El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA
QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Monday, June 4, 2018 – 5:30pm
El Camino Hospital | Conference Rooms A&B (ground floor)
2500 Grant Road Mountain View, CA 94040

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER**	David Reeder, Quality Committee Chair		**5:30 – 5:31pm**
2.	**ROLL CALL**	David Reeder, Quality Committee Chair		**5:31 – 5:32**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David 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.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (April 2, 2018 and April 30, 2018) ***Information*** b. Patient Story c. FY18 Pacing Plan d. Progress Against FY 2018 Committee Goals	David Reeder, Quality Committee Chair	*public comment*	**Motion Required** **5:33 – 5:36**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	David Reeder, Quality Committee Chair		**Discussion** **5:36 – 5:39**
6.	**LEAN PRESENTATION** **ATTACHMENT 6**	Mark Adams, MD Interim Chief Medical Officer		**Discussion** **5:39 – 5:59**
7.	**APPROVE FY19 COMMITTEE GOALS** **ATTACHMENT 7**	David Reeder, Quality Committee Chair	*public comment*	**Possible Motion** **5:59 – 6:09**
8.	**APPROVE FY19 PACING PLAN** **ATTACHMENT 8**	David Reeder, Quality Committee Chair	*public comment*	**Possible Motion** **6:09 – 6:14**
9.	**PROPOSED FY19 ORGANIZATIONAL GOALS** **ATTACHMENT 9**	Cheryl Reinking, RN, Chief Nursing Officer / Mark Adams, MD Interim Chief Medical Officer	*public comment*	**Possible Motion** **6:14 – 6:29**
10.	**FY18 QUALITY DASHBOARD** **ATTACHMENT 10**	Cheryl Reinking, RN, Chief Nursing Officer / Mark Adams, MD Interim Chief Medical Officer		**Discussion** **6:29 – 6:39**

A copy of the agenda for the Regular Committee Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**DRAFT FY19 QUALITY DASHBOARD** **ATTACHMENT 11**	Cheryl Reinking, RN, Chief Nursing Officer / Mark Adams, MD Interim Chief Medical Officer		**Possible Motion** **6:39 – 6:49**
12.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE** **ATTACHMENT 12**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:49 – 6:54**
13.	**READMISSION DASHBOARD** **ATTACHMENT 13**	Mark Adams, MD Interim Chief Medical Officer		**Discussion** **6:54 – 6:59**
14.	**PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN** **ATTACHMENT 14**	Mark Adams, MD Interim Chief Medical Officer		**Possible Motion** **6:59 – 7:14**
15.	**HOSPITAL UPDATE** **ATTACHMENT 15**	Mark Adams, MD Interim Chief Medical Officer		**Discussion** **7:14 – 7:19**
16.	**PUBLIC COMMUNICATION**	David Reeder, Quality Committee Chair		**Information** **7:19 – 7:22**
17.	**ADJOURN TO CLOSED SESSION**	David Reeder, Quality Committee Chair		**Motion Required** **7:22 – 7:23**
18.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Quality Committee Chair		**7:23 – 7:24**
19.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	David Reeder, Quality Committee Chair		**Motion Required** **7:24 – 7:27**
	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 & April 4, 2018)			
20.	**ADJOURN TO OPEN SESSION**	David Reeder, Quality Committee Chair		**Motion Required** **7:27 – 7:28**
21.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Quality Committee Chair		**7:28 – 7:29**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
22.	**ADJOURNMENT**	David Reeder, Quality Committee Chair	*public comment*	**Motion Required** **7:29 – 7:30pm**

Upcoming FY19 Meetings (*pending Board approval*)**:**

- August 6, 2018
- September 5, 2018
- October 1, 2018
- November 5, 2018
- December 3, 2018
- February 4, 2019
- March 4, 2019
- April 1, 2019
- May 6, 2019
- June 3, 2019

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

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

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, April 30, 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; Peter Fung, MD; Katie Anderson, Ina Bauman, Julie Kliger, and Melora Simon	Nancy Carragee, Mikele Epperly Wendy Ron	

** Melora Simon joined via teleconference at 5:32pm*
**Jeffrey Davis, MD joined via teleconference at 5:50pm*

A quorum was not met at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 30th 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 5:33 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Dr. Jeffrey Davis and Melora Simon joined the meeting via teleconference. Nancy Carragee, Mikele Epperly, and Wendy Ron were absent. Chair Reeder introduced the new Interim Chief Medical Officer Dr. Mark Adams to the Committee. Dr. Adams gave a brief introduction about his work and personal life.	***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. The open minutes of the April 2, 2018 Quality Committee were not approved due to lack of quorum and deferred to next meeting, June 4, 2018.	***The open minutes of the April 2, 2018 Quality Committee were not approved.***
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee. He highlighted the action item regarding the approval of a Resolution Delegating Authority to the Executive Compensation Committee to approve	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	annual salary ranges, annual base pay adjustments, individual incentive goals and incentive payment for executives other than the CEO.	
6. SEPSIS UPDATE	Kelly Nguyen, Manager Sepsis Quality, provided an update on the Sepsis program at ECH expanding on the metrics included in the monthly Quality Dashboard. Compliance with the sepsis (SEP-1) core measure has hovered around 60% which is better than the national average. While sepsis cases are increasing, mortality from sepsis is decreasing at ECH. Special emphasis has been directed toward obstetric sepsis. In addition, Kelly briefly went over the internal and external accomplishments.	
7. FY18 QUALITY DASHBOARD	Cheryl Reinking, Chief Nursing Officer, reported that ECH Falls remain low for 4 months, CAUTI trend is down with institution of new nurse protocol for removal of catheters, CLABSI remains at 0, and C. Diff rate reflects 1 case in March. The LOS index remains above 1 at 1.14 related to severe flu season for the months of Dec-Jan. Mortality index is stable at .93 YTD and HCAHPS are just below goal.	
8. REVIEW COMMITTEE CHARTER	Chair Reeder asked the Committee about their option and feedback regarding the Committee's Charter. Some minor changes were noted: • Page 3: (2nd bullet point) – Align should be Aligning • Page 3: (1st bullet point) – remove PaCT and replace with Performance Improvement & Patient Safety Plan The Committee thinks the Charter is too broad and may need to be rewritten based off the Watson Health (Truven Top 100) and be more in line with the Organizational Strategic Plan. Chair Reeder asked the Committee Members to review over for more feedback at a later time.	
9. PROPOSED FY19 COMMITTEE GOALS	Chair Reeder reviewed over the Proposed FY19 Committee Goals stating they are very similar to the ones for FY18. He asked the members about their thoughts regarding the timeline for reviewing Quality, Patient Care, and Patient Experience Committee Reports and Dashboards. The Committee decided to review two times a year on CDI, Core Measure, PSI-90, Readmission, Pt. Experience (HCAHPS), ED Pt. Satisfaction. While FY19 Quality Dashboard are moved to monthly under informational section on the Consent Calendar and Quarterly for group discussion. He reminded the members that the goals would need to be approved by the next meeting on June 4th, so it can go to the Board.	
10. 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	

Agenda Item	Comments/Discussion	Approvals/Action
	metrics have not yet been established because the baseline data is not available until Mid-May. ECH needs 3 full quarters of benchmark data to complete the FY19 Organizational Goals. In addition, another goal was added: Employee Engagement – which is part of Lean. Mrs. Reinking explained that the Watson Health (Truven Top 100) measures Efficiency, Experience, and Quality which aligns with our organizational goals. Mrs. Reinking asked for feedback and questions from the Committee and a brief discussion ensued.	
11. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Mrs. Reinking provided an overview of the number grievances FYD as it relates to total and nature of the grievances received from the patients served. She explained Grievances compared to Discharges and ED Visits for the past 9 months and by campus (MV and LG). Overall incidence was 0.19%. The most common grievance category was clinical care concern followed by staff behavior/respect. Mrs. Reinking asked for feedback from the Committee and a brief discussion ensued.	
12. QUARTERLY QUALITY AND SAFETY REVIEW	Sheetal Shah, Director, Risk Management & Patient Safety, reviewed over the incident report activity (QRRs), RCA activity for fiscal year, and performance improvement activity related to adverse events. Serious safety events for FY18 were reviewed with 4 reportable never events, 2 adverse events with harm, and 2 near misses. FY18 Total number of enterprise QRRs is trending upwards. The top theme in QRRs for both campuses is Clinical Treatment. Mrs. Shah asked for feedback from the Committee and a brief discussion ensued.	
13. PT. EXPERIENCE (HCAHPS) AND ED PT. SATISFACTION (PRESS GANEY)	Mrs. Reinking provided an update on the most recent HCAHPS and ED patient experience survey scores from Press Ganey. ECH improved in all domains for FY18 Inpatient HCAHPS in March except for pain management; due to, change in questions that was placed in effect in January 2018. Lots of improvement in ED Pt. Satisfaction (Press Ganey) but not in all domains. It was noted that ECH is higher than others in the Bay area yet compared to national standards there is room for improvement. Mrs. Reinking asked for feedback from the Committee and a brief discussion ensued.	
14. HOSPITAL UPDATE	Dr. Mark Adams, Interim Chief Medical Officer, provided a brief hospital update to the committee members highlighted the following areas in Information Services, Government and	

Agenda Item	Comments/Discussion	Approvals/Action
	Community Relations, Philanthropy, and Auxiliary. • Interventional Radiology procedural areas is converting to the Epic Cupid platform to improve physicians and patient workflows • We hosted over 100 participants from City Leadership programs from Los Altos/Los Altos Hills, Cupertino, Santa Clara, and Sunnyvale. • ECH Foundation secured $103,320 of its fundraising goal • Auxiliary contributed 6,787 volunteers hours in February 2018	
15. PUBLIC COMMUNICATION	None.	***None***
16. ADJOURN TO CLOSED SESSION	The Committee decided not to adjourn to closed session due to lack of quorum and deferred items under consent calendar to next meeting, June 4, 2018.	***The Committee decided not to adjourn to closed session due to lack of quorum***
17. AGENDA ITEM 22: ADJOURNMENT	The meeting was adjourned at 7:29pm. **Motion:** To adjourn at 7:29 pm. **Movant:** Anderson **Second:** Kliger **Ayes:** Anderson, Bauman, Davis, Epperly, Fung, Kliger, Reeder, **Noes:** None **Abstentions:** None **Absent:** Carragee, Ron, and Simon **Excused:** None **Recused:** None	***Meeting adjourned at 7:29 pm***

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

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

12 April 2018

To: El Camino Hospital ECH 131
2500 Grant Road
Mountain View, CA 94040

[redacted]

I have been going to El Camino Hospital for decades and have been very satisfied with the care and service I have received. Today, however, I had a clear experience of poor service from someone/some people in the Imaging Dept. when I went in for an abdominal ultrasound.

I arrived at 9:30 am as instructed, registered with the Imaging Dept. reception desk, was told everything was in order, and asked to take a seat. At 10:15 am, I inquired what happened with my appointment so the person at reception called to find out. I told her I would just go the restroom in the meantime. When I returned, she was away from her desk so another staff person called again. She was told by someone "in the back" that my appointment did not show up at their end. After several minutes, the technician finally arrived, lukewarmly apologized, and said in a hospital there is always a "stack" of emergency. When I inquired what caused the delay, I couldn't believe what she said next. She asked me: "Are you not glad you are not the person in the emergency?" I thought this "teaching moment" was very inappropriate, if not unprofessional.

The following are the things that further bothered me about the technician:

1. She brought me directly to the room and suggested I change into a gown. After I had removed my top, she asked if I wanted a warm blanket instead. I

agreed because I've done this particular ultrasound many times with a blanket, not a gown. Then she went off to get a blanket somewhere leaving me feeling chilled.

2. When she returned, she asked me WHY I was having an ultrasound. When I told her, she said she had better read my prior report so she would know what to look for. This was particularly concerning, as she obviously did not prepare for my procedure and was clueless about my situation. She did not exactly inspire my confidence. So she went off again for 5 minutes to read the report from my last ultrasound. Upon returning she remarked that I "have a lot of little things."

3. The whole time she was doing the procedure, I just felt that she wasn't being thorough. I've had this same abdominal ultrasound done annually for many years so I've experienced the skill level of various technicians. When it was all over, I was surprised that the whole test lasted only 25 minutes, because my previous experiences have been from 45 -60 minutes. Either she is a whiz at what she does, or she urgently needs to develop and refine her skills as well as her "bedside" manner.

4. While the time delay itself is not that critical, the procedure with the technician has left me unsure as to whether my ultrasound will yield reliable results. This is of great concern to me.

You may reach me at [redacted] if you have any questions. Thank you for your attention and consideration.

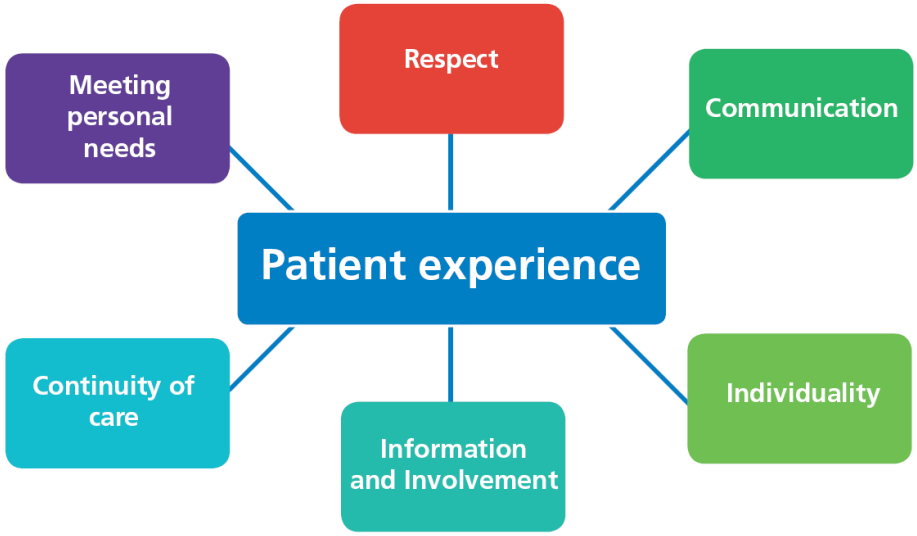
Sincerely,

[redacted]

Patient Letter, Staff Input

- *Patient should have an explanation within 15 minutes if there is a delay*
- *Told by someone "in the back" – patient was most likely not checked in by front desk. Laurie will share this concern with Joann.*
- *May be an add-on patient? Oftentimes there are delays for add-ons*
- *Probably "STAT emergency," not "stack of emergency"*
- *If a patient is on edge, be careful with your humor*
- *Why was the patient changed into a gown and then given a blanket?*
- *Should have opened and read the patient's report in the room*
- *25 minutes for the entire exam would be fine, may have been scanned by students in the past causing it to be longer (?)*
- *May be scanning blind and the patient's exam could have been done elsewhere. What would be the best way to message this to your patient (who is already on edge)?*

Patient Experience



Basically, it all boils down to patient perception. Remember, their experience is their reality. Our job is to make that experience as pleasant and easy as possible.

Remember, you don't have to tell them every detail and divulge every issue you are facing today. Just remain polite and apologetic when there is a delay.

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. Serious Safety/Red Alert Event as needed 5. 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. Review Committee Charter 8. Sepsis Presentation	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. Approve FY19 Pacing Plan 2. Readmission Dashboard ~~3. PSI-90 Pt. Safety Indicators~~ 4. Update on Patient and Family Centered Care 5. Approve FY 19 Committee Goals 6. Proposed FY 19 Organizational Goals 7. Lean Presentation 8. Performance Improvement & Patient Safety Plan 9. FY19 Draft Quality Dashboard

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 ECH Board Actions Quality, Patient Care and Patient Experience Committee June 4, 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 a verbal report by the Chair of the Committee and/or Board members who also serve on the Committee.	
	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 Board Actions	

May 2018 ECH Board Actions*

a. Approved Resolution 2018-07 recognizing the Pathology and Lab Services Department for outstanding service.
b. Approved the following physician contracts:
    i. Pathology Medical Directorship (Enterprise) Renewal
    ii. ICU Nighttime Coverage (MV)
    iii. ICU Daytime Coverage (MV)
c. Approved the Medical Executive Committee's Recommendation to Uphold Medical Staff Bylaws Section 3.2-1(c)(3)

*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:	LEAN Presentation Quality Committee of the Board June 4, 2018
	Responsible party:	Mark Adams, MD, Interim Chief Medical Officer
	Action requested:	For Discussion
	Background: As noted in our strategic framework, ECH is implementing Lean as our operating system to execute the strategy. The Incito Consulting Group has been retained to help ECH further its Lean journey by instilling a management system that will support connecting improvement activities to strategy and deliver the results needed to achieve our vision.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide context for Lean in Healthcare • Provide education on the key elements of a lean management system • Review potential benefits from developing a lean culture	
	Suggested discussion questions: 1. How does a lean management system support the strategic framework and initiatives? 2. What are the key phases of a true lean management system? 3. What are the main barriers to success we face today? 4. What is the expected result of a lean management culture?	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: 1. LEAN Presentation	

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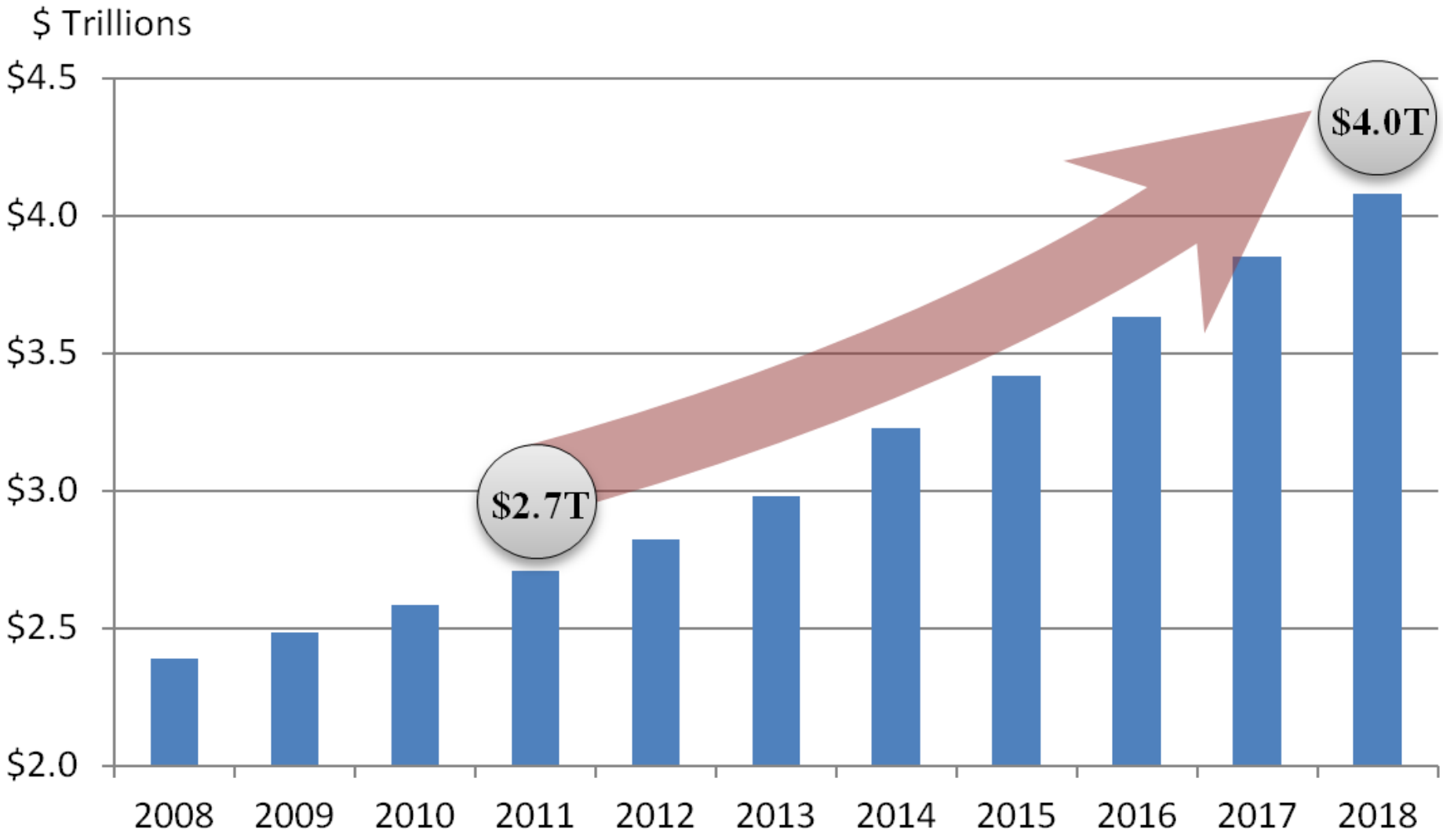
Embedding a Lean Management Culture

Quality Committee

June 4, 2018

Mark Adams, Interim CMO

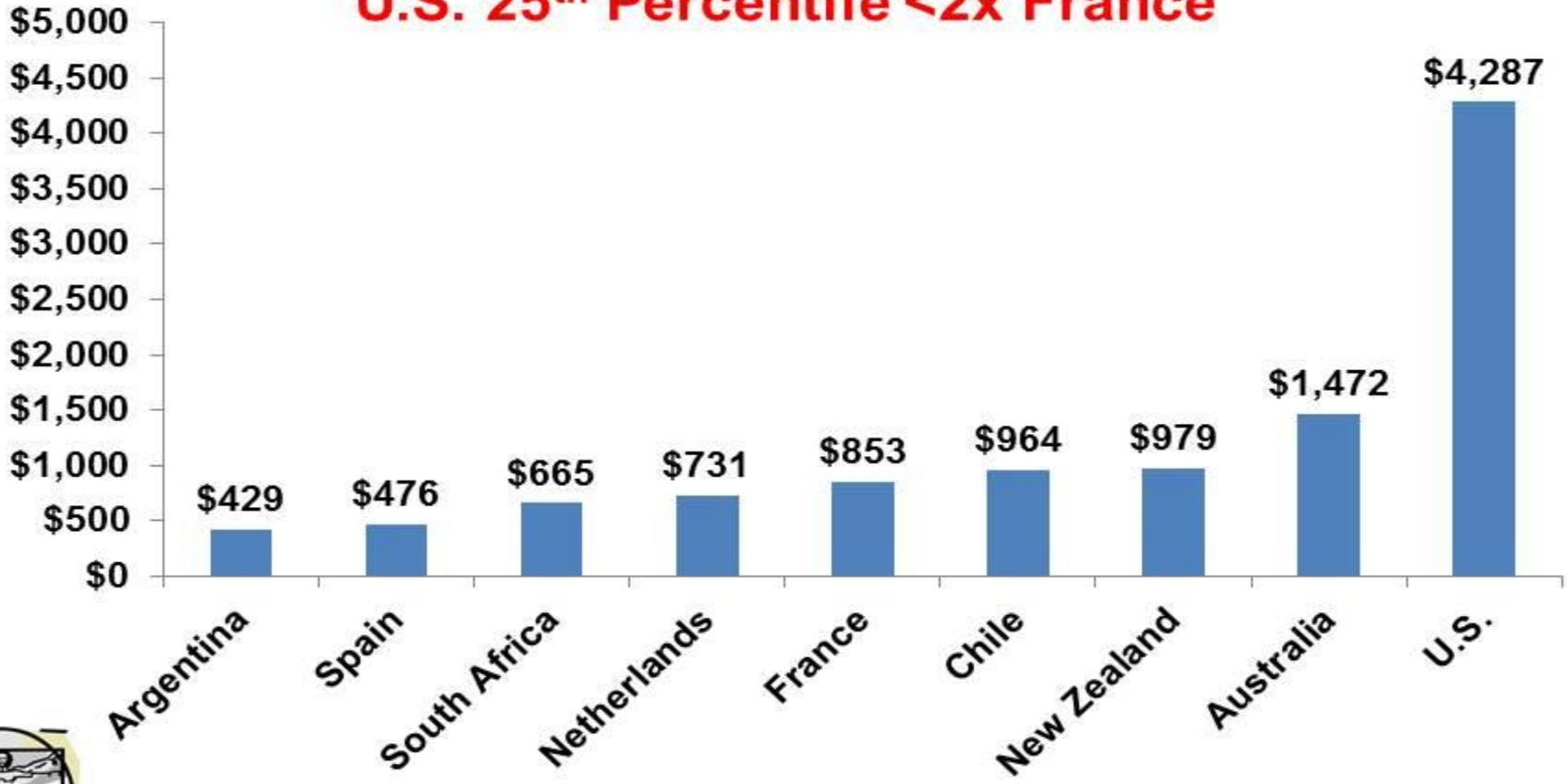
Total U.S. Healthcare Expenditures



Source: CMS National Health Expenditure Data, Jan-11

2012 Cost Per Hospital Day
U.S. Average Compared with Other Nations

Average U.S. Price = 5x France,
U.S. 25th Percentile <2x France

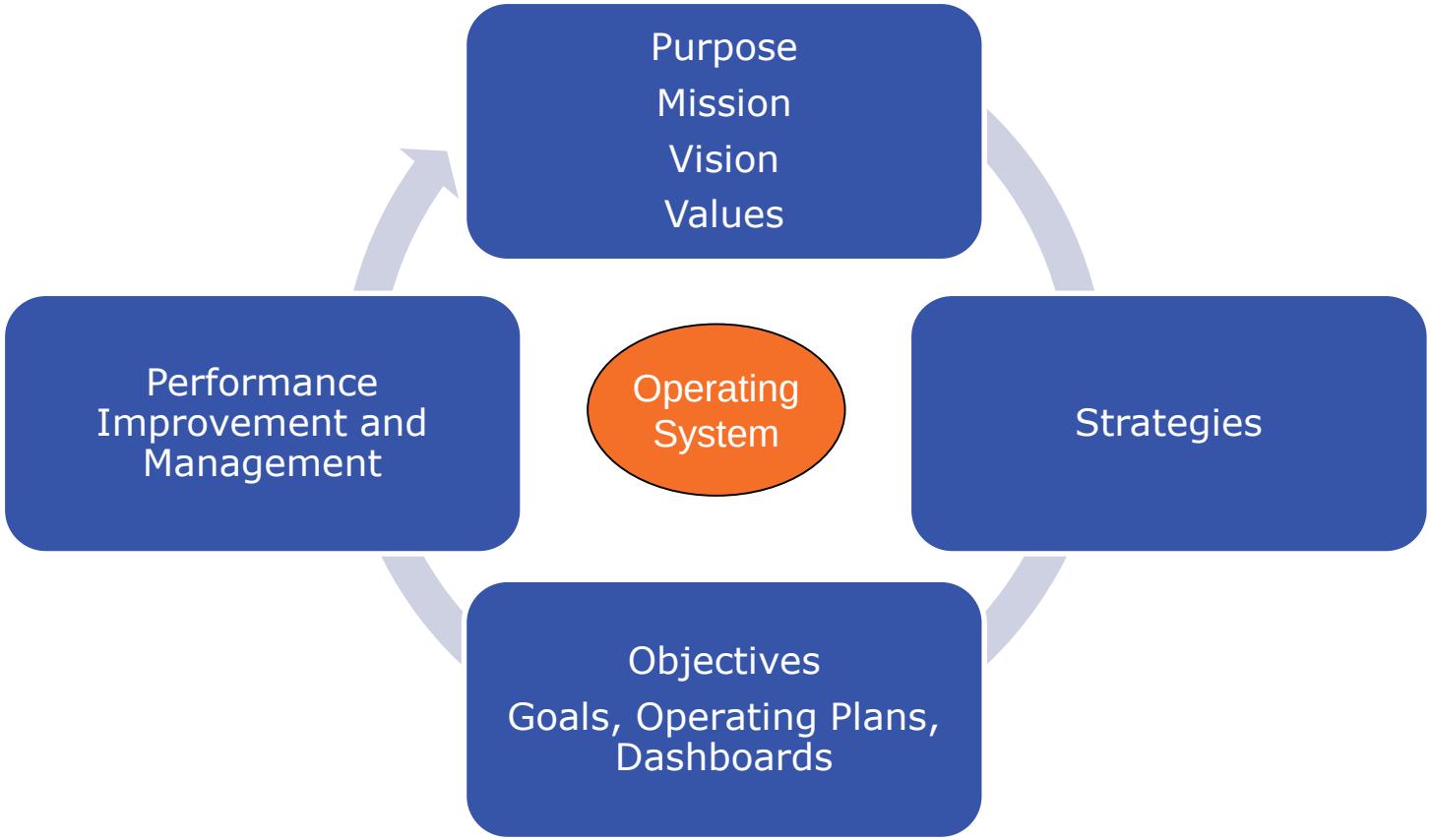


THINK-Health

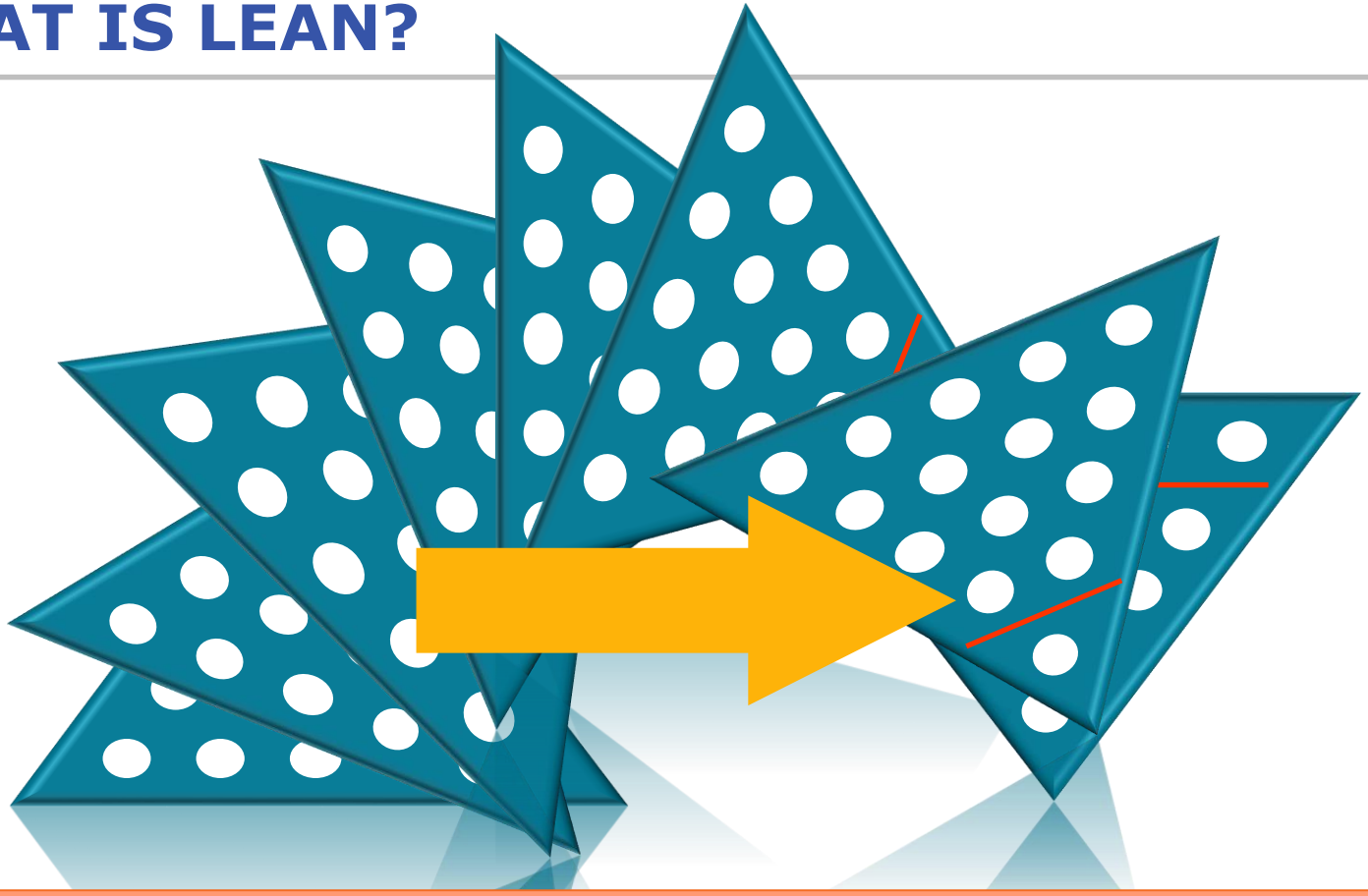
Source: International Federation of Health Plans, 2012 Comparative Price Report, April 2013

STRATEGIC AND OPERATING PLAN

Aligning Purpose with People and Performance Management



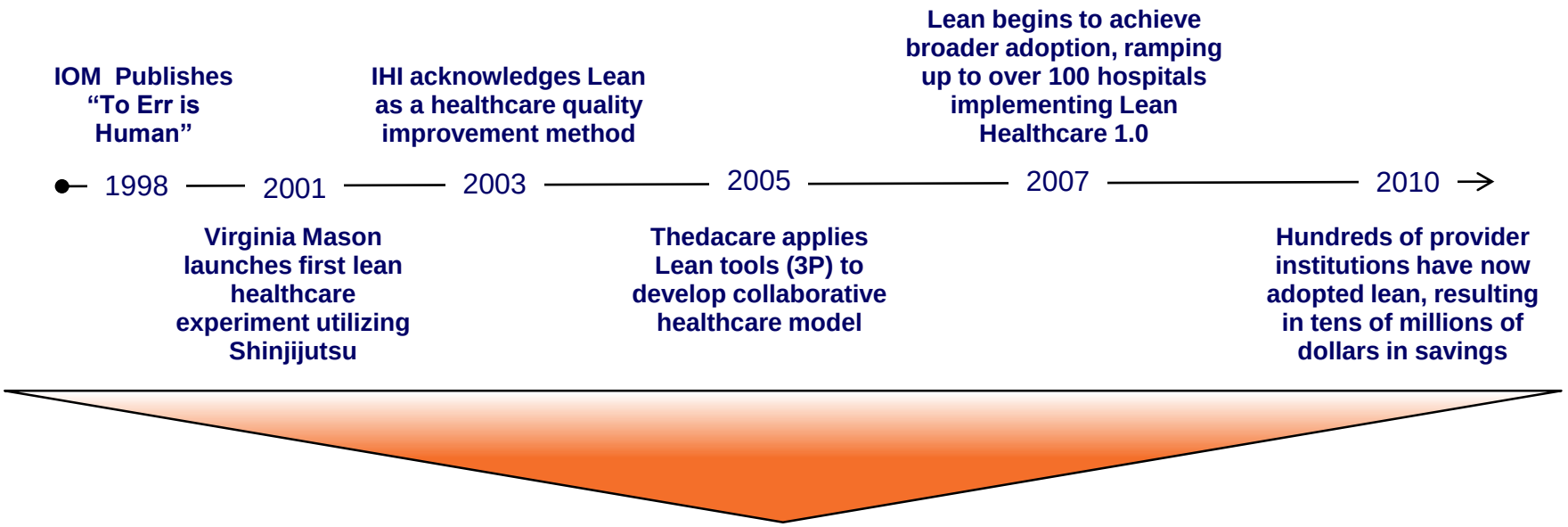
WHAT IS LEAN?



Lean is a systematic approach and total management system that aligns purpose, people and performance. It is a collective system which integrates the strategic utilization of continuous improvement methodologies by empowered and engaged employees that seek to enhance flow for our patients in the pursuit of perfection, allowing us to deliver world-class patient and family centered care for all.

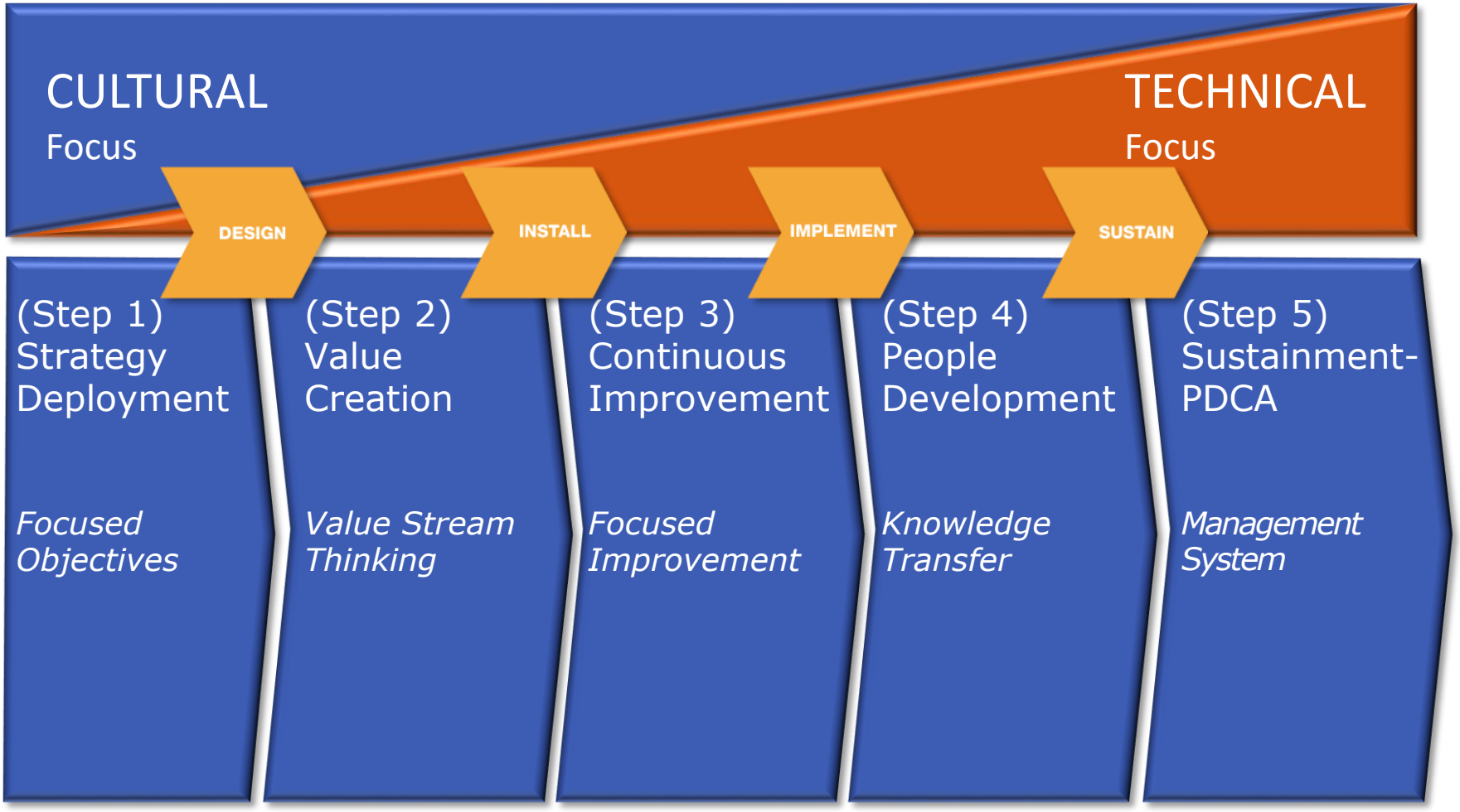
HISTORY OF LEAN IN HEALTHCARE

Lean Healthcare began as an experiment in 2001 at Virginia Mason Hospitals. In the past decade, numerous milestones have been achieved and tremendous value has been created with only a small minority of institutions adopting the principles



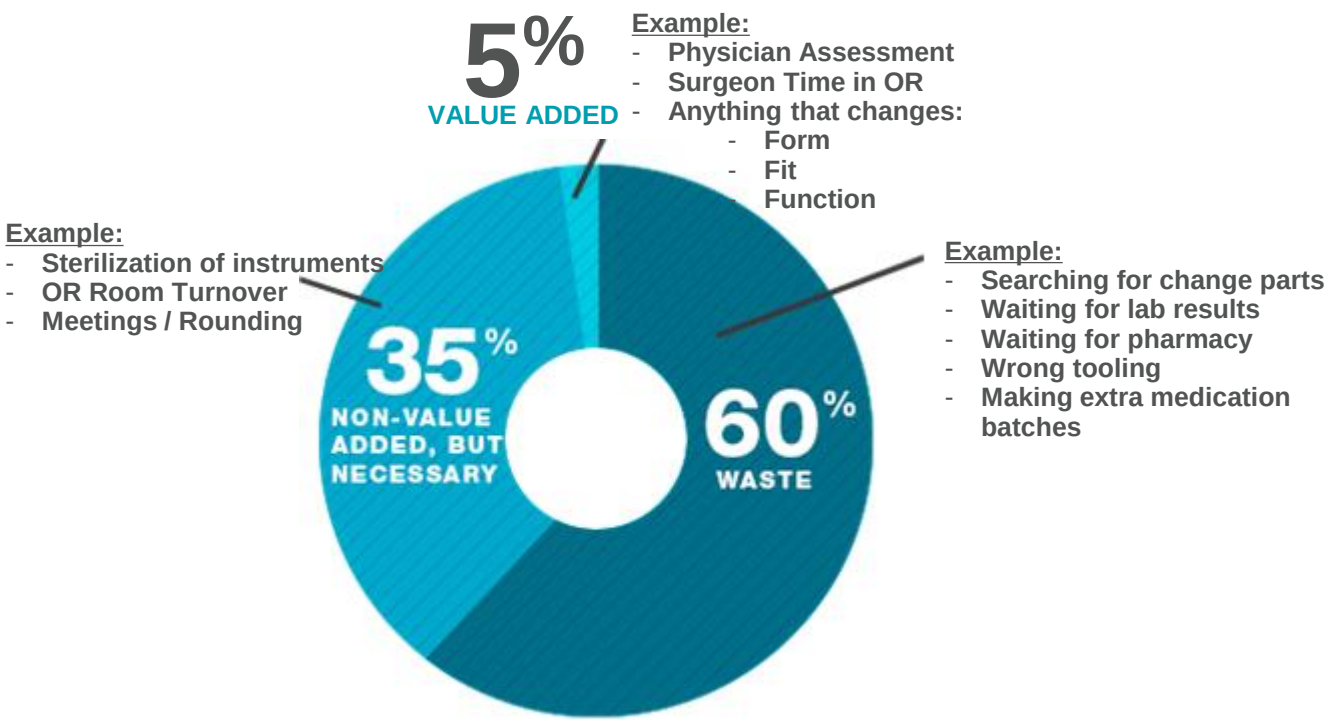
Lean in Healthcare is becoming a proven, accepted method of solving healthcare related issues in clinical and non-clinical environments, and has added value to hundreds of provider institutions including hospitals, physician practices, clinics, and other healthcare provider groups.

EMBED A LEAN MANAGEMENT SYSTEM



VALUE CREATION

MOST PROCESSES ARE ONLY 5% OF VALUE ADDED W O R K



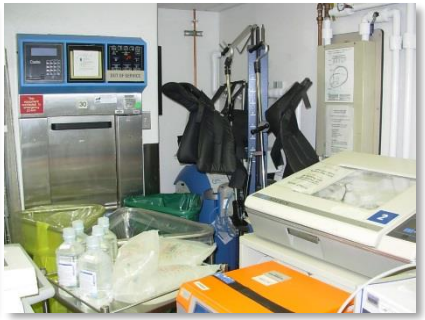
Strategy: To create an arrangement of people, processes, technology and methods in a standardized and sequential order to allow a smooth uninterrupted flow in an effort to minimize variation

EIGHT FORMS OF IMPROVEMENT (FLOW)

TRANSPORTATION

INVENTORY

MOTION



WAITING

EFFICIENCY

PROCESS

PATIENT SATISFACTION

EMPLOYEE ENGAGEMENT

CONTINUOUS IMPROVEMENT

Process

Stability — Capability

Performance

Plan → Do → Check → Act

- Measures - KPI's
- Reports and plans
- Accountability

People

- Organization Design
- Leadership coaching
- Skills and capabilities
- Engaging employees

Behavior Change

Vision → Skills → Resources → Action Plan

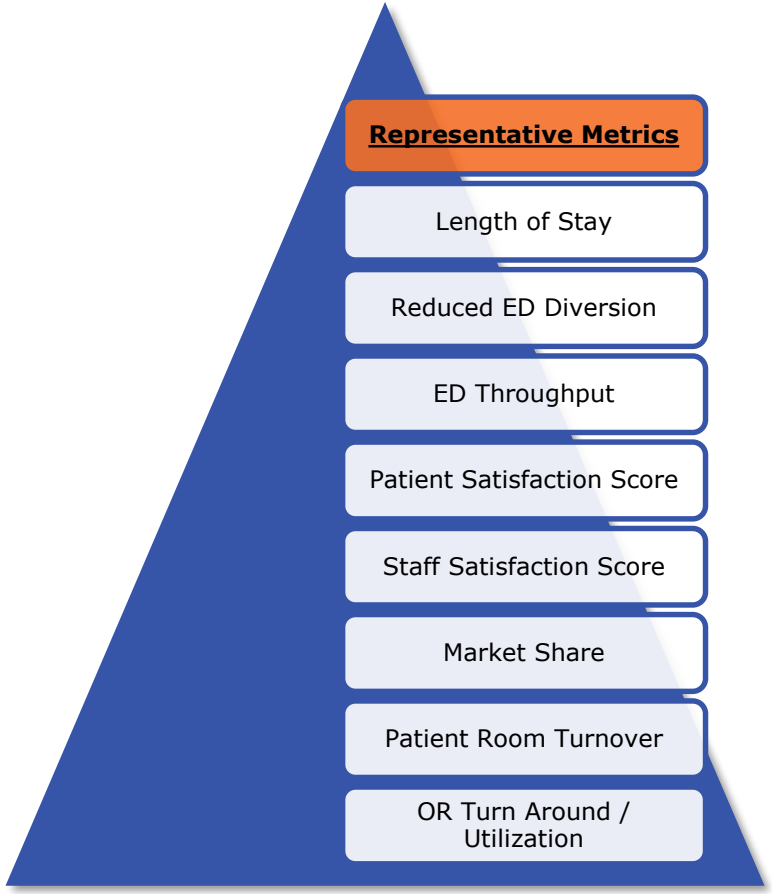
Results

- Measureable
- Sustainable
- Cultural
- ROI

BENEFITS REALIZED

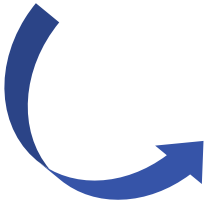
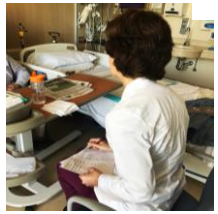
Benefits

- Improved patient safety
- Improved patient satisfaction
- Reduced patient wait times
- Improved access
- Improved process quality
- Improved physician / staff engagement
- Improved resource productivity
- Improved clinical quality outcomes



The pervasive application of lean principles has a dramatic, positive impact on performance metrics

STRATEGY ALIGNMENT AND COMMUNICATION

	MONTHLY	WEEKLY	DAILY
Purpose Mission Vision Values Strategies			
Objectives Goals Operating Plans Dashboards			
Performance Improvement and Team Huddles			  
Daily Management Patient Rounds			 

LEAN MANAGEMENT SYSTEM

- Enterprise-wide organizational alignment
- Focus on providing value
- Engaging physicians and employees
- Transforming the culture
- Results driven execution of strategy
- Delivering excellent patient and family centered care

FURTHER DEVELOPMENT OF OUR LEAN MANAGEMENT SYSTEM

Timeline

6 months	12 months	18 months
Q4 FY18 – Q1 FY19	Q2 FY19 – Q3 FY19	Q4 FY19 – Q1 FY20

Key Deliverables

STRATEGY ALIGNMENT | VALUE CREATION

CONTINUOUS IMPROVEMENT | PEOPLE DEVELOPMENT

SUSTAIN

- Create "common language" and associated processes that aligns with our strategy
- Value Stream Mapping (Enterprise-wide)
- Deploy next "Cycle" of Strategy Deployment across key Divisions with significant execution and impact, (High Impact Events)

- Continuous Improvement focused High Impact Events
- Process Standardization and Documentation ("Common Language")
- Visual Management and Controls of our critical Key Performance Indicators
- Coaching and Mentoring of Standards

- C.I. System Model clearly defined
- Gemba ("Go-and-See") Management
- PDCA Process Embedded
- Leader Standard Work Deployed
- Coaching, Mentoring repetition and mastery for Leaders

Lean Management Culture

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

PROPOSED FY19 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

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

STAFF: Chief Medical Officer

The CMO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the meetings upon the recommendation of the CMO and at the discretion of the CEO and the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurse, and members from the community advisory councils or the community at-large. The CEO is an ex-officio member of this Committee.

GOALS	TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)	METRICS
1. Review the Hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care and Patient Experience Committee.	• Q1 FY19: FY18 Achievement and Metrics for FY19 • Q3 – Q4 FY19: FY20 Goals	• Review Management Proposals, Provide Feedback and Make Recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the recommendations made through the Greeley peer review process.	• Q2	• Receive update on implementation of peer review process changes (FY20) • Review Medical Staff Credentialing Process (FY19)

3. Review Quality, Patient Care, and Patient Experience Committee Reports and Dashboards	• FY 19 Quality Dashboard
	  ○ Q1 – Q2 FY18 – Proposal
	  ○ Monthly – For review and discussion if needed
	• 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 Mortality and Readmissions	• Quarterly	• Review process toward meeting quality organizational goals

SUBMITTED BY:

David Reeder **Chair**, Quality Committee

Mark Adams, MD **Interim CMO and Interim Executive Sponsor**, Quality Committee

Submitted to the Quality Committee For Approval on June 4, 2018

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY19 Pacing Plan

FY2019 Q1		
JULY 2018	**AUGUST 6, 2018**	**SEPTEMBER 5, 2018**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Patient Story ▪ Progress Against FY 2019 Committee Goals (Nov 5, March 4, June 3) ▪ FY19 Pacing Plan ▪ Med Staff Quality Council Minutes	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY18 Committee Goals 4. FY18 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 1. Review proposed new format for Quarterly Quality and Safety Review 2. Approve Committee Charter 3. Culture of Safety Discussion	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY18 Committee Goals 4. FY18 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 1. Update on Patient and Family Centered Care 2. Review AMI and CABG 30 day mortality + AMI and HF 30 day readmission (FY19 Quality Goals) 3. Annual Patient Safety Report
FY2018 Q2		
OCTOBER 1, 2018	**NOVEMBER 5, 2018**	**DECEMBER 3, 2018**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Pt. Experience (HCAHPS) 2. ED Pt. Satisfaction (Press Ganey) 3. Medical Staff Credentialing Process Update	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Safety Report for the Environment of Care 4. Culture of Safety Survey Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda items: 1. Update on Patient and Family Centered Care 2. Review AMI and CABG 30 day mortality + AMI and HF 30 day readmission (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY19 Pacing Plan

FY2019 Q3		
JANUARY 2019	**FEBRUARY 4, 2019**	**MARCH 4, 2019**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Quarterly Quality and Safety Review 2. Physician Survey Results	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Review AMI and CABG 30 day mortality + AMI and HF 30 day readmission (FY19 Quality Goals) 3. Proposed FY20 Committee Goals 4. Proposed FY20 Organizational Goals
FY2019 Q4		
APRIL 1, 2019	**MAY 6, 2019**	**JUNE 3, 2019**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Leapfrog Survey 2. Value Base Purchasing Report 3. Pt. Experience (HCAHPS) 4. ED Pt. Satisfaction (Press Ganey) 5. Approve FY20 Committee Goals 6. Proposed FY20 Committee Meeting Dates 7. Proposed FY20 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. CDI Dashboard 2. Core Measures 3. Approve FY20 Committee Goals (if needed) 4. Proposed FY20 Organizational Goals 5. Proposed FY20 Pacing Plan	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY19 Committee Goals 4. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Review AMI and CABG 30 day mortality + AMI and HF 30 day readmission (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Approve FY20 Pacing Plan

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Proposed FY19 Organizational Goals Quality, Patient Care and Patient Experience Committee June 4, 2018
	Responsible party:	Cheryl Reinking, RN, CNO; Mark Adams, MD, Interim CMO
	Action requested:	Possible Motion

Background:

Each year, the Quality, Patient Care, and Patient Experience Committee reviews and provides input into the leadership team's recommendations regarding annual organizational goals and measures and recommends organizational performance incentive goals for approval by the Board. The Proposed FY19 Organizational Goals are:

1. Patient Throughput (ED Door to Patient Floor – LG & MV, excluding behavioral health): This goal reflects the amount of time it takes (measured in minutes) from the time a patient arrives in the emergency department until they are admitted to an inpatient unit. It is an important efficiency measure, impacts patient satisfaction, and requires collaboration by many departments throughout the enterprise to improve and maintain. We have excluded behavioral health patients because county-wide inpatient bed availability for these patients who present in our ED is outside of our control. We are using an internal benchmark as our baseline. Target for FY19 is 280 minutes.
2. HCAHPS Service Metrics (Nurse Communication, Responsiveness, and Cleanliness): These goals represent the percentage of our randomly surveyed patients who answered "always" to the standard HCAHPS Nurse Communication, Responsiveness, and Cleanliness questions. The proposed recommended incremental improvement may seem small, but improvement in these areas is very difficult to achieve, and a small improvement can result in a large improvement in percentile ranking. We are using an External Benchmark (Press-Ganey, our survey vendor), but have also provided our current performance as a baseline.
3. Quality Metrics: We are proposing Mortality and Readmissions goals for all patients for FY19 (not limited by disease or payor). The external benchmark would be Premier Quality Advisor. The metrics are risk adjusted (for acuity) ratios and reflect observed deaths over expected. So, for example, the minimum goal for mortality of 1.0 means the number of deaths observed at ECH equals the expected number of deaths and the target goal of .95 means there would be fewer deaths observed at ECH than expected.
4. People (Employee Engagement): Employee engagement is a critical component of employee recruitment and retention, as well as, importantly, patient safety and clinical outcomes. The target goal is to increase our overall score by 0.05 for FY19, which moves our percentile nationally from the 40th to the 50th. Press Ganey indicates that this change is very aggressive in a one year period, but we have implemented numerous strategies and feel confident in attaining our goal. This goal is for manager level staff

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	and above. 5. Budgeted Operating Margin (95%): Same threshold from FY18 being proposed for FY19. *Other ECH employees also participate in performance incentive plans tied to these goals.
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: This Committee reviewed the proposed efficiency and service goals at its April 30th meeting. However, the proposed metrics were not available at that time so the Committee will review the proposed goals again at its June 4th meeting. In addition, management is now recommending different quality goals (Mortality and Readmissions) than the Quality Committee reviewed in April. This Committee will also review these on June 4th. The Executive Compensation Committee reviewed all of the proposed goals and metrics at its May 24th meeting and the Finance Committee will discuss the threshold goal (% of budgeted operating margin) at its May 29th meeting.
	Summary and session objectives: To discuss and recommend approval of the Proposed FY19 Organizational Goals.
	Suggested discussion questions: 1. Are there any questions about the proposed goals and measurements? 2. Are there any suggestions? 3. See Added Goal for Employee Engagement. 4. Note that Quality Goal has changed to reflect broader patient populations for mortality and readmissions.
	Proposed Committee motion, if any: To recommend approval of the Proposed FY19 Organizational Goals.
	LIST OF ATTACHMENTS: 1. Proposed FY19 Organizational Goals

DRAFT FY19 Organizational Goals

Organizational Goals FY19	Benchmark	Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe
Organizational Goals							
Patient Throughput ED Door to Patient Floor - LG & MV	Internal Benchmark *Based on CMS Core Measure Data*	Minutes - 339	306	280	270	30%	Q4
HCAHPS Service Metric Nurse Communication 10% Responsiveness 10% Cleanliness 10%	External Benchmark *PG-HCAHPS Adjusted/Received*	Nurse Comm - 80 Responsiveness - 65.1 Cleanliness - 74.5	80.5 65.6 75	81 67 76	82 68.5 77	30%	Q4
Quality Metrics Mortality Index - All Patients 10% Readmissions Index - All Patients 10%	External Benchmark *Premier Quality Advisor Top Quartile*	Mortality 1.02 Readmission 1.08	1.00 1.07	0.95 1.05	0.90 1.03	20%	FY
People Employee Engagement	External Benchmark *Press Ganey*	4.09	4.09	4.14	4.17	20%	FY
Threshold Goals							
Budgeted Operating Margin	Internal *95% Threshold*	Achieved FY18 Budget	95% of Budgeted Operating Margin			Threshold	FY

1. Patient Throughput
Baseline Measurement Period: Q4 FY 17- Q3 FY 18 (one year)
Benchmark: Top Quartile =276 Minutes. Target set just below top quartile, but max set above top quartile.

2. HCAHPS
Baseline Measurement Period: Q4 FY 17-Q3 FY 18 (one year)
Benchmarks:
Nurse Communication: Target 81 = 57th percentile nationally
Responsiveness: Target = 67 =50th percentile nationally
Cleanliness: Target = 76 =57th percentile nationally

3. Quality
Mortality Index:
Baseline measurement period: FY 17
Benchmark: Top Quartile=0.77 (2016 Premier Top Quartile Performers)
Readmissions Index:
Baseline Measurement period: Q3 FY 18
Benchmark: Top Quaritle=0.95 (2016 Top Quartile Performers)

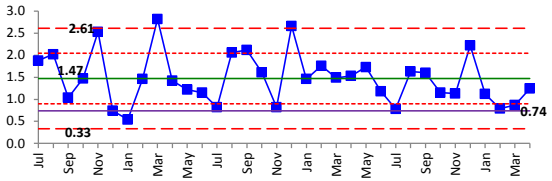
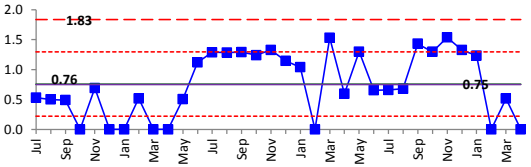
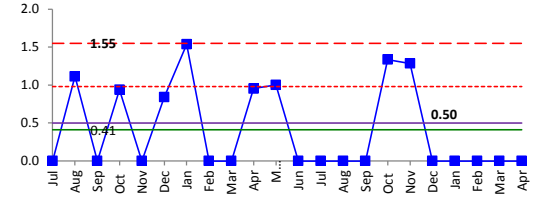
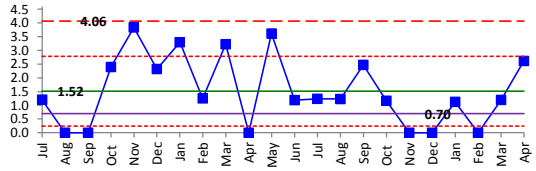
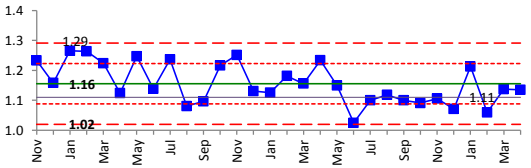
4. People
Employee Engagement Survey

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	FY18 Quality Dashboard Quality Committee of the Board Meeting Date: June 4, 2018
	Responsible party:	Cheryl Reinking, RN, Chief Nursing Officer Mark Adams, MD, Interim Chief Medical Officer
	Action requested:	For Discussion
	Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY2018 Quality, Efficiency and Service Goals. The Sepsis metrics and Patient Falls continued from FY2017.	
	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. 5 consecutive months of zero CLABSI – Jan-April 2018 2. 2 of last 3 months of zero CLABSI – Jan. & March 3. Sepsis Core measure compliance improved to 88% 4. HCAHS Top Box improved to 80.7	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: 1. FY18 Quality Dashboard	

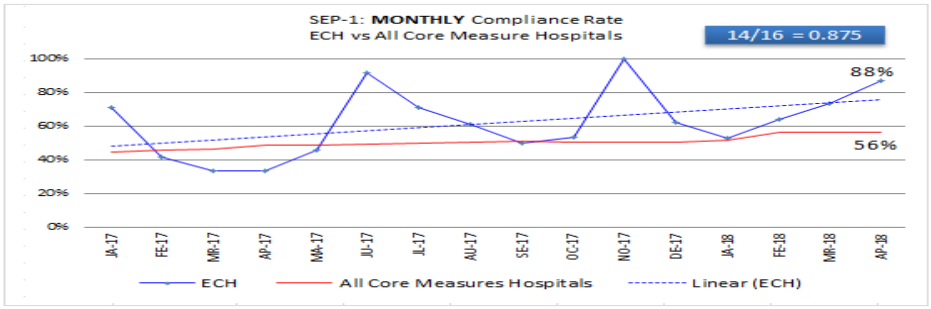
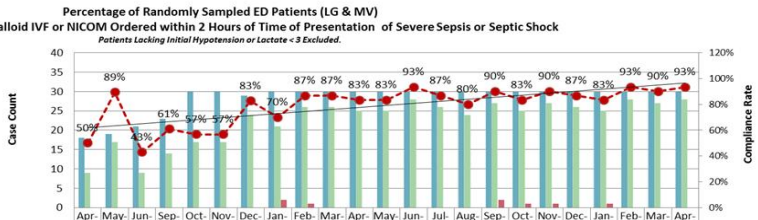
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly) April 2018

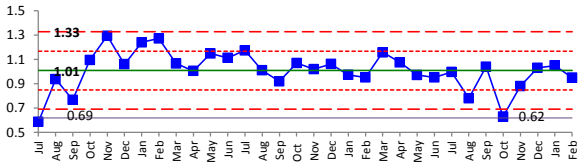
		Performance		Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS		Month	FYTD	FY2017 Actual	FY2018 Goal		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: April 2018*	1.24 (6/4826)	1.26 (67/53226)	1.49	0.74 (Top decile CALNOC)		6 new falls in April : 2 pts. fell with dizziness/panic attack, could have utilized fall prevention chair while getting the pt. up, 2 falls related to failure to lock guerney or overbed table, 2 w/bed alarms not utilized.
2	*Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: April 2018* *SIR Goal: <= 0.75*	0.0 (1/1186)	0.88 (13/14796)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		No new CAUTI in April. Team addressing standardization of urine collection for culture using Lipponcott standard and RN education, request for change in EPIC documentation to provide for external catheters, "badge buddy" in print for CAUTI prevention and straight cath process.
3	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: April 2018* *SIR Goal: <= 0.50*	0.0 (0/739)	0.23 (2/8635)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		5 consecutive months without a new CLABSI through April. Sage warmers for CHG bath cloths rolled out. Step by Step Central line dressing change kit being customized for ECH, 100% compliance with CLIP (central line insertion process) form in March, Peer support 1:1 RN education for central line dressing change initiated April 30th, blood culture draw competencies plan in process.
4	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: April 2018* *SIR Goal: <= 0.70*	2.62 (2/7641)	1.09 (9/81972)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		2 new C. Diff cases in April: 1. Pos. c.diff antigen on day 5, though pt. had loose stools on Day 1-3. Opportunity for nursing to notifiy MD of loose stools & C.diff toxin to be drawn on day 2-3. 2. ICU pt. noted C.diff colonization on Day 2, ABX use appropriate, MD looking for infection source, C.Diff toxin anitgen positive on Day 11. Both rooms UV disinfection completed appropriately
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: April 2018*	1.13	1.11	1.16	1.11		April LOS at 4.71. Trend in ratio tightly clustered around goal in FY 18 as compared to FY 17.

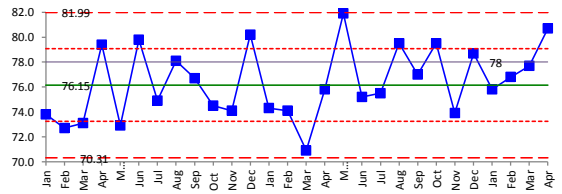
Definitions and Additional Information

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.		

			Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** SEP-1 100% or O% *Date Period: April 2018*					Trend of improved compliance since Jan. 2018. April's rate of 88% with only 2 fallouts. Non-compliance related to missed blood culture collection in time frame and 3 minutes "late" for appropriate ABX delivery.
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: April 2018*					No date received for TJC Sepsis Certification visit. In 5 of last 7 months ED rate of compliance at 90% or greater, results becoming stable above 90%.

	Apr-16	May-16	Jun-16	Sep-16	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	Mar-18	Apr-18
Number of Sampled Cases	18	19	21	23	30	30	29	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30
Cases with 30ml/kg or NICOM ordered within 2h TOP	9	17	9	14	17	17	24	21	26	26	25	25	28	26	24	27	25	27	26	25	28	27	28
Cases with 30ml/kg ordered or NICOM within 3h TOP	0	0	0	0	0	0	0	2	1	0	0	0	0	0	0	2	1	1	0	1	0	0	0
Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation	50%	89%	43%	61%	57%	57%	83%	70%	87%	87%	83%	83%	93%	87%	80%	90%	83%	90%	87%	83%	93%	90%	93%

Mortality	Performance Month	Performance FYTD	FY 2017	FY 2018 Goal	Trend	Comments
8 **Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Feb 2018*	0.95(1.97%/2.07%)	0.93 (1.65%/1.77%)	1.02 (1.88%/1.83%)	0.62		Mortality O/E improved, to below 1.0, indicating more patients lived who were expected to die. CDI improved expected rate with physician documentation of co-morbidilties and complications.

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: April 2018*	80.7 (217/269)	77.5 (1878/2422)	76.30	78.0%		4 months of continuous improvement in score, related to focused action plans for Nurse Communications: Listening Carefully Tool Kit, Care Team Coaching, and Leader rounding.

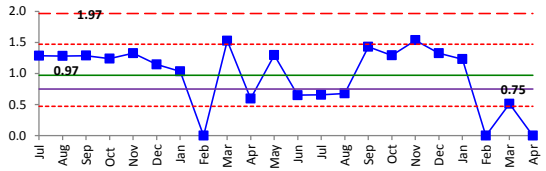
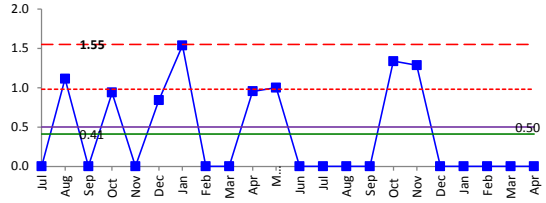
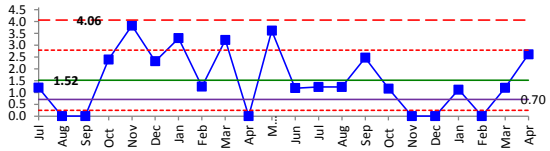
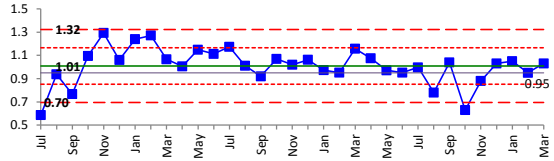
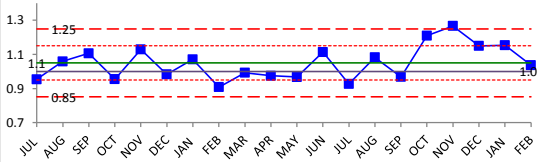
Measure Name	Definition Owner	Work Group	FY 2017 Definition	Source
Sepsis Core Measure- SEP-1: MONTHLY Compliance Rate ECH vs. All Core Measure Hospitals	Catherine Carson/Kelly Nguyen	Sepsis Steering Committee	New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate > 2 or evidence of organ dysfunction, Hospital must meet ALL 4 measures in order to be compliant with this core measure, Patients with septic shock require an assessment of volume status and tissue perfusion within 6 hours of presentation, Patients NOT included are those transferred from another facility or those placed on comfort cares.	**EPIC Chart Review**
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded)Shock	Catherine Carson		Percentage of Randomly Sampled ED Patients (LG & MV) who had IVF >=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate <3 Excluded)	**EPIC Chart Review**
Mortality Rate (Observed/Expected)	Catherine Carson			**Premier Quality Advisor**
HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10	Michelle Gabriel; Ashley Fontenot Cheryl Reinking	Patient Experience Committee	"'9' or '10' (high)" for the Overall Hospital Rating item	**Press Ganey Tool**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Draft FY19 Quality Dashboard Quality Committee of the Board June 4, 2018
	Responsible party:	Cheryl Reinking, RN, Chief Nursing Officer Mark Adams, MD, Interim Chief Medical Officer
	Action requested:	For Approval
	Background: These eight metrics reflect the Hospital's FY 2019 Quality, Efficiency and Service Goals and include a continuation of the FY2018 HAI Quality and Efficiency Goal metrics. The sepsis metric has been changed to Sepsis Mortality Index.	
	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 FY2018 and the FY2019 goal.	
	Suggested discussion questions: 1. Review the selected metrics and how they reflect the ECH FY 2019 Quality, Efficiency and Service Goals 2. Continuation of metrics from FY2018 Goals assist in oversight and sustainability	
	Proposed Committee motion, if any: To recommend that the Board approve the Draft FY19 Quality Dashboard	
	LIST OF ATTACHMENTS: 1. Draft FY2019 Quality and Safety Dashboard	

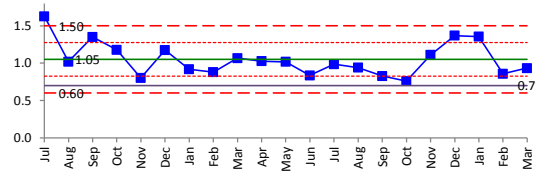
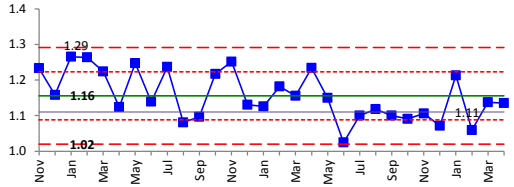
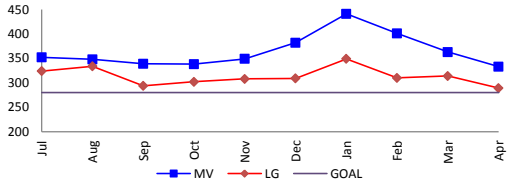
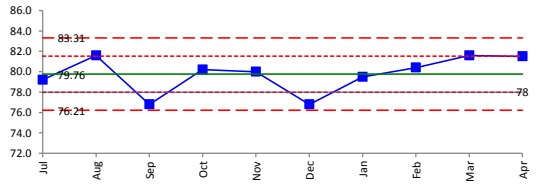
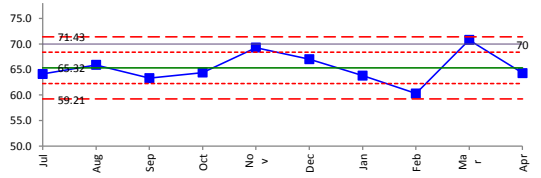
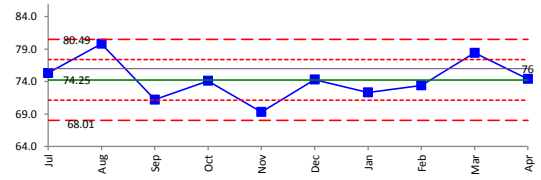
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Draft Quality and Safety Dashboard (Monthly)

		Performance		Baseline	FY19 Goal	Trend	Comments
Quality		Month	FYTD	FY2017 Actual	FY2019 Goal		
1	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: April 2018* *SIR Goal: <= 0.75*	0.0 (1/1186)	0.88 (13/14796)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		
2	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: April 2018* *SIR Goal: <= 0.50*	0.0 (0/739)	0.23 (2/8635)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		
3	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: April 2018* *SIR Goal: <= 0.70*	2.62 (2/7641)	1.09 (9/81972)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		
4	***Organizational Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Mar 2018*	1.03 (1.98%/1.92%)	0.94 (1.65%/1.77%)	1.02 (1.88%/1.83%)	0.95		
5	***Organizational Goal** **Readmission Index (All Patient, All Cause Redmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** Date Period: Feb 2018	0.98	1.10	1.02	1.0		

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract 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) CLABSI (Central line associated blood stream infection)	Catherine Carson/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Catherine Carson/Catherine Nalesnik				
Mortality Index (Observed/Expected)	Catherine Carson				**Premier Quality Advisor**
Readmission Index (All Patient, All Cause Redmit) Observed/Expected	Catherine Carson				**Premier Quality Advisor**

				Baseline	FY19 Goal	Trend	Comments
Quality		Month	FYTD	FY 2017	FY 2019		
6	**Sepsis Mortality Index** *(Observed over Expected)* *Date Period: March 2018*	0.93	1.03	1.05	0.70		
Efficiency		Month	FYTD	FY 2017	FY 2019		
7	★Organizational Goal **Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: April 2018*	1.13	1.11	1.16	1.11		
8	★Organizational Goal **Patient Throughput-Average minutes from ED Door to Patient Admitted** (excludes Behavioral Health Inpatients) *Date Period: April 2018*	MV: 333 mins LG: 289 mins			280 mins		
SERVICE		Month	FYTD	FY 2017	FY 2019		
9	«Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: April 2018*	81.5 (197/242)	79.8 (1875/2350)	76.30	78.0		
10	«Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: April 2018*	64.3 (145/225)	71.2 (1596/2243)	76.30	70.0		
11	«Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: April 2018*	74.4 (198/266)	75.8 (1834/2418)	76.30	76.0		

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Index Observed over Expected	Catherine Carson				**Premier Quality Advisor**
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.		**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	Catherine Carson				**EPIC**
HCAHPS Nursing Communication Domain Top Box Rating of Always	Michelle Gabriel; Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10		**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always	Michelle Gabriel; Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital StaffTop Box Rating 9 and 10		**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always	Michelle Gabriel; Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10		**Press Ganey Tool**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Patient and Family Centered Care: Grievance Update Quality, Patient Care and Patient Experience Committee June 4, 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 Nursing Communication Toolkit that has been executed per the Patient Experience Roadmap. • Share the Nursing Communication--Listening Carefully HCAHPS scores and analyze the results in comparison to the implementation of the Nursing Communication Toolkit.	
	Suggested discussion questions: 1. Do you think the Nursing Communication Toolkit topics adequately cover the important concepts of effective communication from a patient perspective? 2. Is sharing the HCAHPS information on VIS boards and at huddle an effective mechanism to communicate with frontline staff, how their actions affect change?	
	Proposed Committee motion, if any: None. This is a discussion item.	
	LIST OF ATTACHMENTS: 1. Update on Patient and Family Centered Care: Nursing Communication	

El Camino Hospital®

THE HOSPITAL OF SILICON VALLEY

Patient Experience
Nursing Communication

Cheryl Reinking, MSN, RN, NEA-BC

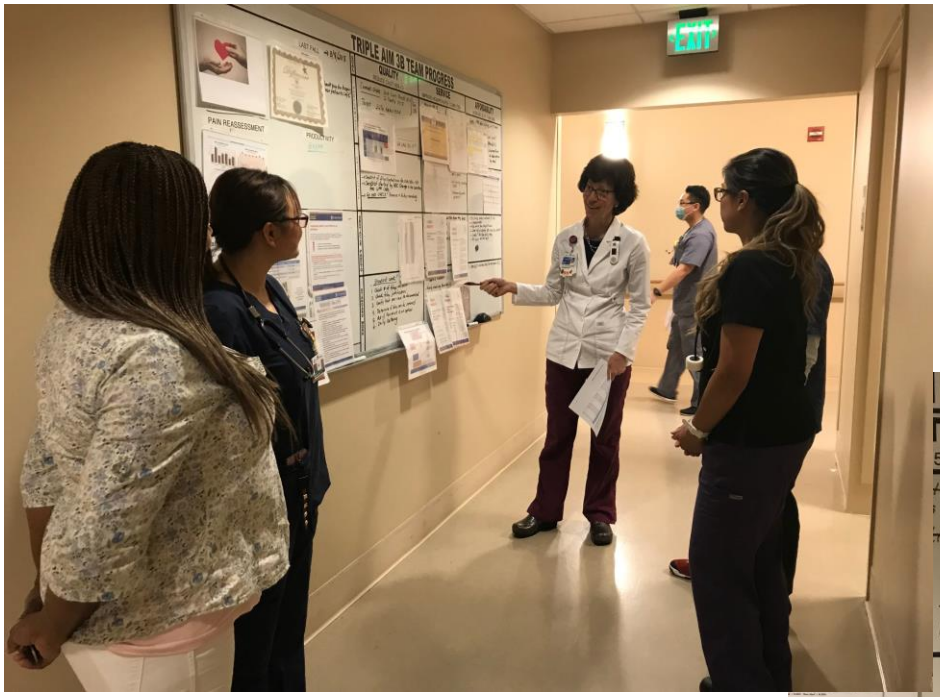
Be the Difference—Understanding Nursing Communication

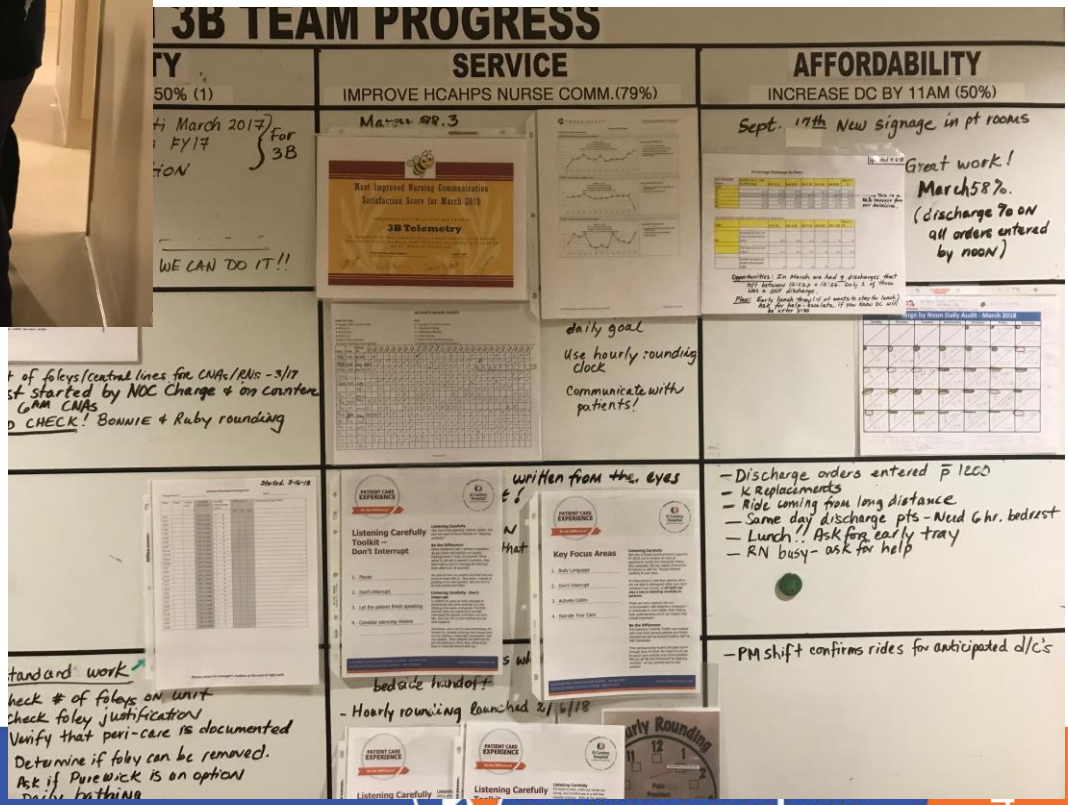
Understanding Nursing Communication

Communication Toolkit Topics

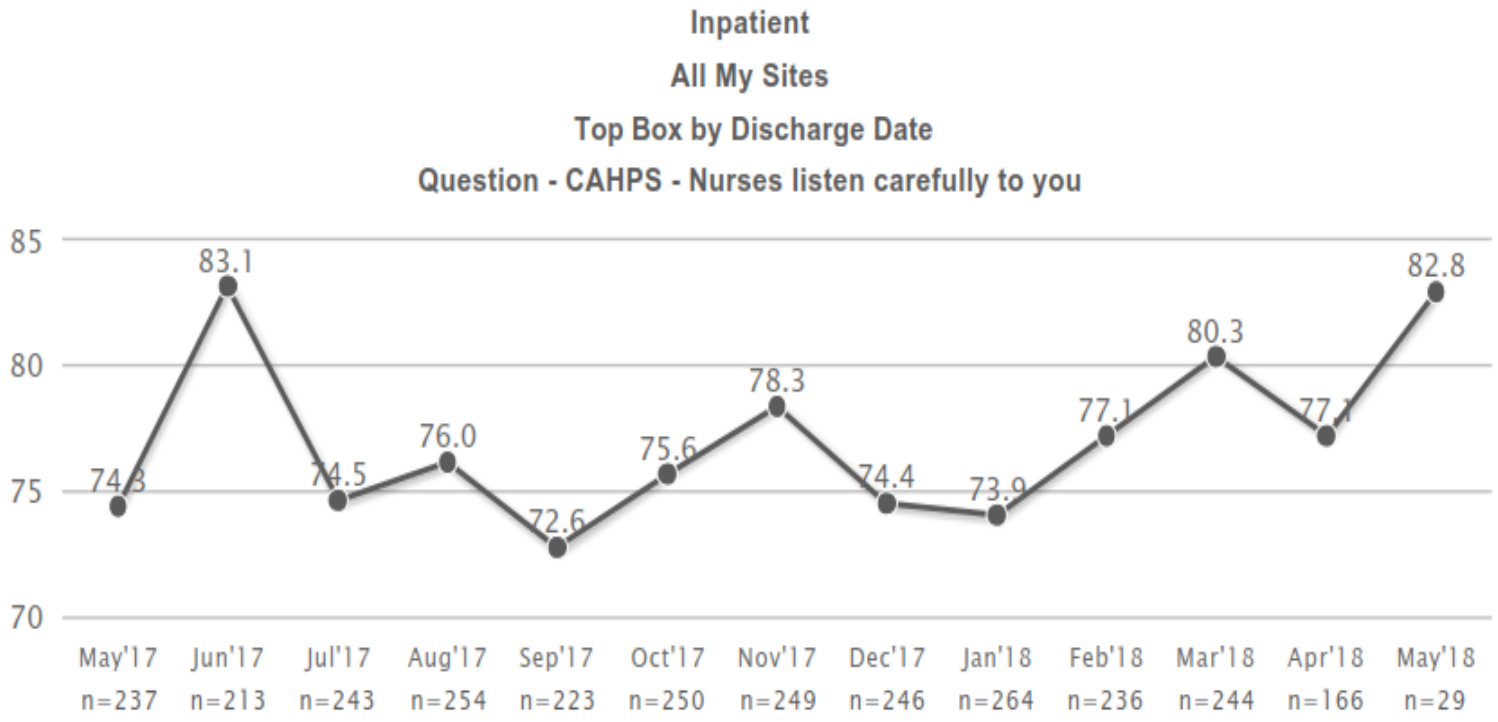
Macro Topic	Key Care Practices	Timeline
Orientation	For Leaders (30 minutes before All Leaders) managers, directors, NUCs, leads, educators, champions, charge nurses	1-Mar
Kickoff	For staff (4 times with telepresence to both campuses)	5-Mar
Introduction	Why is this important?, Data, Goals, Overview of macro topics/timeline	12-Mar
Body Language	Non-verbal's, open posture, eye contact	19-Mar
Body Language	Sitting down	26-Mar
Listen Carefully	Don't interrupt	2-Apr
Listen Carefully	Mindful presence	9-Apr
Actively Listen	Repeat back	16-Apr
Actively Listen	Retain a fun fact (bedside shift report)	23-Apr
Narrate your care	Narrate Computer Use & eye contact	30-Apr
Narrate your care	Invitation (open-ended questions)	7-May
Narrate your care	Triangle of Trust & sit down	8-May
NAR	Video highlighting staff and patient testimonials - Be the Difference	8-May
Transition	Wrap up/Review	14-May
Body Language	Reinforce	21-May
Listen Carefully	Reinforce	28-May
Actively Listen	Reinforce	4-Jun
Narrate your care	Reinforce	11-Jun
Body Language	Reinforce	18-Jun
Listen Carefully	Reinforce	25-Jun

VIS Board


TRIPLE AIM 3B TEAM PROGRESS
EXIT


3B TEAM PROGRESS
SERVICE
IMPROVE HCAHPS NURSE COMM.(79%)
AFFORDABILITY
INCREASE DC BY 11AM (50%)
Sept. 17th New signage in pt rooms
Great work!
March 58%.
(discharge 9a ON all orders entered by noon)
WE CAN DO IT!!
daily goal
Use hourly rounding clock
Communicate with patients!
Most Improved Nursing Communication Satisfaction Score for March 2018
3B Telemetry
Listening Carefully Toolkit – Don't Interrupt
Key Focus Areas
standard work
Check # of foleys on unit
Check foley justification
Verify that peri-care is documented
Determine if foley can be removed.
Ask if PureWick is on option
bedside handoff
- Hourly rounding launched 2/16/18
written from the eyes
– Discharge orders entered by 1200
– K Replacements
– Ride coming from long distance
– Same day discharge pts - Need Ghr. bedrest
– Lunch!! Ask for early tray
– RN busy - ask for help
– PM shift confirms rides for anticipated d/c's

Nurses Listen Carefully HCAHPS Question



ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Readmission Dashboard Quality Committee of the Board June 4, 2018
	Responsible party:	Cheryl Reinking, RN, Chief Nursing Officer
	Action requested:	For Discussion
	Background: Through the ACA, CMS applies a readmission penalty to DRG reimbursement according to the expected Readmission rates for 7 diagnosis categories of up to 3%, if any the observed readmission rate is higher than the expected readmission rate for any of the diagnosis categories. The diagnoses involved are AMI, COPD, CABG, HF, PN, Stroke and Total Hip & Knee Arthroplasty.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Review the readmission rate trends for each of the 7 diagnosis categories • In reviewing data expressed as O/E (observed over expected) 1.00 or lower is better	
	Suggested discussion questions: 1. The Readmissions Steering Committee reviews and analyzes each readmission to discover opportunities for reduction in the readmissions, i.e. Anticoagulant therapy is a primary reason for readmission, orders for Ambien were associated with readmission, more than 50% of the readmissions did not a follow up appointment at the time of discharge. 2. Diagnosis specific issues: • GI bleed due to anticoagulant therapy causative in AMI pts. • COPD deep dive into understanding primary causes, implemented a COPD protocol, exploring telemonitoring and portable home vent.	
	Proposed Committee motion, if any: None. This is a discussion item.	
	LIST OF ATTACHMENTS: 1. Readmission Dashboard	

FY 2018 30 Day All-Cause, Unplanned Readmission Dashbaord

Premier Medicare Grouping, All Ages

		Baseline 7/1/2016-3/31/2017			Qtr 1, FY 2018			Qtr 2 , FY 2018			Qtr 3, FY 2018			Qtr 4, FY 2018		
		Observed Rate	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*
1	Overall	11.27%	10.63%	1.06	11.40%	10.01%	1.14	12.58%	9.66%	1.30						
2	Acute Myocaridal Infarction (AMI)	12.20%	10.51%	1.16	6.69%	8.58%	0.78	24.32%	10.65%	2.28						
3	Chronic Obstructive Pulmonary Disease (COPD)	15.15%	14.52%	1.04	25.00%	14.59%	1.71	34.09%	14.89%	2.29						
4	Coronary Artery Bypass Graft (CABG)	14.29%	8.03%	1.78	5.88%	8.86%	0.66	15.38%	9.16%	1.68						
5	Heart Failure	17.88%	14.45%	1.24	14.29%	13.91%	1.03	11.65%	13.21%	0.88						
6	Pneumonia	11.11%	12.88%	0.86	17.65%	14.88%	1.19	12.93%	12.04%	1.07						
7	Stroke	6.70%	7.31%	0.92	10.53%	8.26%	1.27	9.26%	8.15%	1.14						
8	Total Hip Arthroplasty and/or Toal Knee Arthroplasty	2.87%	2.67%	1.07	2.56%	2.55%	1.01	2.54%	2.72%	0.93						

* Source: Premier Quality Advisor-Standard CS 30 day CMS Readmission methodology

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Performance Improvement & Patient Safety Plan Quality Committee of the Board June 4, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ, Sr. Director/Chief Quality Officer
	Action requested:	For Approval
	Background: CMS Conditions of Participation requires the hospital to have a Quality Assessment and Performance Improvement Program, often referred to as QAPI and this is reflected in Joint Commission standards as well. This plan is to provide a road map and explanation of how this work is accomplished. CDPH through SB 158 requires all acute hospitals to establish a Patient Safety Committee and Plan, and articulates the information to be included. Both plans are combined into one document at ECH.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • The PI & PS Plan provides an overview of how quality assessment and performance improvement is organized at ECH, the approaches to both patient safety and performance improvement work and the organizational structure that supports these processes.	
	Suggested discussion questions: 1. The PI & PS Plan is required to be reviewed and revised as necessary, at least annually 2. The measures and indicators required by regulators are included as well as the flow of performance improvement and quality information and data registries in use.	
	Proposed Committee motion, if any: To recommend that the Board approve the Performance Improvement & Patient Safety Plan	
	LIST OF ATTACHMENTS: 1. Performance Improvement & Patient Safety Plan	

TITLE:	Performance Improvement & Patient Safety Plan
CATEGORY:	Administration
LAST APPROVAL:	

TYPE:	☐ Policy ☐ Protocol ☐ Practice Guideline ☐ Standardized ☐ Procedure ☑ Plan ☐ Scope of Service/ADT Procedure
SUB-CATEGORY:	Performance Improvement
OFFICE OF ORIGIN:	Clinical Effectiveness
ORIGINAL DATE:	5/2018

I. PURPOSE

The Performance Improvement & Patient Safety Plan describes the multidisciplinary, systematic performance improvement framework utilized by El Camino Hospital to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of the hospital.

II. ORGANIZATION OVERVIEW

El Camino Hospital (ECH) is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 25 acute psychiatric beds headquartered in Mountain View, California and a 143-bed acute hospital in Los Gatos, California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Primary Stroke Center, in Joint Replacement for Hip and Knee, Hip Fracture and Spinal Fusion. The Los Gatos campus has been certified as a "baby friendly hospital" by WHO/UNICEF.

The ECH Medical Staff includes 1606 active, courtesy or provisional physicians/independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

III. El CAMINO HOSPITAL MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

IV. El CAMINO HOSPITAL VISION

To lead the transformation of healthcare delivery in Silicon Valley.

TITLE:	Performance Improvement & Patient Safety Plan
CATEGORY:	Administration
LAST APPROVAL:	

V. El CAMINO HOSPITAL VALUES

Quality: We pursue excellence to deliver evidence based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

VI. SERVICES/PROGRAMS

EMC provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:	Emergency Services	Outpatient Services
Intensive & Critical Care Unit	Basic Emergency	Behavioral Services – Outpatient
Progressive Care Unit (PCU) (Step-		Cancer Center
Operating Room (OR)		Cardio Pulmonary Wellness Center
Post-Anesthesia Care Unit (PACU)		Outpatient Surgical Unity
Telemetry/Stroke		Endoscopy
Medical/Surgical/Ortho		Interventional Services
Pediatrics		Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiology Services (Imaging, Interventional,
Labor and Delivery (L&D)		Radiation Oncology
Mother/Baby		Rehabilitation
Neonatal Intensive Care Unit		Infusion Services
Behavioral Health Services		Nuclear Medicine
Acute Rehabilitation		Wound Care Clinic
Cardiac Catheterization Services		

VII. OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care.

2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety.

3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.

4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.

5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.

6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.

7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.

8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.

9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating accrediting bodies.

10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.

11. Provide a mechanism for integration of performance improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.

VIII. ACCOUNTABILITY FOR PERFORMANCE IMPROVEMENT and PATIENT SAFETY

A. Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Hospital bears ultimate responsibility for the performance and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards,

and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility for implementing the Performance Improvement & Patient Safety Plan to the medical staff and hospital administration.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, cause the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting the Joint Commission, College of American Pathology accreditation standards, California Code of Regulations; Title 22 and complying with applicable laws and regulations.

Other specific responsibilities with regard to performance improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the Governing Board.

B. Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.14, the Medical Executive Committee is responsible for the quality and efficiency of patient care rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

1. Fulfill the Medical Staff's responsibility of accountability to the Board of Directors for medical care rendered to patients in the hospital;
2. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and making recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
3. Assisting in obtaining and maintenance of accreditation.

C. Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of a combination of campus-specific departments and enterprise departments. Enterprise departments are those departments that serve constituency at all campuses (including Mountain View – MV and Los Gatos- LG). All departments report to a unified Medical Staff Executive Committee.

Other specific responsibilities with regard to performance improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A.

D. Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes performance improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

1. Adopt an approach to performance improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support activities
2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for performance improvement and safety giving priority to high-volume, high-risk, or problem- prone processes for performance improvement activities and reprioritize performance improvement activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental performance improvement and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff is trained in performance improvement and safety improvement approaches and methods and receives education that focuses on safety and quality
7. Continuously measure and assess the effectiveness of performance improvement and safety improvement activities, and implement improvements for these activities

E. Medical Staff, Employees, and Contracted Services

1. Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on

multidisciplinary teams, reporting adverse events, and implementing actions to sustainimprovements.

F. <u>Quality & Patient Safety Committees: Medical Staff Quality Council and Hospital Quality Improvement and Patient Safety Committees</u> <u>(See Flow of Information Appendix A)</u>

The Medical Staff Bylaws describe the composition and duties of the **Medical Staff Quality Council** as a medical staff committee that will provide to the Medical Executive Committee reports on the quality of medical care provided to patients at ECH. This Council receives reports from the vice chiefs of department and divisions and their improvement activities on an annual basis and information on medical record review, transfusion, tissue, and autopsy review.

The **Hospital Quality Improvement Committee** reports to the Medical Staff Quality Council which reviews and approve its minutes. The Committee provides oversight for the hospital's performance improvement activity and patient satisfaction data, coordinates and monitors departmental and service line performance improvement reports. It also receives reports and data regarding all regulatory reviews, surveys and accreditation activity. The Quality and Safety Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Committee may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues.

The **Patient Safety Committee** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Ulcers, Hospital-acquired Infections A3 Teams (CAUTI, CLABSI, C. Diff, and Hygiene), National Patient Safety Goals, Safety/Security, Antibiotic Stewardship, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene and the Grievance Committee. The Committee also reviews reports from Culture of Safety Surveys and works with the medical staff and hospital administration to develop action plans in response to the results. The Director of Risk Management also conducts risk assessments regarding the safety of patient care including Failure Mode Effects Analysis (FMEA) for new or changed hospital services. The Director of Risk Management/Patient Safety Officer provides data on the Quality Review Reports (QRR – Adverse Event Report) and the adequacy of the reporting process, including updates on the number and type of QRRs, serious safety events and RCAs (root cause analyses). Updates are also provided on the performance improvement teams that are chartered through this committee and as a result of RCAs or Intensive Analyses. This Committee uses the Management of Serious Safety Events policy to outline the process for categorizing patient safety events, including serious safety events, defining those events that reach the level of a Red Alert, ensuring compliance with all regulatory requirements for oversight of adverse events and to outline the procedure for notifying ECH leadership and the ECH Board of serious safety events.

The **Patient Safety Oversight Committee (PSOC)** is also a subcommittee of the Medical Staff Quality Committee and is described in the *Management of Serious Safety and Red Alert Procedure*

(Administrative). The Patient Safety Oversight Committee is a committee that meets weekly to review and categorize Quality Review Reports, serious patient safety events, behavior, safety and operational issues. The Committee is comprised of the Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Medical Director for Quality Assurance, Associate Chief Medical Officer, Sr. Director/Chief Quality Officer, Director of Risk Management/Patient Safety Officer, Director of Accreditation/Public Reporting, Director of Medical Staff Services and a representative of the Medical Staff. These leaders provide direction to the organization and the Medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

G. Clinical Effectiveness Department

A responsibility of the Clinical Effectiveness Department is to coordinate and facilitate quality management and performance improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Clinical Effectiveness Department staff serves as an internal resource for the development and evaluation of performance improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams such as the Falls Team, and the Surgical Site Infection Task Force and all of the HAI Teams. The Clinical Effectiveness Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Clinical Effectiveness Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of performance improvement activities from all sources
2. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
3. Managing the peer review process and the peer review data base for the medical staff and providing data and reports for the OPPE and FPPE process of the medical staff
4. Providing clinical and provider data from hospital and external registry data bases as needed for performance improvement
5. Maintaining a performance improvement and patient safety reporting calendar and communicating it to all groups responsible for performance improvement activities
6. Risk Management for the hospital and Quality Review Reporting System (QRR-adverse event reporting). This also includes conducting Root Cause Analyses and Intense Analyses as responses to adverse events and near misses
7. Facilitating a failure mode and effectiveness analysis (FMEA) at least every 18 months through the leadership of both the Director of Risk Management & Patient Safety and the Director of Accreditation & Public Reporting
8. Leading performance improvement teams that are commissioned as a result of findings of Root Cause Analyses or Intense Analyses
9. Working with the Medical Staff Department leaders to ensure effective use of resources through the identification and sharing of “best practices”
10. Supporting Infection Prevention efforts within the hospital, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections

and conditions

11. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
12. Providing data as requested to external organizations, see List with data provided in Appendix B
13. Providing oversight for the hospital's participation in Clinical Registries, see Appendix C for current list
14. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, managing NSQIP Registry and quality improvement, the MBSAQIP, and all Transfusion review and data

H. Improving Organizational Performance

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Performance improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. Performance improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(s) to performance improvement. These leaders set priorities for performance improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities. Nursing performance improvement is conducted at both organizational and unit levels through Councils. See Appendix A.

Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives will be based upon the following criteria:

1. Low volume, high risk processes and procedures
2. Severity of adverse events and trends of events reported in the electronic adverse event reporting system
3. Regulatory expectations and requirements
4. The Joint Commission (TJC) standards and CMS Conditions of Participation
5. Meeting the needs of the patients, staff and others
6. Resources required and/or available
7. Results of performance improvement, patient safety and risk reduction activities
8. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices, CDPH, Joint Commission Sentinel Event Alerts)
9. Accreditation and/or regulatory requirement(s) of the Joint Commission and the California Department of Public Health (CDPH)
10. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix B.

TITLE:	Performance Improvement & Patient Safety Plan
CATEGORY:	Administration
LAST APPROVAL:	

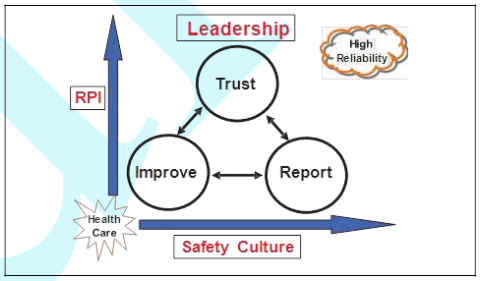
I. Performance Processes

1. Design

The design of processes should be in keeping with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

2. Patient Safety

ECH strives to prevent errors and adverse effects to patients that are associated with complex patient care. While patient safety events may not be completely eliminated, harm to patients can be reduced and our goal is always zero harm. To learn from and to make changes to reduce harm, all hospital-acquired conditions, infections and complications of care are reviewed and results shared with involved departments and providers. Root cause analyses and intense analyses are conducted to more clearly understand the factors involved in a near miss or untoward event. The purpose is to develop and sustain a culture of safety. The leadership, risk management and quality staff work to promote a "just culture" that focuses on the systems involved in care and to create a trust-report-improve cycle to promote reporting of all event and near misses.



3. Measurement

ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Board of Directors set organizational goals for quality, service and efficiency. The data collected for priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.

Performance measures are structured to follow the Joint Commission dimensions of

performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:

a. Consistent with the organization's mission, vision, goals, objectives, and plans;
b. Meeting the needs of individuals served, staff and others;
c. Clinically sound and current;
d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
f. Incorporated into the results of performance improvement activities.

Data collection includes process, outcome, and control measures as well as improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:

a. Establish a performance baseline;
b. Describe process performance or stability;
c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
d. Identify areas for more focused data collection to achieve and sustain improvement.

4. Analysis

Data shall be analyzed on an ongoing basis to identify performance improvement opportunities. Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.

When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.

ECH requires an intense analysis of undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;
d. Blood Utilization to include confirmed transfusion reactions;
e. Significant adverse events and drug reactions;
f. Significant medication errors, close calls, and hazardous conditions;
g. Significant adverse events related to using moderate or deep sedation or anesthesia;

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

TITLE:	Performance Improvement & Patient Safety Plan
CATEGORY:	Administration
LAST APPROVAL:	

J. Improvement Model And Methodology

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other PDSA Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

The model has two parts:

1. ***Three fundamental questions, which can be addressed in any order.***
   - What are we trying to accomplish?
   - How will we know that a change is an improvement?
   - What changes can we make that will result in improvement?

This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The Plan-Do-Study-Act (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

2. ***The Plan-Do-Study-Act (PDSA) Cycle***

The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

Step 1: Plan
Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?

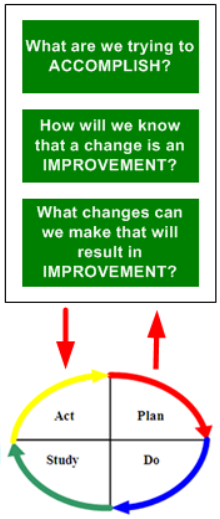
Step 2: Do
Try out the test on a small scale. What did we observe that was not a part of our plan?

Step 3: Study
Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
Summarize and reflect on what was learned.

Step 4: Act
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next

cycle, if necessary. The cycle is ongoing and continuous.

In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



K. <u>Lean Improvement Methodology:</u>

ECH has applied the use of Lean methodology and principles to the process of performance improvement. The Performance Improvement Department provides resources to the organization in deploying Lean strategies and tools. This Department provides trained A3 team facilitators and education to the organization on Lean principles. For FY 2019, the Performance Improvement Department is focusing on using Lean tools to address Through-put involving patient flow beginning in the Emergency Departments. Patient Throughput (ED door to Patient floor) is the FY 2019 Efficiency Goal.

Lean is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. Lean organizations deliver exactly what is needed, at the right time, in the right quantity without defects, and at the lowest possible cost. The currency of lean is value. As you take out "muda" (i.e., waste) in the process, you take out time. Waste is anything other than the minimum amount of equipment, materials, technology, space, and a colleague's time that are essential to add value to the product or service. Lean is a long term strategy in that it takes time to change. Testing turnaround time and OR utilization are classic examples. Lean thinking specifies value from the standpoint of the customer.

Systems critical to the success of lean include reward and recognition, education and training, idea generation, communication, and engagement. Lean behaviors require everyone to be a problem-solver, managers solicit ideas from colleagues and encourage continuous improvement, everyone is treated with respect and challenged to grow professionally and personally, and everyone is

transparent about results and areas for improvement. Lean leadership guiding principles require a belief that problems are "treasures" and that you will go to the "gemba" (i.e., the actual workplace) to see the actual situation for understanding.

1. Lean Principles

The five-step thought process for guiding the implementation of lean techniques is easy to remember, but not always easy to achieve:

a. Specify value from the standpoint of the end customer by product family.
b. Identify all the steps in the value stream for each product family, eliminating whenever possible those steps that do not create value.
c. Make the value-creating steps occur in tight sequence so the product will flow smoothly toward the customer.
d. As flow is introduced, let customers pull value from the next upstream activity.
e. As value is specified, value streams are identified, wasted steps are removed, and flow and pull are introduced, begin the process again and continue it until a state of perfection is reached in which perfect value is created with no waste.

Lean practices are the actions that enable the lean process. They are tactical. Improvements are the result of their repeated execution. Examples of lean practices are many and include the 5S model, standardization, visual management, and problem solving.

L. Performance Improvement Link With Organizational Goals

ECH's Performance Improvement & Patient Safety Plan focuses on specific quality measures in three areas: quality/safety, service and efficiency. For FY 2018 and FY 2019 the Organizational Goals are:

FISCAL YEAR	QUALITY	SERVICE	EFFICENCY	PEOPLE
FY 2018	HAI's CAUTI,CLABI, C. Diff SIR (standardized infection ratio)	HCAHPS: Rate the Hospital	ALOS/GMLOS (Medicare)	N/A
FY 2019	Mortality Index (Observed/Expected Readmission Index (Observed/Expected)	HCAHPS: Nurse Communication Responsiveness Cleanliness	Patient Throughput ED Door to Patient Floor	Employee Engagement Press Ganey Overall Engagement Score

TITLE:	Performance Improvement & Patient Safety Plan
CATEGORY:	Administration
LAST APPROVAL:	

M. Commitment to Person-Centered Care

ECH has embraced Person-Centered Care and believes that its goal is to create partnerships among health care practitioners, patients and families that will lead to the best outcomes and enhance the quality and safety of health care. As a result, ECH has implemented a Patient and Family Advisory Council as a formal mechanism for involving patient and families in performance improvement efforts, policy and program decision making. The patient and family advisors act as champions of the ideal patient experience, and ensure its implementation across ECH. They are involved in reviewing communication to patients and families to ensure that it builds on patient and family strengths and engages them in a partnership in health care services and serve as members of some hospital committees. As needed, the advisors make recommendations to senior leaders for improvements in service quality.

N. Allocation of Resources

The CEO and the Executive Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Hospital Quality Council, the Medical Staff Quality Council, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization shall allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities shall be supported through monies allocated for education. Budgetary planning shall include resources for effective information systems, when appropriate.

O. Confidentiality

The Performance Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Performance Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information shall be presented so as to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the Performance Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Clinical Effectiveness Department and the Medical Office and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Sr. Director/Chief Quality Officer or the Compliance Officer.

TITLE:	Performance Improvement & Patient Safety Plan
CATEGORY:	Administration
LAST APPROVAL:	

P. Annual Evaluation

The Sr. Director/Chief Quality Officer shall coordinate the annual evaluation of the program and written plan for submission to the Medical Staff Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address the program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program shall also be addressed.

Modifications shall be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Medical Staff Quality Council, Medical Executive Committee, and the Governing Board.

IX. Cross References:

1. Management of Serious Safety Events and Red Alert Procedure
2. Medical Staff Peer Review Policy

X. APPROVAL:

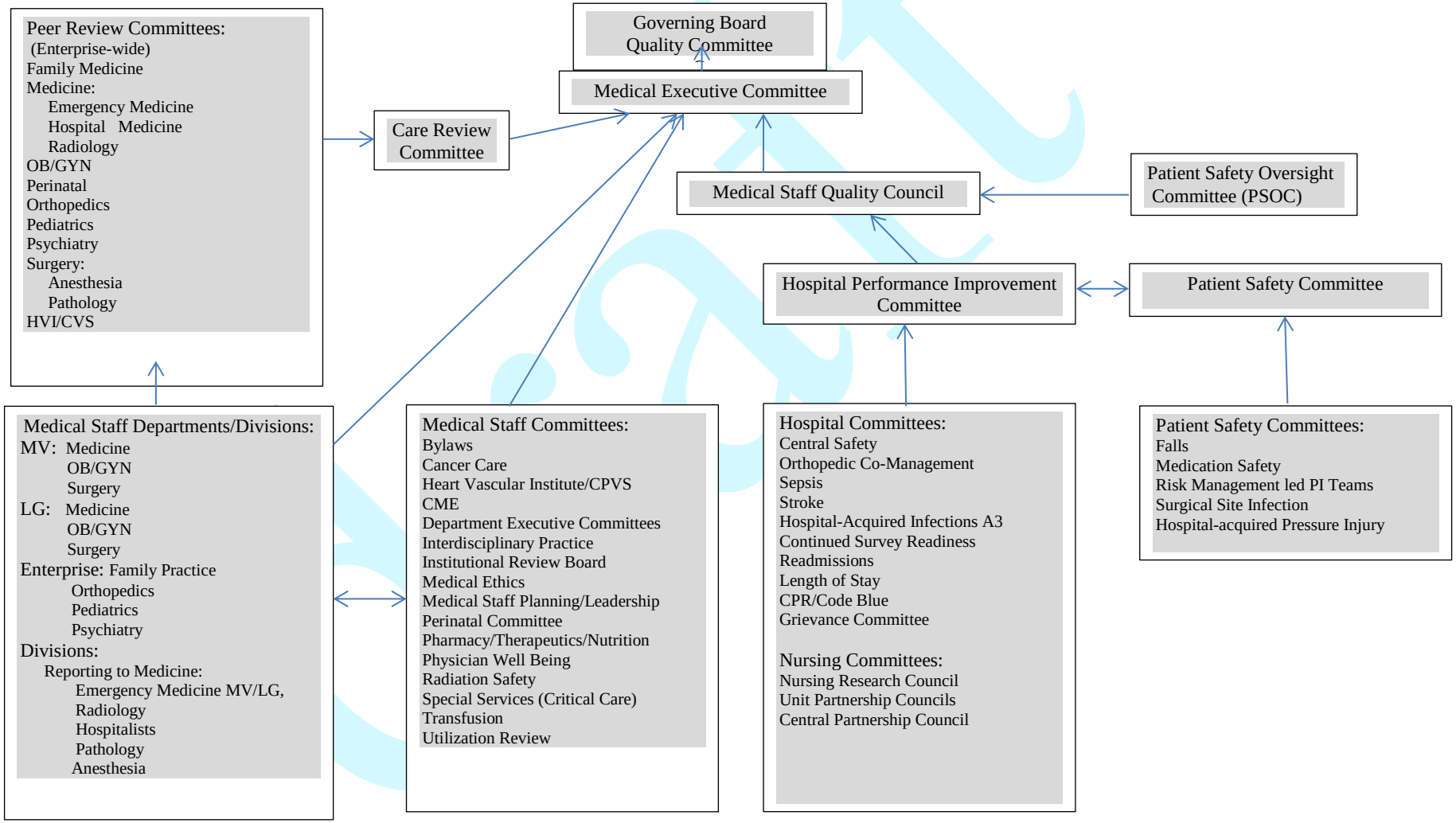
APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
Performance Improvement/Patient Safety Committee:	5/2018
Medical Staff Leadership/Planning Committee:	5/2018
ePolicy Committee:	5/2018
Medical Executive Committee:	5/2018
Board of Directors:	
Historical Approvals:	

XI. ATTACHMENTS:

Appendix A – Performance Improvement & Patient Safety Plan – Flow of Information
Appendix B – External Regulatory Compliance Indicators/Measures
Appendix C – El Camino Hospital Data Registries – May 2018

PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN

APPENDIX A – Flow of Information



APPENDIX B

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES

Indicator Name	Regulatory Source
Clinical Core Measures: Chart Abstracted and Electronic eCQMs • ED-1b- Median time ED arrival to ED Departure for admitted pts. • ED-2b – Admit decision time to ED Departure time for admitted pts. • IMM-2 – Influenza Immunization • PC-01 – Elective Delivery • PC-02 - Cesarean Section • PC-03 – Antenatal Steroids • PC-04 – Hospital-associated blood stream infection - newborn • PC-05 – Exclusive breast milk feeding • HBIPS-2 – Physical Restraints • HBIPS-3 - Seclusion • HBIPS-5- Pts. discharged on multiple antipsychotic medications • Sep-1 – Sepsis Perfect care • VTE-6 – Hospital-acquired preventable venous thromboembolism • VTE-1- VTE prophylaxis for adult patients • VTE-2 –VTE prophylaxis for critical care patients	CMS Hospital IQR Program
Use of Blood and Blood Components	TJC Medical Staff Standard 05.01.01 EP 5
Operative and other procedures	TJC Medical Staff Standard 05.01.01 EP 6
Appropriateness of clinical practice patterns	TJC Medical Staff Standard 05.01.01 EP 7
Review of Autopsies	TJC Medical Staff Standard 05.01.01 EP 9
Patient Perception of Quality of Care – via HCAHPS	TJC Performance Improvement Standard 01.01.01 EP 16 & Hospital Value Based-Purchasing Program (VBP)
Significant discrepancies between preop and postop diagnosis	TJC Performance Improvement Standard 01.01.01 EP 5
Transfusion Reactions	TJC Performance Improvement Standard 01.01.01 EP 8
Results of Resuscitation	TJC Performance Improvement Standard 01.01.01 EP 11
Significant medication errors and adverse drug reactions	TJC Performance Improvement Standard 01.01.01 EP 11 & 14
National Patient Safety Goals	TJC National Patient Safety Goals 01.01.01 – 1501.01 & UP standards
Hospital-acquired Infections and Conditions	CDC for National Safety Health Network, Hospital Value Based-Purchasing Program (VBP) and CDPH
Mortality	Hospital Value Based-Purchasing Program (VBP)
Patient Safety Indicators	AHRQ Patient Safety Indicators
Readmission	CMS Hospital Readmissions Reduction Program (HRRP)

El Camino Hospital Data Registries – May 2018			Appendix C			
#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	ICD RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Establishes a national standard for understanding treatment patterns, clinical outcomes, device safety and the overall quality of care provided to implantable cardioverter defibrillator (ICD) patients.	Performance: Composite: Discharge Medications (ACE/ARB and beta blockers) in Eligible ICD Implant Patients; Indication: Proportion of patients that receive an ICD for class I, IIa, or IIb guideline indications; Outcome: Risk Adjusted Complications (All implants)	HVI	Quarterly
2	CathPCI Registry®	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90' . Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all patients)	HVI	Quarterly
3	ACTION Registry®–GWTG™	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI process performance: Overall AMI performance composite; STEMI performance composite; NSTEMI performance composite	HVI	Quarterly
4	ACC Patient Navigator Program Focus MI	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	This is a national program specifically designed to enhance the care and outcomes for myocardial infarction patients.	National benchmarks, with comparison data to reduce AMI patient readmission for quality improvement project	HVI	Quarterly
5	STS/ACC TVT RegistryTM	STS (Society of Thoracic Surgeons) ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)– Median Post Procedure (days) and outcome (TAVR & MitraClip): Mortality Rate – In Hospital Observed (UNADJUSTED)	HVI	Quarterly
6	LAAO RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per FDA indications; Proportion of LAAO procedures successful and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
7	AFib Ablation RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures.	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
8	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for isoCABG, isoAVR and MV repair. Composite quality rating (star rating) for isoCABG, and isoAVR	HVI	Quarterly
9	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly
10	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDIF; MRSA; CRE; VRE Device Associated Surveliace: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP Influenza Vaccination Data	Quality; Nursing EW&HS	monthly Yearly
11	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards.	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
12	Get With The Guidelines (GWTG) - Heart Failure	American Heart Association	Promoting consistent adherence to the latest scientific treatment guidelines.	Heart failure education patient care: adherence to guideline rate and mortality	HVI	Yearly
13	PVI RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Provide national banchmarks and risk adjusted outcome of carotid artery stent, carotid endarterectomy and low extremity peripheral artery intervention procedures.	Assesses the prevalence, demographics, management and outcomes of patients undergoing lower extremity peripheral arterial catheter-based interventions and includes carotid artery stenting (CAS) and carotid	HVI	Quarterly
14	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
15	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality indicators	Quality; Neuro	quarterly
16	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
17	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
18	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
19	California Maternity Quality Care Collaborative (CMQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
20	California Alliance for Nursing Outcomes	CALNOC	Actionable information and reearch on nursing sensitive quality indicators	Nursing indicators	Nursing	Quarterly
21	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit leel	Nursing indicators	Nursing	Quarterly
22	National Surgical Quality Improvement Program (NSQIP)	American College of Surgeons	Leading nationally validated program to measure and improve the quality of surgical care. Provides opportunity to prevent complications, save lives, and reduce costs.	Risk adjusted, case-mix adjusted mortality and complications based on 30 day outcomes.	Quality	Rolling continuous data abstraction

23	American Joint Replacement Registry	American Joint Replacement Registry	Outcomes Joint Replacement Surgery		Ortho	Monthly
24	The Joint Commission - Disease-Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years
25	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	outcome (part of STS, no dashboard)	HVI	biannually
26	Santa Clara County-AMI	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome (part of ACTION, no dashboard)	HVI	Quarterly
27	CMS carotid stent	CMS	CMS mandate, carotid stent	indication (part of VQI-carotid stent, no dashboard)	HVI	biannually
28	National Cancer Data Base	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Date Center	Annually
29	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Date Center	Monthly
30	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
31	Hospital Based Inpatient Psychiatrics Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
32	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
33	Parkinsons Registry	California Department of Public Health			HIMS Coding	Every month
34	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Hospital Update
June 4, 2018
Mark Adams, MD, Interim CMO

Organizational Goal Update

Organizational Goals FY18	Benchmark	2017 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY18 through April	
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		1.12
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		78%
Standarized Infection Ratio (SIR)* Observed HAIs/Predicted HAIs (Hospital Acquired Infections)	External Benchmark	July- Dec 2016 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: **0.727**
Threshold Goals									
Budgeted Operating Margin*	95% Threshold	Achieved Budget	95% of Budgeted			Threshold	FY 18		Met

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

Quality and Safety

Our length of stay work continues to progress and we are still meeting maximum on the organizational goal. The steering committee is focusing on numerous approaches to improving LOS including tactics to discharge patients by 12 noon. This is a multidisciplinary approach that requires great coordination by all caregivers, patients, and families. The organizational goal to reduce hospital acquired infections continues to track well for CLABSI and C. Diff. We have been quite challenged to achieve the target for CAUTI—although performing 40% better than last year. Nursing staff and medical staff have adopted the new nurse driven protocol to allow nurses to remove foley catheters. We have seen an 8% reduction in foley catheter use so far this fiscal year.

Patient Experience

We are tracking to the organizational service goal target of 78 with a score of 77.7 for March. The patient experience team is progressing against the work plan developed by DTA including leader rounding, care team coaching, nurse communication tool kit, and supplementing Patient and Family Advisory Council (PFAC).

Financial Services

All of our Registration and Scheduling Departments are actively helping our patients enroll in myCare. Our cash collections remain strong with the team consistently reaching beyond their goal and achieving tier 3 results most of the year, which is $2.5 million or higher than goal.

As of April 24, 2018, we surpassed our cost-savings initiative goal, having implemented $5,152,788 of our $4.8 million savings challenge and cost avoidance of $328,000. The savings amount achieved is double that of the past several years' goals that ranged from $2.3 million to $2.6 million. Our reprocessing initiative has not only resulted in substantial savings which helped to reach our cost initiative goal, it also enabled us to avert 15,000 pounds from going to the landfill.

The secondary transcription platform adding iMedx to HIMs current platform is in progress with a tentative go-live date is 06/04/2018.

Operations

The CNO and other leaders are engaged in LEAN management processes on a regular basis. During the May All Leaders Meeting (ALM), senior leadership will recognize a few leaders for their ongoing commitment and valuable work to ensure meaningful outcomes for our patients by using various LEAN protocols.

During the first three quarters of FY18, every one of our service lines improved financial performance compared to the same time a year ago (7/1-3/31). Service line leaders are primarily focusing on growth, physician relations, and strategic planning, and they are also working in collaboration with department managers to reduce operating costs and make healthcare more affordable for our patients and the communities we serve.

Workforce

The Employee Transportation Strategy Task Force continues its work to develop and reassess employee transportation alternatives to mitigate travel to and from the hospital sites as well as increase recruitment and retention of our current and future workforce.

We are conducting an employee engagement "pulse" survey in May for specifically identified hospital departments; a full employee engagement survey will be conducted in the fall for all employees. The executive team recently conducted a talent review at the director level of the organization with a focus on development and succession planning.

Marketing and Communications

We launched our new creative campaign in April across all channels. Videos of the participating patients can be found at www.elcaminohospital.org/stories. In their words, these volunteer patients share their stories about why they chose El Camino Hospital and their experience.

The media covered former ECH patient Ann Marie and her marathon world record effort to benefit the NICU, El Camino Hospital's **first in the country** performance of a robotic bronchoscopy procedure to obtain a lung tissue sample, and for our renewed recognition by Human Rights Coalition as a HEI leader. We are planning and will be supporting the following events: Annual Auxiliary General Meeting, Hospital Week, Mental Health Awareness Week, Robotics Symposium, Annual Men's Health Fair, and the summer "Jazz on the Plazz" concert series.

Government and Community Relations

ECH sponsored the Silicon Valley Leadership Group's Workplace Wellness Symposium, the Family & Children's Services Circle of Support Luncheon, and a two-day Adolescent Mental Wellness Conference hosted by Stanford Children's Health. At the conference, ECH programs were presented (ASPIRE and a teen suicide prevention curriculum ECH developed and taught to students and parents in the Fremont Union High School District, which has five high schools in Cupertino, Sunnyvale and San Jose).

ECH submitted a letter opposing AB 3087 (Kalra), *California Health Care Cost, Quality, and Equity Commission,* which would create a commission to unilaterally set commercial payments to hospitals, doctors and other healthcare providers. It is estimated it would result in the loss of $18 billion dollars to California hospitals, and is opposed by a large coalition of hospitals, physician and dental groups, health plans, and business groups.

Information Services

All of our registration and scheduling departments are actively helping our patients enroll in myCare. Physician experts in the Epic system have completed individualized training and personalization sessions for identified physicians Positive feedback and requests for continued training has been received by participating physicians and measurement of improved physician efficiency is currently underway.

The Enterprise Resource Planning (ERP) system that supports supporting the Human Resources, Finance and Supply chain areas we have in place in outdated and no longer supported by the vendor. New ERPs operate in the cloud decreasing hardware and software costs for employers and providing increased business efficiency, analytics and security.
To impact cultural transformation, selection of a new cloud based ERP System for HR, Finance, and Supply Chain Management will wrap up this week with a recommendation planned for review at the next Finance Committee meeting.

Corporate and Community Health

CONCERN's CEO presented at Chevron's Medical Directors and Medical Professionals conference in San Francisco attended by over 200 professionals. The topic was EAP 2.0 Input from Silicon Valley and we described the expanded role for CONCERN:EAP in many large technology companies. A significant focus was on the digital transformation that is impacting EAPs and the top five trends.

The Community Benefit staff met with the Community Benefit Advisory Council and Board Liaisons to review and discuss the FY19 El Camino Healthcare District and El Camino Hospital grant applications. We provided sponsorships to enhance the work of the following organizations and events were attended by many Community Benefit grantees and some El Camino Hospital staff:

- Healthier Kids Foundation Symposium on the Status of Children's Health
- Uplift Family Services, supporting community mental health needs
- City of Sunnyvale senior support event
- Bay Area Older Adults
- Congregation Shir Hadash: community health fair for underserved
- Services for Brain Injury

Philanthropy

During Period 9 of FY18, the Foundation secured $390,178, bringing the total raised by the end of March to $4,959,165. We raised $39,821 in annual gifts during the month of March, bringing the total year to date to $546,595, which is 99% of goal. The donations came from Path of Hope, Circle of Caring, Healthy Giving Newsletter, an external fundraiser, and online donations.

Auxiliary

The Auxiliary contributed 7,000 volunteer hours in March 2018.