in the Chinese community and (2) held its annual health fair, this year focused on diabetes prevention and hypertension screening and prevention. The South Asian Heart Center raised $348,000 at is annual gala.

Government and Community Relations

We hosted over 100 participants from City Leadership programs from Los Altos/Los Altos Hills, Cupertino, Santa Clara, and Sunnyvale. Staff presented on community health needs and

services, mental health, and health technology. Sixty high school students in a college prep program (AVID) for low income families met with ECH leaders including a physician, a NICU nurse, a behavioral health nurse, as well as imaging, marketing, information technology, and human resources staff. Students spent ten minutes with each staff person in a dynamic "speed dating" format to learn about their education and career journey and ask questions. MVLA Superintendent Dr. Jeff Harding stopped by to express his appreciation.

Brenda Taussig visited legislators in Sacramento, discussing transport of behavioral health patients, homeless patient discharge, CDPH licensing delays, and nurse hiring requirements. This is a very active year for state health legislation, and for county initiatives on many of the same issues. ECH submitted support letters on: AB 1795 (Gipson) *Alternate Destinations-Transporting Patients to the Care They Need*, AB 2798 *CDPH Centralized Application Unit: Reduce Wait Times*, and AB 1397 (Hill) *AEDs in Renovated Buildings*, a follow up to SB 658 (Hill), now law, which Senator Hill agreed to author at ECH's request to modernize California's law on automated external defibrillators.

Philanthropy

During the month of February, the El Camino Hospital Foundation secured $103,320, bring its FYTD total to $4,568,987, which is 74% of its fundraising goal.

Auxiliary

The Auxiliary contributed 6,787 volunteer hours in February 2018.