El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Monday, August 6th, 2018, **5:45 p.m.**
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Mikele Epperly will be joining via teleconference from 3252 Clay St. San Francisco, CA 94115

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER**	Dave Reeder, Quality Committee Chair		**5:45 – 5:46pm**
2.	**ROLL CALL**	Dave Reeder, Quality Committee Chair		**5:46 – 5:47**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**5:47 – 5:48**
4.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair	*public comment*	**Motion Required** **5:48 – 5:51**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (June 4, 2018) ***Information*** b. Patient Story c. FY19 Pacing Plan d. Progress Against FY 2018 Committee Goals			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion** **5:51 – 5:54**
6.	**FY18 QUALITY RESULTS** **a. DASHBOARD** **b. HAI A3**	Mark Adams, MD Interim Chief Medical Officer / Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **5:54 – 5:59**
7.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 7**	Mark Adams, MD Interim Chief Medical Officer / Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **5:59 – 6:14**
8.	**APPROVE COMMITTEE CHARTER** **ATTACHMENT 8**	Dave Reeder, Quality Committee Chair		**Possible Motion** **6:14 – 6:24**
9.	**CULTURE OF SAFETY DISCUSSION** **ATTACHMENT 9**	Mark Adams, MD Interim Chief Medical Officer		**Discussion** **6:24 – 6:44**

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
10. LEAN PROGRESS REPORT **ATTACHMENT 10**	Mark Adams, MD Interim Chief Medical Officer / Cheryl Reinking, RN, Chief Nursing Officer		**Discussion 6:44 – 7:04**
11. HOSPITAL UPDATE **ATTACHMENT 11**	Mark Adams, MD Interim Chief Medical Officer		**Discussion 7:04 – 7:14**
12. PUBLIC COMMUNICATION	Dave Reeder, Quality Committee Chair		**Information 7:14 – 7:17**
13. ADJOURN TO CLOSED SESSION	Dave Reeder, Quality Committee Chair		**Motion Required 7:17 – 7:18**
14. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Dave Reeder, Quality Committee Chair		**7:18 – 7:19**
15. CONSENT CALENDAR *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required 7:19 – 7:22**
Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (June 4, 2018) ***Information*** b. Quality Council Minutes (May 2, 2018)			
16. CMO Report	Mark Adams, MD Interim Chief Medical Officer		**Motion Required 7:22 – 7:27**
17. ADJOURN TO OPEN SESSION	Dave Reeder, Quality Committee Chair		**Motion Required 7:27 – 7:28**
18. RECONVENE OPEN SESSION/REPORT OUT	Dave Reeder, Quality Committee Chair		**7:28 – 7:29**
To report any required disclosures regarding permissible actions taken during Closed Session.			
19. ADJOURNMENT	Dave Reeder, Quality Committee Chair		**Motion Required 7:29 – 7:30pm**

Upcoming FY19 Meetings

- 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, June 4, 2018
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder, Peter Fung, MD, Katie Anderson, Ina Bauman Julie Kliger, and Melora Simon. **Dr. Peter Fung left the meeting @ 7:22pm*	Nancy Carragee, Jeffrey Davis, MD, Wendy Ron and Mikele Epperly.	

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 4th of June, 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 5:36 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Wendy Ron was absent for the meeting.	***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 (April 2, 2018 and April 30, 2018). **Movant:** Kliger **Second:** Simon **Ayes:** Anderson, Bauman, Fung, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly and Ron. **Excused:** None **Recused:** None	***The open minutes of the April 2, 2018 and April 30, 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 action items regarding the approval of the Medical Executive Committee's Recommendation to Uphold Medical Staff Bylaws and approval physicians' contracts.	***None***
6. LEAN PRESENTATION	Dr. Mark Adams, Interim Chief Medical Officer, provided an overview of our strategic framework in implementing Lean as our operating system to execute strategy, and further disclosed that 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. The Committee discussed the oversight of Lean Management to be within the scope of the Quality Committee and asked that they view the Strategic Deployment Room at the next meeting. They further discussed the use of A3's, how the committee can stay informed, in what matter, and how best to be useful in this deployment.	***None***
7. APPROVE FY19 COMMITTEE GOALS	Chair Reeder reviewed the Proposed FY19 Committee Goals and reminded The Committee of their decision to review CDI, Core Measure, PSI-90, Readmission, Pt. Experience (HCAHPS), ED Pt. Satisfaction twice a year and move the FY19 Quality Dashboard to a monthly review and group discussion if needed. The Committee asked for the following revisions: Goal #2 – Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the Medical Staff Department peer review and credentialing process, Goal #4 - Oversee Execution of the Patient and Family Centered Care Plan, Lean Management and Cultural Transformation Work. **Motion:** To approve FY19 Committee Goals with the above noted revisions. **Movant:** Kliger **Second:** Anderson **Ayes:** Anderson, Bauman, Fung, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly and Ron. **Excused:** None **Recused:** None	***The FY19 Committee Goals with the requested revisions were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
8. APPROVE FY19 PACING PLAN	Chair Reeder reviewed the proposed FY19 Pacing Plan. Feedback from the Committee included reduction of items included in the Quality Committee agendas in order to allot more time for discussion of key items.	***None***
9. 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). She further reviewed the new people goal and the updated metrics associated with each goal. Mrs. Reinking asked for feedback and questions from the Committee and a brief discussion ensued. Dr. Teagle noted the lack of Physician Engagement goal on the FY19 organizational goals and Dr. Adams agreed to address this at a later date. **Motion:** To approve FY19 Organizational Goals for recommendation for Board approval. **Movant:** Kliger **Second:** Fung **Ayes:** Anderson, Bauman, Fung, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly and Ron. **Excused:** None **Recused:** None	***The FY19 Organizational Goals were approved for recommendation to the Board.***
10. FY18 QUALITY DASHBOARD	Cheryl Reinking, Chief Nursing Officer, provided the Committee with a snapshot of the monthly metrics/trends and compared these actual results from FY2017 to the FY 2018 goal. She further noted that we have had 5 consecutive months of zero CLABSI (Jan-April 2018), 2 of last 3 months of zero CLABSI (Jan. & March), Sepsis Core measure compliance improved to 88%, and HCAHS Top Box improved to 80.7.	***None***
11. DRAFT FY19 QUALITY DASHBOARD	Dr. Adams presented the draft FY19 Quality Dashboard to the Committee and noted that the dashboard reflects all of hospital's FY 2019 Quality, Efficiency and Service Goals to include a continuation of the FY 2018 HAI Quality and Efficiency Goal metrics, and that the sepsis metric has been changed to Sepsis Mortality Index. Dr. Adams asked for feedback and questions from the Committee and a brief discussion ensued.	***The FY19 Quality Dashboard was approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	The Committee asked for exception reporting of both good and bad outcomes. **Motion:** To approve FY19 Quality Dashboard **Movant:** Simon **Second:** Bauman **Ayes:** Anderson, Bauman, Fung, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly and Ron. **Excused:** None **Recused:** None	
12. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Mrs. Reinking provided an overview of the Nursing Communication Toolkit that has been executed per the Patient Experience Roadmap. She shared the Nursing Communication--Listening Carefully HCAHPS scores and explained the results in comparison to the implementation of the Nursing Communication Toolkit. Mrs. Reinking asked for feedback from the Committee and a brief discussion ensued.	***None***
13. READMISSION DASHBOARD	Dr. Adams presented the readmission dashboard to the Committee and noted that 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. He further explained the methodology of the dashboard and asked the Committee for feedback. A brief discussion ensued. The Committee asked to review the Service Line Quality Dashboards at the next meeting.	***None***
14. PERFORMANCE IMPROVEMENT & PATIENT SAFETY PLAN	Dr. Adams provided the Performance Improvement & Patient Safety Plan which 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 to the Committee and asked for feedback. Dr. Adams asked for feedback and questions from the Committee and a brief discussion ensued. **Motion:** To approve the Performance Improvement & Patient Safety Plan for recommendation to the Board of	***The Performance Improvement & Patient Safety Plan was approved for recommendation to the Board of Directors.***

Agenda Item	Comments/Discussion	Approvals/Action
	Directors. **Movant:** Simon **Second:** Anderson **Ayes:** Anderson, Bauman, Fung, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly and Ron. **Excused:** None **Recused:** None	
15. HOSPITAL UPDATE	Dr. Adams provided a brief hospital update to the committee members as further detailed in the packet with the Committee.	***None***
16. PUBLIC COMMUNICATION	None.	***None***
17. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:30 pm. **Movant:** Anderson **Second:** Simon **Ayes:** Anderson, Bauman, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly, Fung and Ron. **Excused:** None **Recused:** None	***Adjourned to closed session at 7:30 pm.***
18. AGENDA ITEM 20: ADJOURNMENT	The meeting was adjourned at 7:31pm. **Motion:** To adjourn at 7:31 pm. **Movant:** Kliger **Second:** Simon **Ayes:** Anderson, Bauman, Kliger, Reeder, and Simon. **Noes:** None **Abstentions:** None **Absent:** Carragee, Davis, Epperly, Fung and Ron. **Excused:** None **Recused:** None	***Meeting adjourned at 7:31 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

[redacted]
Sent: Saturday, July 21, 2018 3:44 PM
To: Patient Experience
Subject: amazing birth experience at El Camino Los Gatos

Hello,

I wanted to share some positive feedback on the amazing care I received during birth and recovery at El Camino Hospital Los Gatos on Feb 2-5, 2018. The L&D and recovery nursing teams are truly best-in-class, and I am so grateful for every single one of the wonderful nurses who cared for me during my stay.

My birth experience was everything I could have hoped for, thanks to my amazing nurse Alice and midwife Maria. Alice was the perfect balance of attentive to our needs and respectful of our privacy. Alice actually HELD the fetal monitor delicately and discreetly against my stomach for 15 minutes during transitional labor to avoid disrupting my focus, and allowed me to climb up onto the bed and deliver on all fours without saying a word! I felt so safe and comfortable in her presence. Maria was wonderful as always, with such calmness and supportiveness of my natural labor goals.

24 hours later I unfortunately developed a serious reaction, with lip/hand swelling and hives (likely due to the antibiotic IV or a postpartum hormone imbalance). Despite the severity of the situation, the nursing staff stayed amazingly calm, stabilized my condition quickly and conservatively with Benadryl, and recruited the anesthesiologist to gently find my vein in my extremely swollen wrist for a steroid IV treatment -- all while preventing any disruption to the breastfeeding process or bonding with my baby.

I especially appreciated my night-shift nurse Ferieann -- her kind, sweet demeanor and gentle reassurance were such a blessing. And in the midst of my swelling & hives, my baby was diagnosed with jaundice! Ferieann calmly and objectively walked me through my options to accept or decline formula supplementation -- options that I was relieved to know I even had, and which enabled me to make the best choice for my baby's health.

This hospital truly prioritizes not only a healthy birth outcome, but also an incredible experience for both mom and baby during those first precious days...and your amazing nursing staff is central to making that all happen. El Camino Los Gatos is truly the best place to have a baby!

[redacted]

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. FY19 Quality Dashboard 5. Hospital Update 6. Serious Safety/Red Alert Event as needed Special Agenda Items 1. FY18 Quality Dashboard Results 2. Approve Committee Charter 3. Culture of Safety Discussion 4. LEAN Progress Report	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. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Annual Patient Safety Report 4. Delegation of Authority to the Advisory Committees 5. FY18 Quality Dashboard Final Results
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. Mortality and Readmissions Metrics (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. Mortality and Readmissions Metrics (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. Mortality and Readmissions Metrics (FY19 Quality Goals) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Approve FY20 Pacing Plan

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY18 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

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

STAFF: **Mark Adams, MD**, Interim 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, 3rd and 4th quarter reviewed quality dashboard including standardized infection ratios

SUBMITTED BY:

David Reeder **Chair**, Quality Committee

Mark Adams, MD **Executive Sponsor**, Quality Committee

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

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality, Patient Care and Patient Experience Committee August 6, 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 June 2018 ECH and ECHD Board Actions	

ECH Board Actions*

1. June 13, 2018
    a. Approved the following Finance Committee Recommendations:
        i. FY 18 Period 9 and 10 Financials
        ii. Proposed FY19 ECH Capital and Operating Budget
        iii. $9.6 million Purchase of Enterprise Resource Planning System
        iv. Revised Charity Care Policy
        v. Medical Director Agreement Renewals
    b. Approved the following Governance Committee Recommendations:
        i. Guidelines for Communication with Staff
        ii. FY19 Board Goals
        iii. FY19 Master Calendar
        iv. FY19 Advisory Committee Goals
        v. Revised Governance, Compliance and Audit, and Executive Compensation Committee Charters
        vi. FY19 Slate of Advisory Committee Chairs and Members
    c. Approved the FY19 ECH Community Benefit Plan awarding a total of $3,565,000 in funding to 49 grantees
    d. Approved Revised Executive Compensation Policies in accordance with previously approved delegation of authority to the Executive Compensation Committee
    e. Approved FY19 Auxiliary Slate of Officers

ECHD Board Actions*

1. June 19, 2018
    a. Approved Proposed FY19 ECH Capital and Operating Budget, Consolidated, and ECHD Stand Alone Budget
    b. Approved ECHD FY 18 YTD Financials
    c. Allocated $6,174, 000 to the ECH Women's Hospital Expansion Project
    d. Approved the ECHD FY19 Community Benefit Plan – awarding $7,499,335 including awards to 54 grantees as well as sponshorships
    e. Approved Guidelines for Communication with Staff
    f. Appointed Neysa Fligor as the District Board's Liaison to the Community Benefit Advisory Council
    g. Appointed Julie Kiger as an advisor to the FY19 El Camino Hospital Board Member Election and Re-Election Ad Hoc Committee.
    h. Approved a District Director Vacancy Policy (identified as Alternative A in the Board materials)

*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:	FY18 Quality Dashboard Quality Committee of the Board Meeting Date: August 6, 2018
	Responsible party:	Mark Adams, MD, Interim CMO Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director/Chief Quality Officer
	Action requested:	For Discussion
	Background: These nine metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2018 Quality, Efficiency and Service Goals. The Sepsis metrics and Patient Falls continued from FY 2017.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide the Committee with a snapshot of the metrics monthly with trends over time and compared to the actual results from FY2017 and the FY 2018 goal. • Annotation is provided to explain actions taken affecting each metric.	
	Suggested discussion questions: 1. Zero new CAUTIs for June. This is the 3rd month for zero CAUTI's 2. One new CLABSI after 6 months with none 3. Average LOS below FY17 average since February 2018, and continues to improve 4. Data for final Organizational goal results will not be in until Mid-August.	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: FY18 Quality Dashboard	

Executive Summary of FY18 Quality Dashboard Results:

1. Patient Falls exceeded the top decile target of .74. (Many organizations have switched from tracking all falls to falls with injury which has greater patient impact.)
2. CAUTI rate has significantly declined but the FY18 target of .75 will not be achieved. (Please note that the goal is defined in terms of Standardized Infection Rate (SIR) which is only available every 6 months and is not the rate that is charted for trending.)
3. CLABSI rate continues to be low and will meet target for FY18.
4. C. diff rate is down and will most likely meet target for FY18.
5. The LOS index is very close to goal with one more month of data pending. The trend is positive.
6. While the Sepsis Core Measure (SEP-1) goal of 100% has not been met the upward trend is very positive. There is much discussion about the relevancy of this core measure as it does not correlate scientifically with improved sepsis outcomes.
7. The IV fluid within two hours is above goal which was 85%. This measure does correlate with improved sepsis survival.
8. The mortality index is did not meet the goal of 0.62. (Not sure how this was set but note that top 15-20% of hospitals are at 0.77)
9. The HCAHPS Rate Hospital score is close to goal so far with June data still pending.

Summary: FY18 goal achievement includes #3, #4, and #7. #5 and #9 are very close to goal and may exceed goal once the final data is in. #2 and #6 will not meet goal but both show a very positive trend. #1 did not meet goal and has a flat trend. #8 did not meet goal and was the only goal showing a negative trend.

El Camino Hospital
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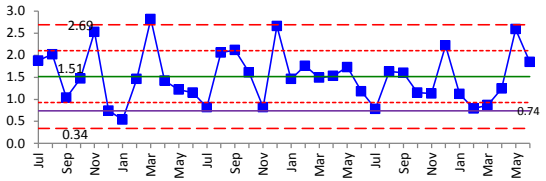
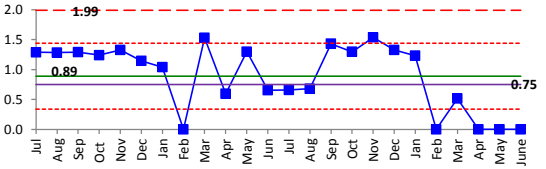
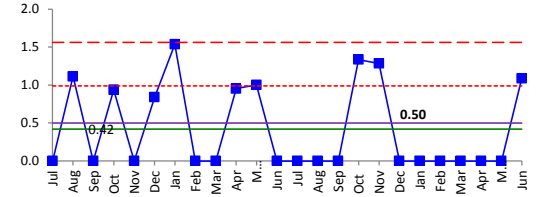
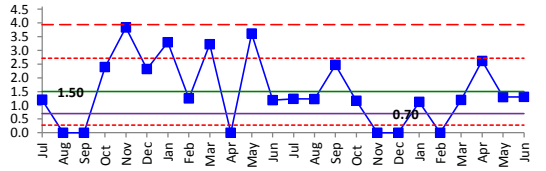
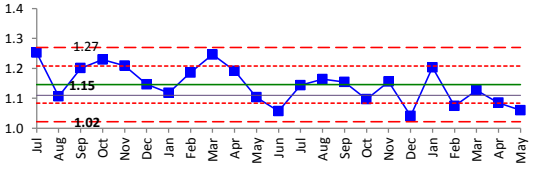
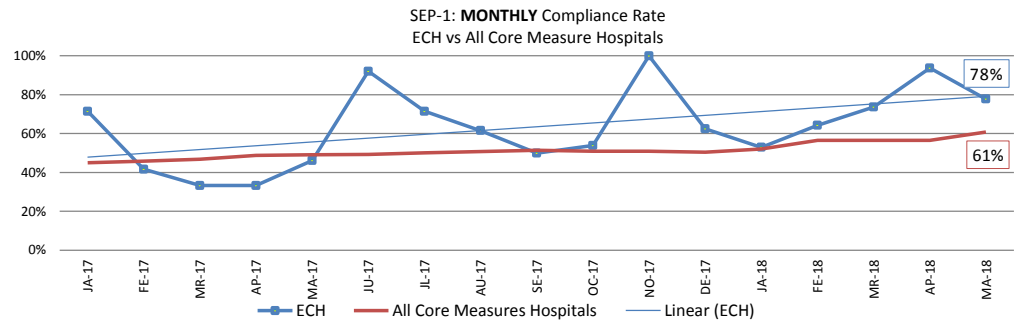
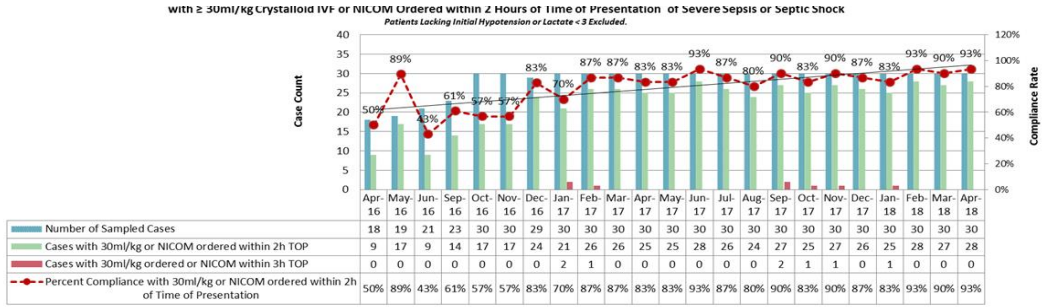
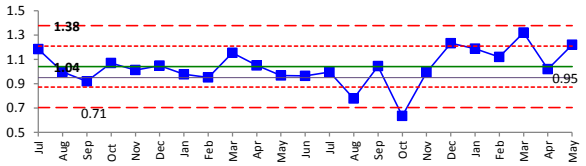
Quality and Safety Dashboard (Monthly)

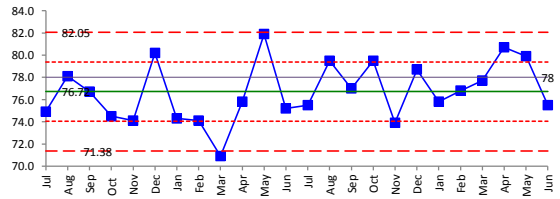
		Performance		Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS		Month	FYTD	FY2017 Actual	FY2018 Goal		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: June 2018*	1.85 (9/4875)	1.41 (89/63120)	1.49	0.74 (Top decile CALNOC)		Falls Committee increased membership of front line nursing staff and LG staff. With Employee Health, Committee is trialing a line clamp to secure IV and other lines, as both staff & pts. have tripped over lines. With fall risk tool validated, Committee members will begin monthly audits of completion of the Fall Risk Assessment.
2	*Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: June 2018* *SIR Goal: <= 0.75*	0.0 (0/919)	0.77 (13/16929)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		No new CAUTi's in June! Foley catheter days have been reduced by 29% over 2017. Each day a patient has a foley catheter increases the risk of CAUTI by 5%.
3	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: June 2018* *SIR Goal: <= 0.50*	1.09 (1/919)	0.23 (2/8635)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		1 new CLABSI in June. Young patient admitted though ED with psychiatric issues; polydypsia resulting electrolyte issues. Central line needed for hypertonic saline infusion. Pt. picked at CL dressing, was reinforced, not changed.
4	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: June 2018* *SIR Goal: <= 0.70*	1.31 (1/7662)	1.13 (11/97325)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		1 new C.Diff in June. Elderly pt. flown from Chicago by son to ECH, with history of loose stools. ED MD ordered C.Diff toxin test, was canceled by hospitalist. Could not prove C.Diff was present on admission.
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: May 2018*	1.06	1.12	1.16	1.11		Improvements in LOS continue in May with 1.06 below goal.

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: May 2018*				Non-compliance due to 2 failures; 1 - the physician focused exam completed but not in the required time frame, 2nd - Repeat Lactic acid not drawn w/i 6 hrs of Time of Presentation.
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*				TJC Sepsis Certification Survey on July 11-12, 2018. Result is 3 requirements for improvement; evaluate program patient satisfaction, provide patient education on sepsis earlier in hospital stay, one provider's license and verification was not up-to-date. Responses due w/i 60 days, Surveyor stated these findings would not prevent TJC Certification.

Mortality		Performance Month	Performance FYTD	FY 2017	FY 2018 Goal	Trend	Comments
8	***Organizational Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: May 2018*	1.22 (2.00%/1.64%)	1.06 (1.70/1.61)	1.02 (1.88%/1.83%)	0.62		Open positions in CDI affect the expected mortality rate, as CDI staff have fewer queries to physicians regardig Major Co-morbidities. May's MCC rates were reduced in May for both Medical & Surgical cases.

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: June 2018*	75.5 (216/286)	77.5 (2281/2942)	76.30	78.0%		Nursing Communication team is now focusing on Leader rounding and Purposeful rounding.

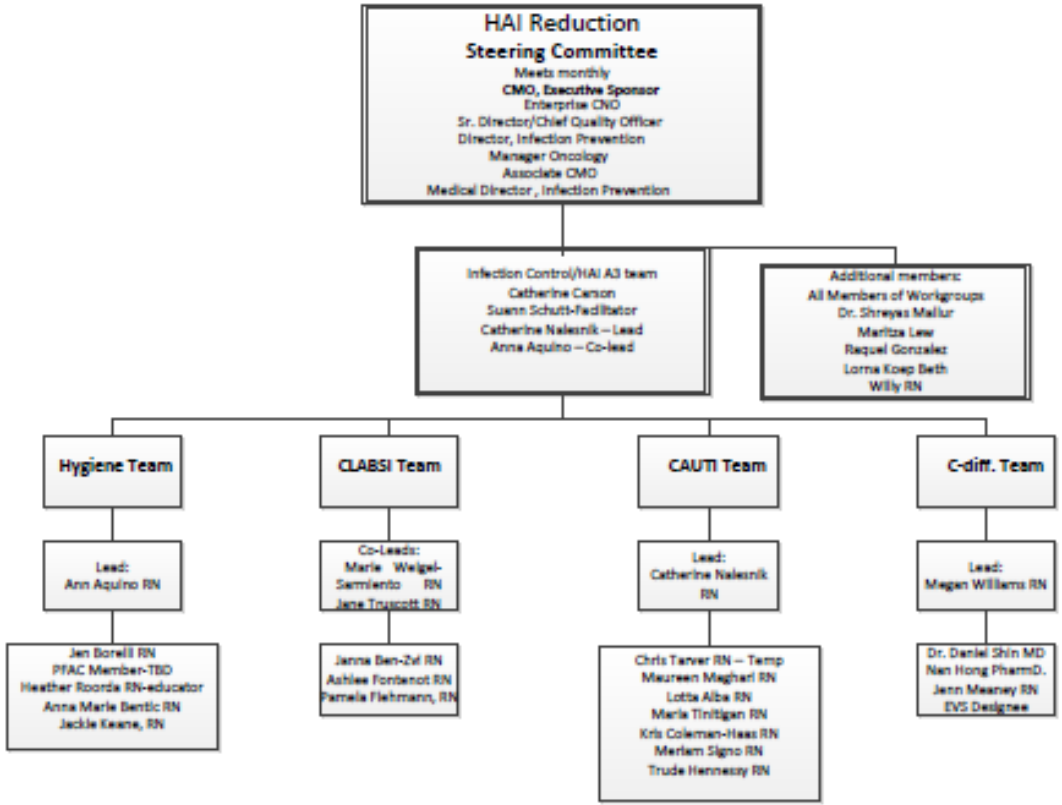
Measure Name	Definition Owner	Work Group	FY 2017 Definition	Source
Sepsis Core Measure- SEP-1: MONTHLY Compliance Rate ECH vs. All Core Measure Hospitals	Catherine Carson/Kelly Nguyen	Sepsis Steering Committee	New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate > 2 or evidence 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

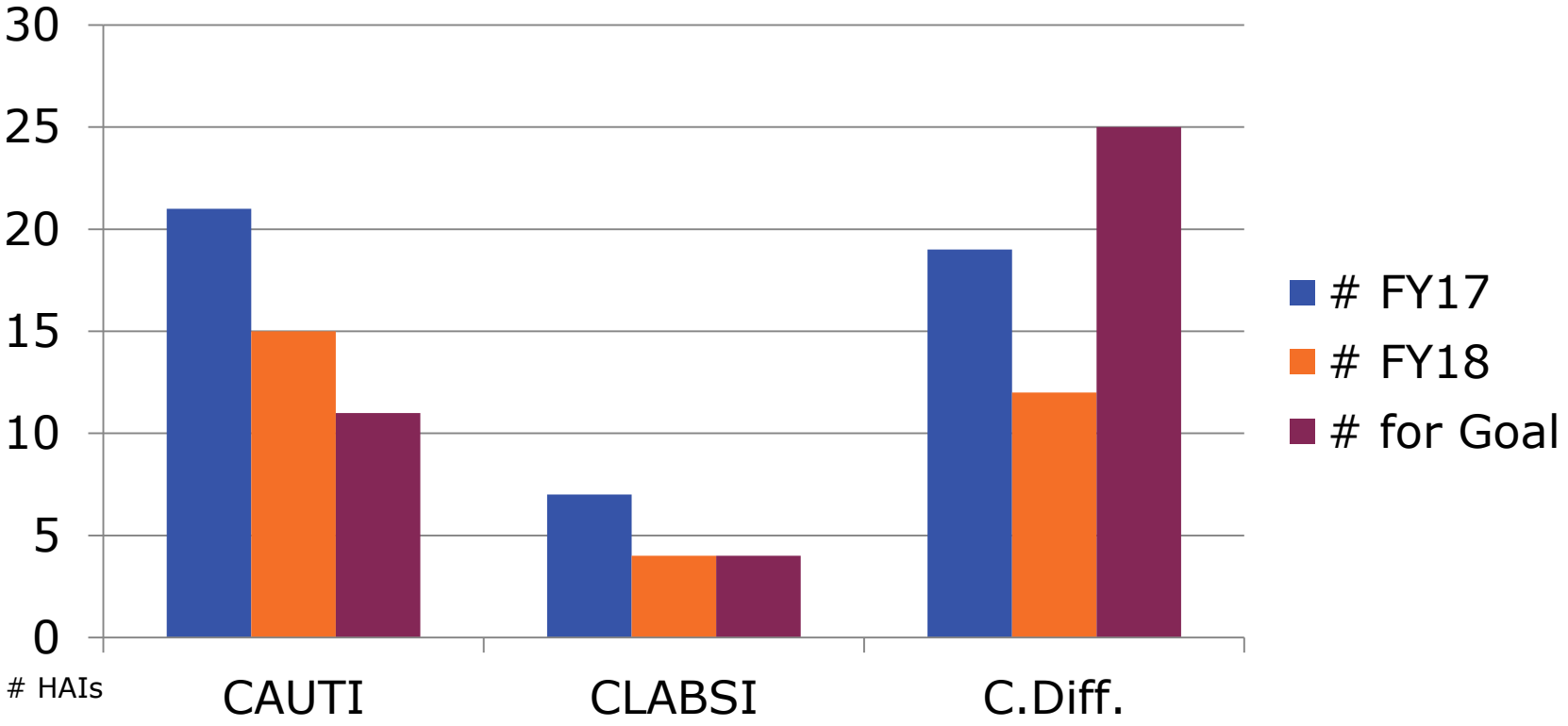
	Item:	HAI A3 Results and Accomplishments Quality Committee of the Board Meeting Date: August 6, 2018
	Responsible party:	Mark Adams, MD, Interim CMO Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director/Chief Quality Officer
	Action requested:	For Discussion
	Background: The FY17 Quality Goal was set to reduce Hospital-Acquired Infections (HAI) and it was determined that this work would focus on CAUTI, CLABSI, and C.Diff. The slides articulate the A3 – Lean structure that was developed for this work, with 4 teams meeting on a staggered bi-weekly schedule. The numbers of infections that approximate the HAI SIR (standardized infection rate) goal are included.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Review of the HAI A3 work in FY18 and some of the team's accomplishments	
	Suggested discussion questions: 1. CAUTI HAI's were reduced but did not meet the goal; which was a 50% reduction over FY 17 2. CLABSI HAI's were reduced and did meet the goal 3. C. Diff infections were reduced and exceeded the goal, which was large due the estimated # of infections from the NHSN SIR rate.	
	Proposed Committee motion, if any: None. This is a Discussion item. (OR, insert motion)	
	LIST OF ATTACHMENTS: HAI A3 results and accomplishments	

FY17 Quality Goal: Reduce Hospital-Acquired Infections

- Teams met every other week, reported to Steering Committee monthly in FY18
- Members included front line staff, managers, educators, EVS leaders, Purchasing, EPIC analysts, etc.
- To sustain gains, one HAI team to meet monthly in FY18



HAI Reduction in FY18



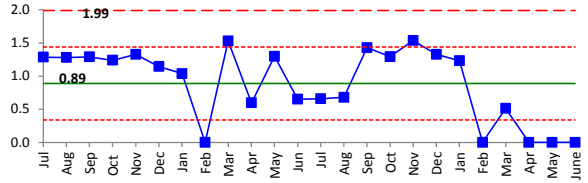
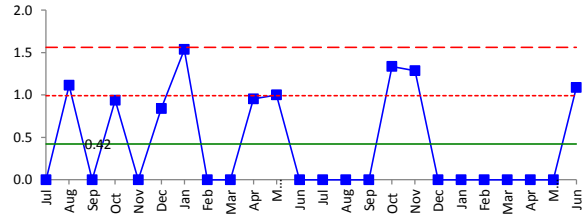
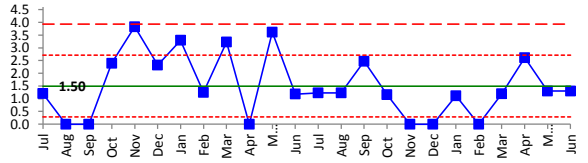
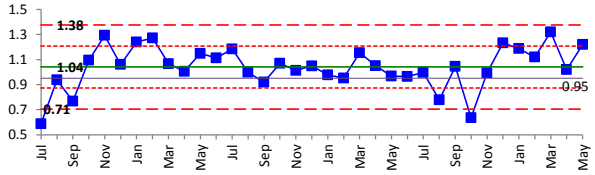
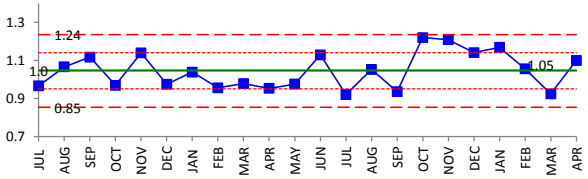
Team Accomplishments to Achieve HAI Reduction

- Implementation of a nursing standardized procedure for criteria-based foley catheter removal
- Replacement of indwelling foley catheters with external male/female collection devices
- Implementation of a new foley insertion kit with nursing competencies
- Reduction of foley catheter device days of **29%** in 2018 over 2017.
- Adoption of best practice of daily CHG baths for all central-line patients
- Use of daily bath and linen change for adequate hygiene for all patients
- Competencies for nursing staff in central line dressing changes and line blood draws
- Use of Curos caps and dialysis catheter covers in all central line and dialysis patients
- Expanded use of UV disinfection for procedure rooms, MRI & CT Scan rooms, all C.Diff discharges, OR suites and all ICU/CCU patient rooms
- Nursing EHR alert for contact isolation and soap/water hand washing with all C.Diff toxin orders
- The financial impact of the reduction of these HAIs in FY 2018 to date (May 2018) was calculated to be a minimum of $227,602.00 to a maximum of **$417,430.00.**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

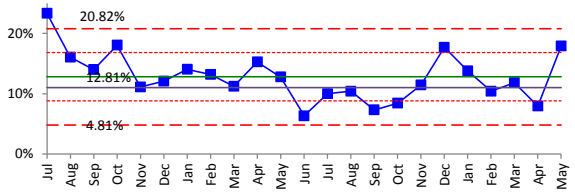
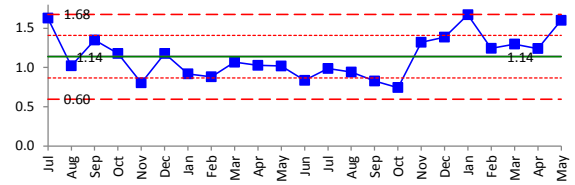
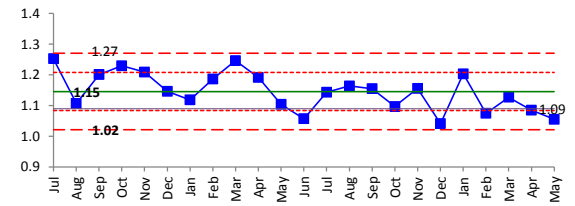
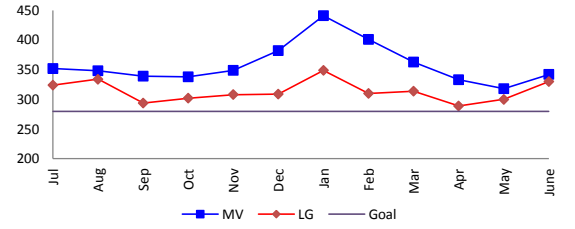
	Item:	FY19 Quality Dashboard – begins with July 2018 data Quality Committee of the Board Meeting Date: August 6, 2018
	Responsible party:	Mark Adams, MD, Interim CMO Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director/Chief Quality Officer
	Action requested:	For Discussion
	Background: These eight metrics reflect the Hospital's FY 2019 Quality, Efficiency and Service Goals and include a continuation of the FY 2018 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 FY 2019 goal. • Annotation is provided to explain actions taken affecting each metric.	
	Suggested discussion questions: 1. Continuation of metrics from FY 2018 Goals assist in oversight and sustainability a. CAUTI, CLABSI, C.Diff – the SIR goals remain the same as they reflect the 2020 targets for SIR rates from the U.S. Department of Health & Human Services. b. ALOS/GMLOS 2. Data present for trends over time, Dashboard is effective with July 2018 data, not available until mid-August.	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: Final Draft FY 2019 Quality and Safety Dashboard	

Final Draft Quality and Safety Dashboard (Monthly)

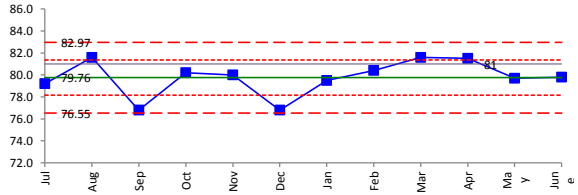
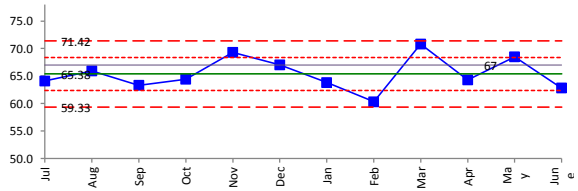
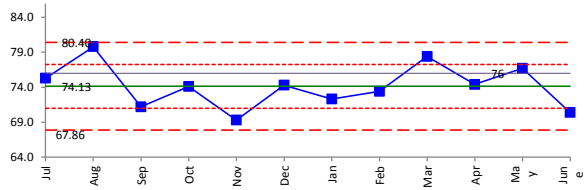
		FY18 Performance		Baseline	FY19 Goal	Trend	Comments
Quality		Month	FYTD	FY2017 Actual	FY2019 Goal		
1	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: June 2018* *SIR Goal: <= 0.75*	0.0 (0/919)	0.77 (13/16929)	1.09	SIR Goal: <= 0.75		
2	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: June 2018* *SIR Goal: <= 0.50*	1.09 (1/919)	0.23 (2/8635)	0.56	SIR Goal: <= 0.50		
3	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: June 2018* *SIR Goal: <= 0.70*	1.31 (1/7662)	1.13 (11/97325)	1.89	SIR Goal: <= 0.70		
4	*Organizational Goal **Mortality Index** *Observed/Expected* ***Premier Standard Risk Calculation Mode*** *Date Period: May 2018*	1.22 (2.00%/1.64%)	1.06 (1.70/1.61)	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: April 2018	1.10	1.08	1.02	1.05		

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		FY18 Performance Month	FYTD	FY 2017	FY 2019		
6	**Sepsis Mortality Rate Enterprise** *Date Period: May 2018*	17.91	11.52%	13.66%	11%		
7	**Sepsis Mortality Index** *(Observed over Expected)* *Date Period: May 2018*	1.60	1.20	1.05	1.14		
Efficiency		FY18 Performance Month	FYTD	FY17 Actual	FY 2019 Goal		
8	★Organizational Goal **Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: May 2018*	1.06	1.12	1.16	1.09		
9	★Organizational Goal **Patient Throughput-Average minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: June 2018*	MV: 342 mins LG: 330 mins			280 mins		

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Rate Enterprise	Catherine Carson				**Premier Quality Advisor**
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**

	SERVICE	FY18 Performance Month	FY18 Performance FYTD	Baseline Q4 FY17 + Qtrs 1,2,3 FY18	FY19 Goal FY 2019 Goal	Trend	Comments
10	«Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: June 2018*	79.8 (213/267)	79.8 (2318/2905)	80.00	81.0		
11	«Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: June 2018*	62.8 (158/252)	70.1 (1942/2769)	65.10	67.0		
12	«Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: June 2018*	70.4 (202/287)	75.4 (2276/3018)	74.50	76.0		

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
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:	Biennial Committee Charter Review Quality, Patient Care, and Patient Experience Committee August 6, 2018
	Responsible party:	Mark Adams, MD, Interim CMO
	Action requested:	Possible Motion
	Background: The Governance Committee's charter provides that it will ensure that each Board Advisory Committee reviews its Charter every other year. The Quality Committee last reviewed its Charter in April. The Governance Committee will review any proposed revisions and make a recommendation to the Board. There were some revisions to the Charter. However, there may be some proposed revisions as a result of the work being done at the April 25th Joint Board and Committee Educational Session.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
	Summary and session objectives: For the Committee to review its Charter and discuss whether (1) it is meeting the mandates of its Charter and (2) any desired changes.	
	Suggested discussion questions: 1. Are these changes consistent with the committee's recommendations?	
	Proposed Committee motion, if any: Approve the revised charter for submission to the Board for final approval	
	LIST OF ATTACHMENTS: 1. Current Committee Charter (with track changes)	

Quality, Patient Care and Patient Experience Committee Charter

Purpose

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

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

The organization will ~~measure the degree to which we have achieved high quality healthcare using the CMS value based purchasing program among other measures.~~provide to the committee standardized quality metrics with appropriate benchmarks so that the committee can adequately assess the level of quality care being provided.

Authority

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

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

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

Membership

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

Staff Support and Participation

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

General Responsibilities

The Committee's primary role is to develop a deep understanding of the organizational strategic plan, the quality plan and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop

and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for:

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

Specific Duties

The specific duties of the Quality Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (Performance Improvement & Patient Safety Plan) ~~to benchmark progress using a dashboard~~
- Review and approve an annual "Quality Dashboard" for tracking purposes
- Oversee management's development of Hospital's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services
- Review reports related to ECH-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    a. ECH-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan
    b. ECH-wide patient safety goals and hospital performance relative to patient safety targets
    c. ECH-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports and risk management reports
    d. ECH-wide LEAN management activities and cultural transformation work
    e. ECH-wide patient satisfaction and patient experience surveys
    ~~e.~~f. ECH-wide physician satisfaction surveys
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to include, but not be limited to, The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR)
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements

- Review Ssentinel Eevents (SE), Serious Safety Events (SSE), and red alerts as per the hospital and board policy
- Oversee organizational quality and safety performance improvement for both hospital and medical staff activities ~~and ensure that tactics and plans, including large-scale IT projects that target clinical needs, are appropriate and move the organization forward with respect to objectives described in the strategic plan~~
- Ensure that ECH scope of service and community activities and resources are responsive to community need.

Committee Effectiveness

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

Meetings and Minutes

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

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

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

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Culture of Safety Discussion Quality, Patient Care and Patient Experience Committee August 6, 2018
	Responsible party:	Mark Adams, MD, Interim CMO
	Action requested:	For Discussion
	Background: Many healthcare organizations are now focusing on their culture of safety as defined by the Agency for Healthcare Research and Quality (AHRQ) and supported by the Institute for Healthcare Improvement (IHI)	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide a general overview of the culture of safety as defined by AHRQ • Review our current state and progress toward becoming a high reliability organization • Engage the board to support advancing our culture of safety	
	Suggested discussion questions: 1. How can the Board support an enhanced culture of safety? 2. Does this approach to establish a strong culture of safety make sense? 3. What suggestions or insights do committee members have to enhance this journey?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: Culture of Safety	

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Culture of Safety
Quality Committee

August 6, 2018

Mark Adams
Interim CMO

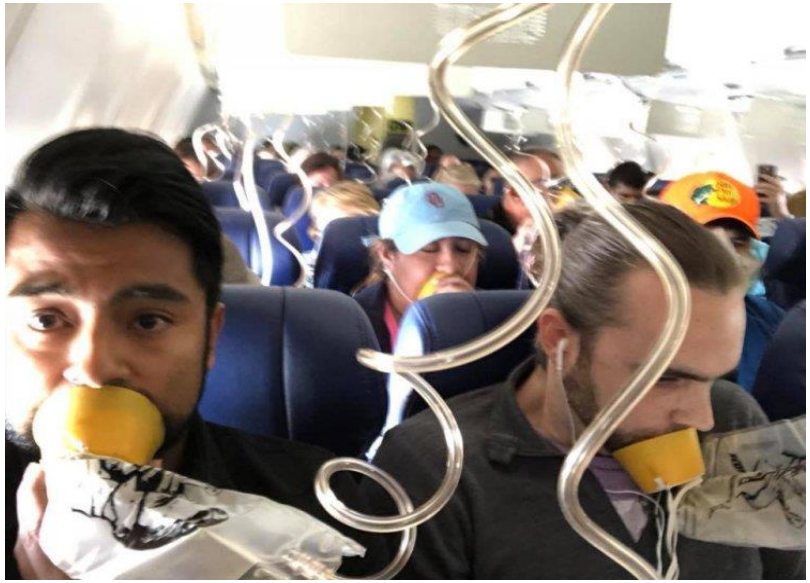
Culture of Safety

- What is it?
- Why does it matter?
- What does it look like?
- How do we get there?
- How do we measure success?

Culture of Safety

Examples from other industries:

- Aviation CRM
- Alcoa aluminum
- O-ring catastrophe



Culture of Safety

What is it?

"…healthcare professionals are held accountable for unprofessional conduct, yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near misses and prevent recurrence"

Culture of Safety

Why does it matter?

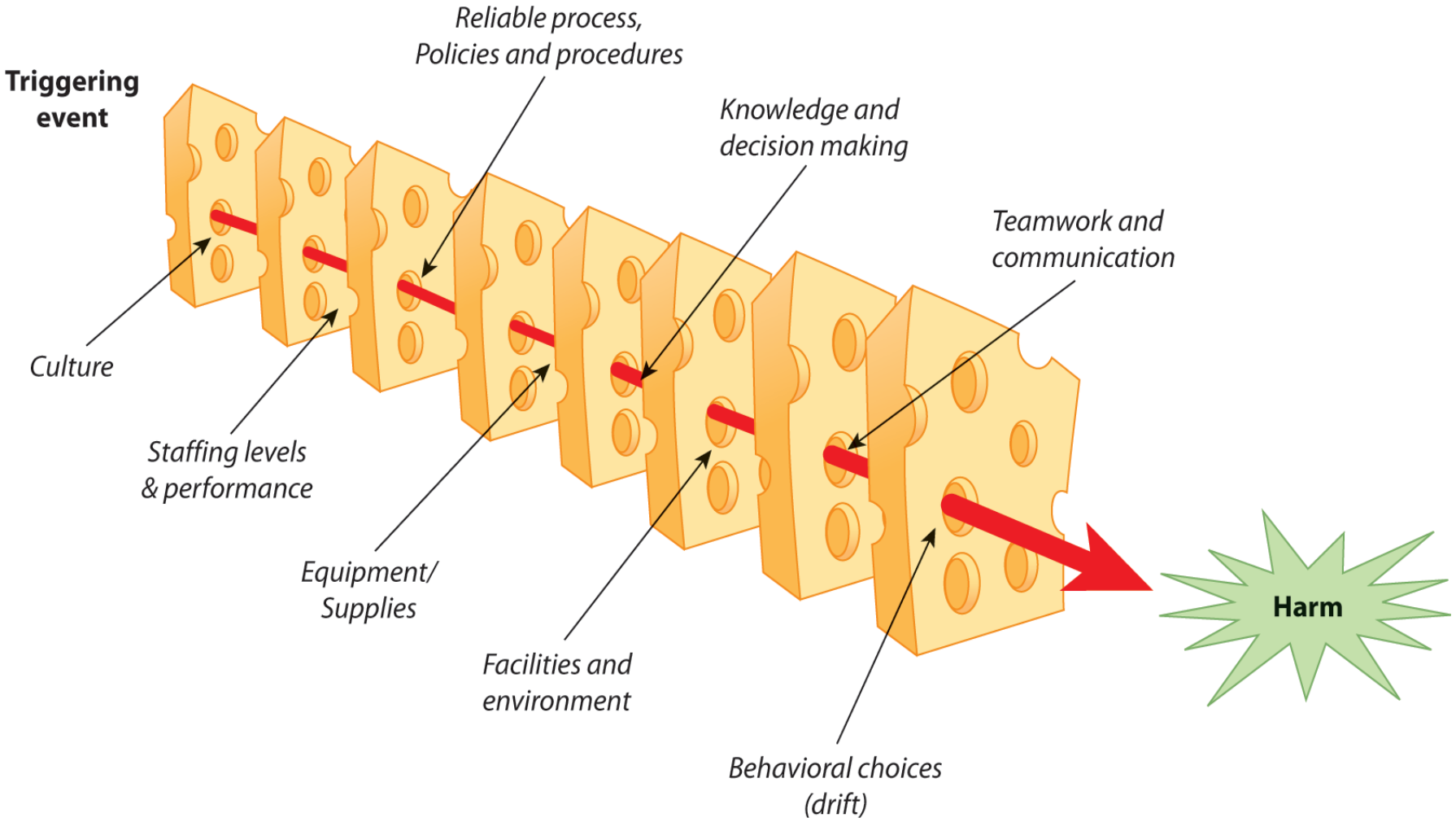
- Leading cause of death and injury
- Financial fallout
- Workforce impact

Culture of Safety: What does it look like?

Culture of Safety: How Do We Get There?

1. Establish a compelling vison for safety
2. Build trust, respect, and inclusion
3. Select, develop, and engage the Board
4. Prioritize safety in the selection and development of leaders
5. Lead and reward a just culture
6. Establish organizational behavior expectations

Culture of Safety



Source: Karen S. Frush, Steven E. Krug: *Pediatric Patient Safety and Quality Improvement*: www.accesspediatrics.com

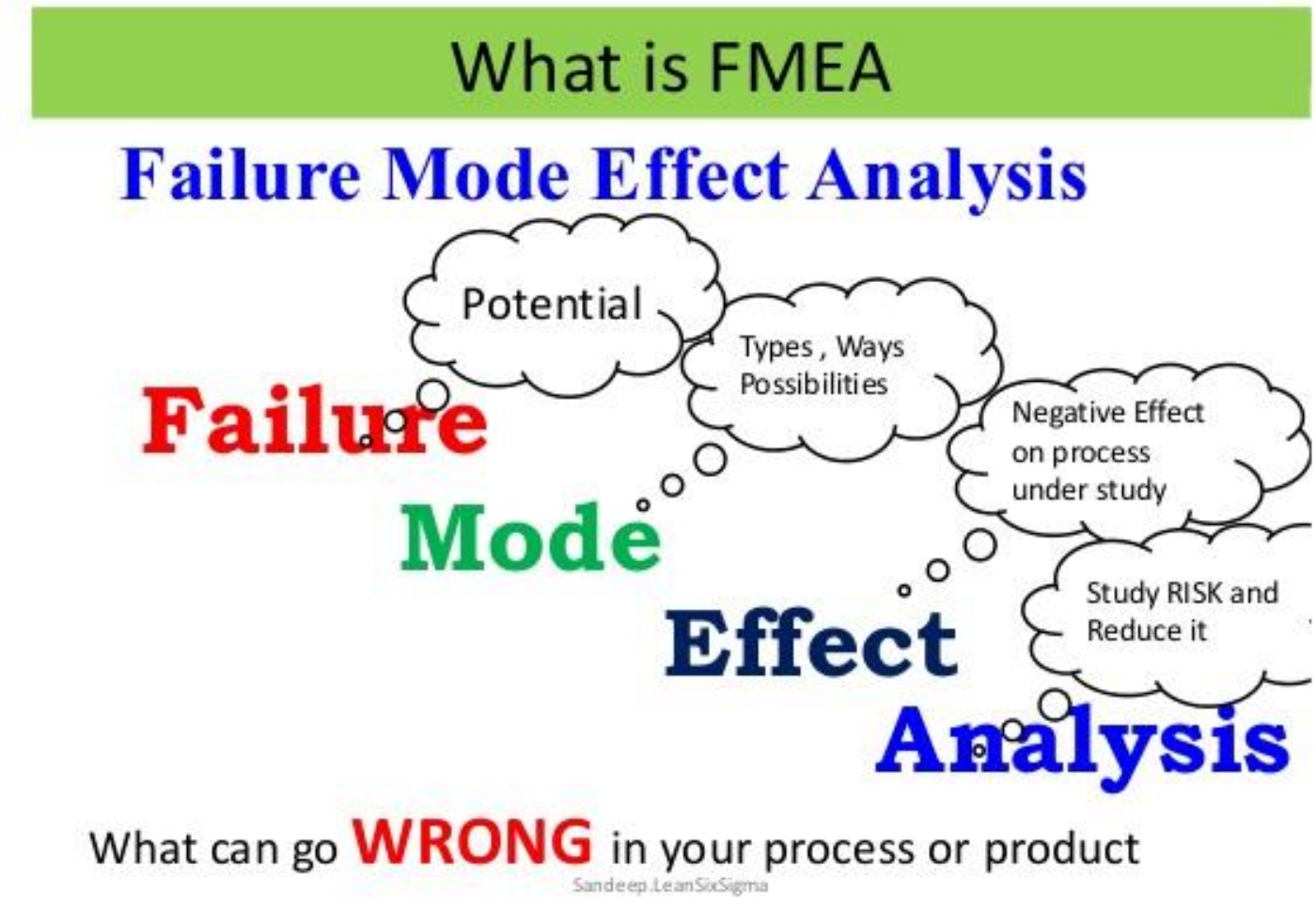
Culture of Safety

jrt CONSULTANCY TRAINING SUPPORT

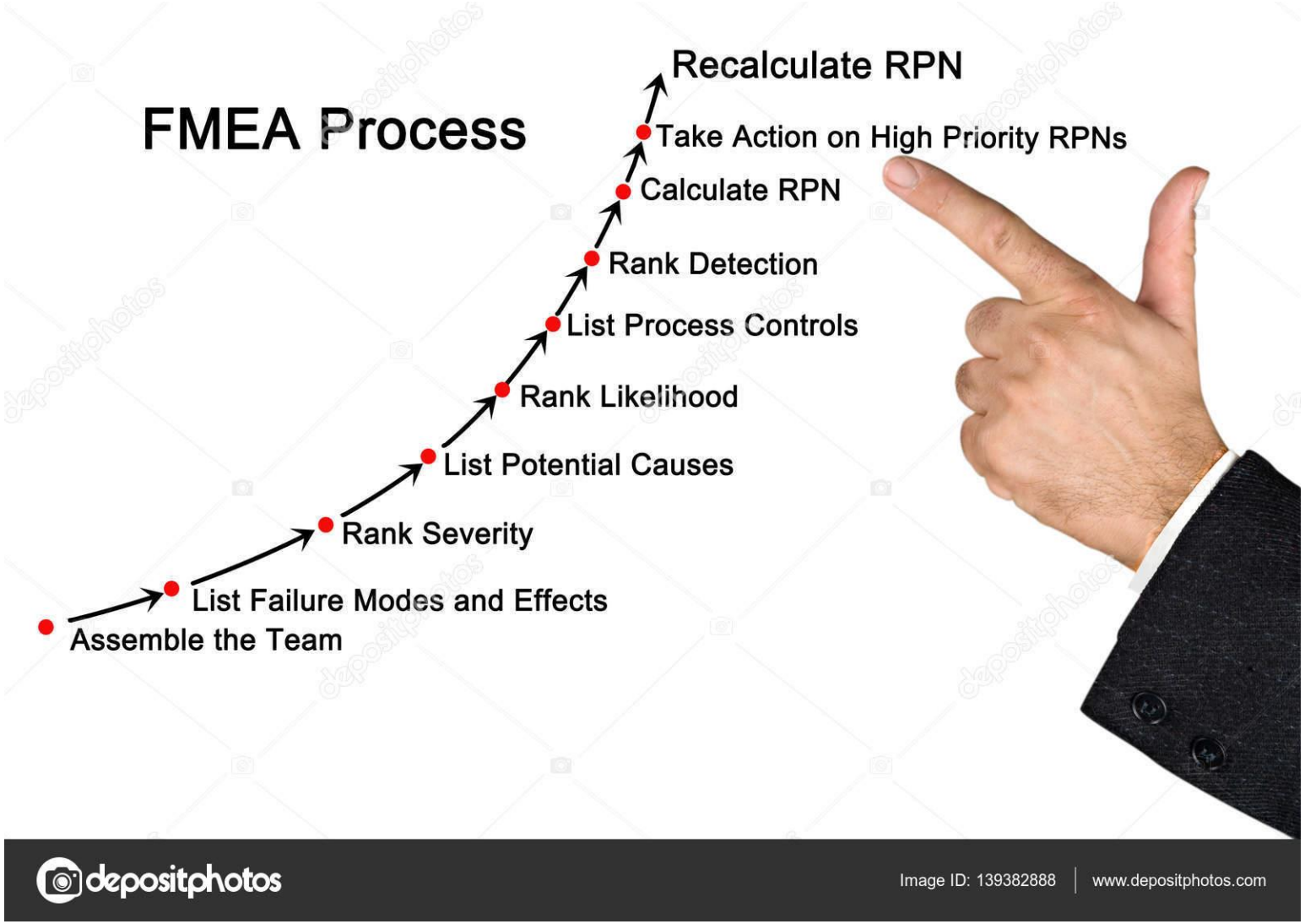
FMEA

Failure Mode Effects Analysis

Culture of Safety



Culture of Safety



Culture of Safety

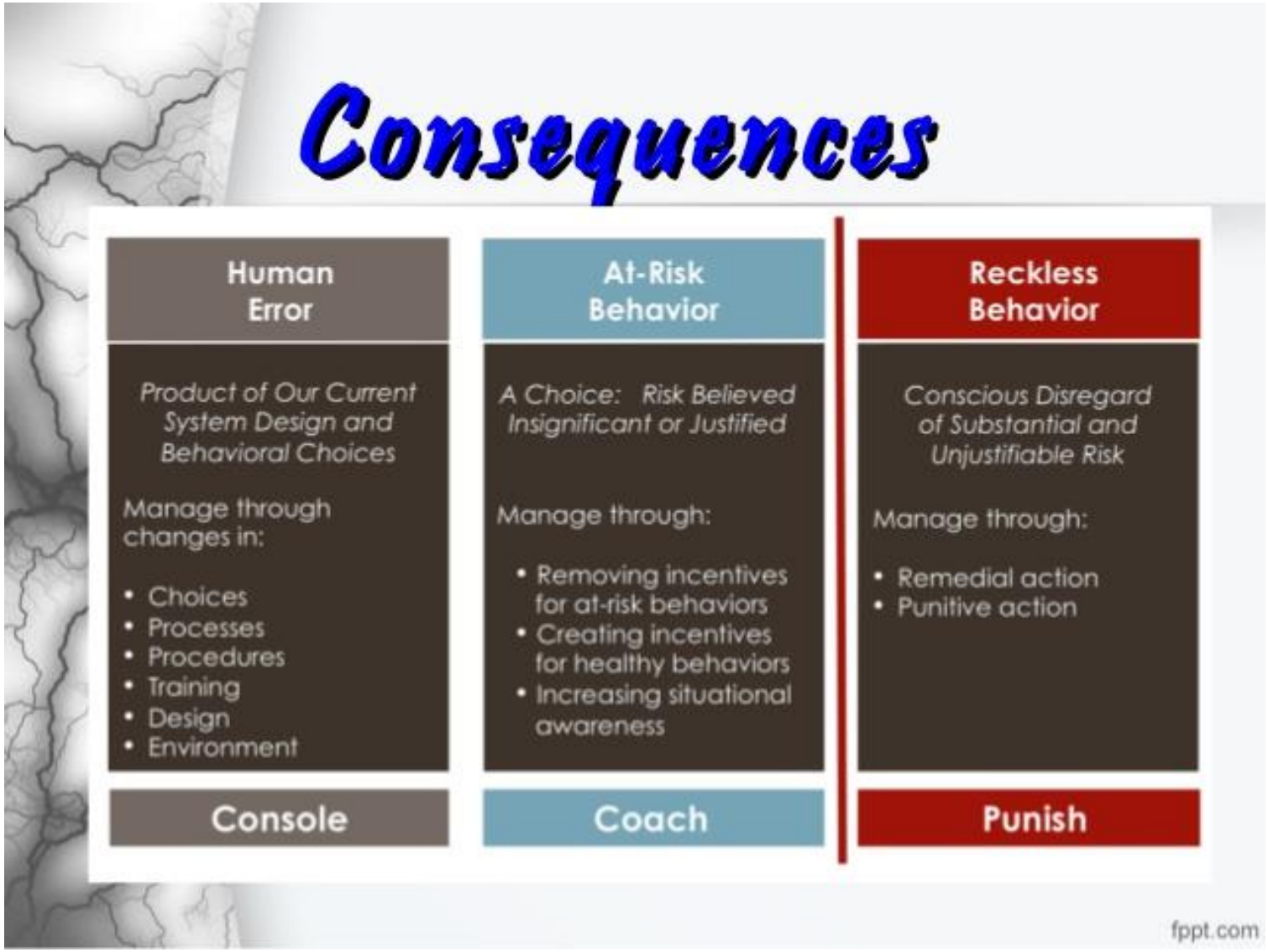
What is Just Culture

- An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour.

Culture of Safety

"Today we are going to decide who to blame."

Culture of Safety



Culture of Safety

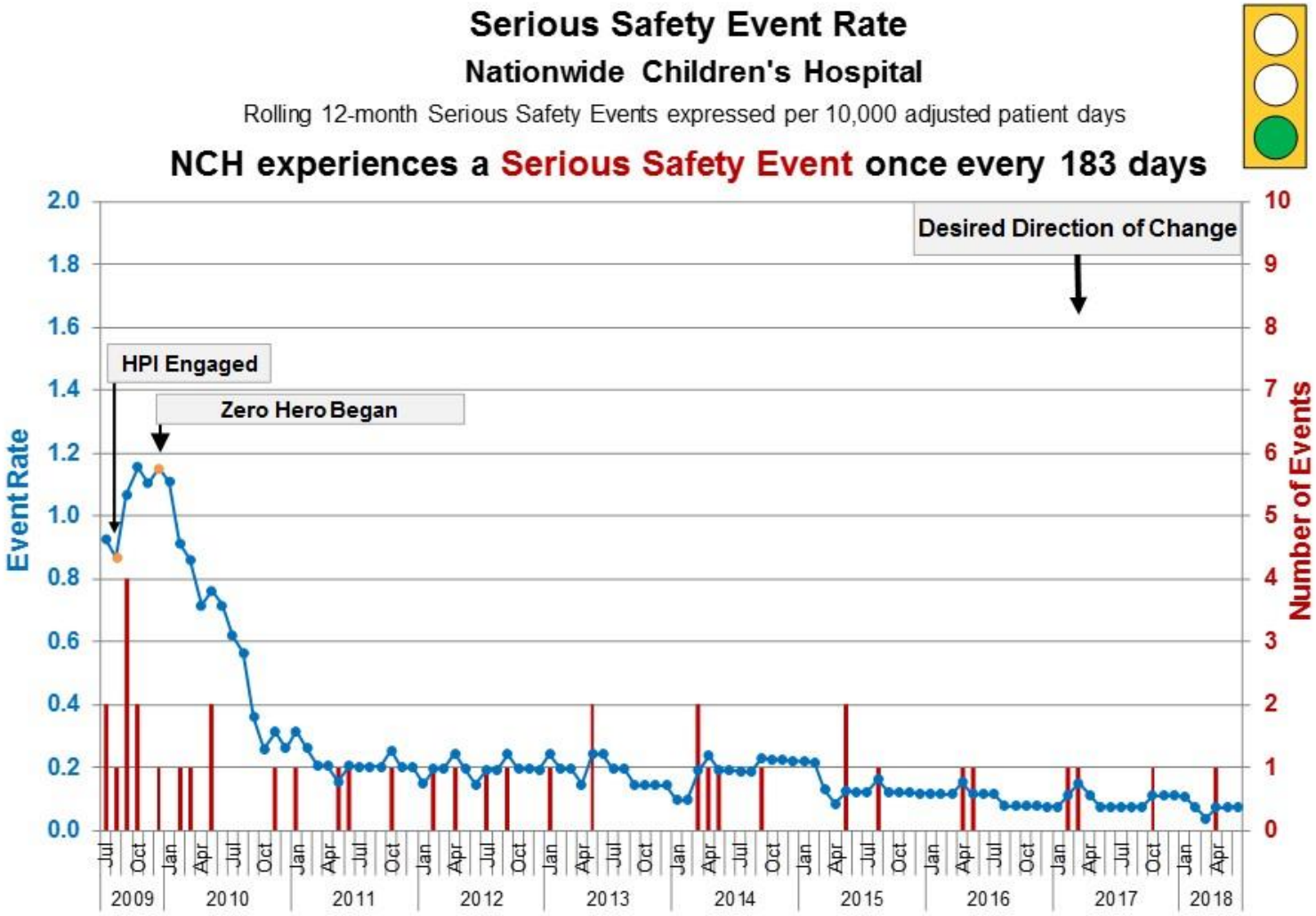
How do we measure success?

Serious Safety Event: deviation from generally accepted practice or process that reaches the patient and causes severe harm or death

Culture of Safety 2017

	Employees	Physicians
Press Ganey Safety Culture Solution Overall Score	3.83	3.81
Senior management provides a work climate that promotes patient safety	3.85	3.90
When a mistake is reported, the focus is on solving the problem, not writing up the person	3.60	3.32

Culture of Safety



Safety Culture and High Reliability Journey

January 2017	February 2017	March 2017	June 2017	August 2017	December 2017	March 2018	May 2018	August 2018	September 2018
•Patient Safety Oversight Committee established •Revision of Board Policy on Management of Serious Safety Events and Red Alerts	•Culture of Safety Introduction @ All Leaders	•Culture of Safety Survey questions embedded in Employee & Physician Engagement Survey	•Culture of Safety Summit with Dr. Bob Wachter •Libby Hoy on Patient Centered Care	•Teams established to Reduce HAIs as FY18 Quality Goal •FY17 Pain Assessment Goal sustain plan started	•ECH submitted Leapfrog Hospital Survey for 1st time	•ECH engages HPI to begin High Reliability Journey in next fiscal year	•Employee Engagement Pulse Survey •Culture of Safety questions show improvement	•HPI Safety & Reliability Culture Assessment	•Culture of Safety Survey questions embedded in Employee & Physician Engagement Survey

Culture of Safety

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Lean Progress Report Quality, Patient Care and Patient Experience Committee August 6, 2018
	Responsible party:	Mark Adams, MD, Interim CMO
	Action requested:	For Discussion
	Background: As a follow up to the overview of our introduction of lean management into the organization, the committee members requested that a progress report be delivered to the committee.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide a progress report on the application of lean management • Provide a specific example of lean management in action • Review the overall status of lean management deployment	
	Suggested discussion questions: 1. Does this progress report meet the expectations of the committee request? 2. Any thoughts or suggestions regarding the application of lean management to our organization? 3. Are there any concerns or potential pitfalls in this approach based on committee members' experiences elsewhere?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: Lean Progress Report	

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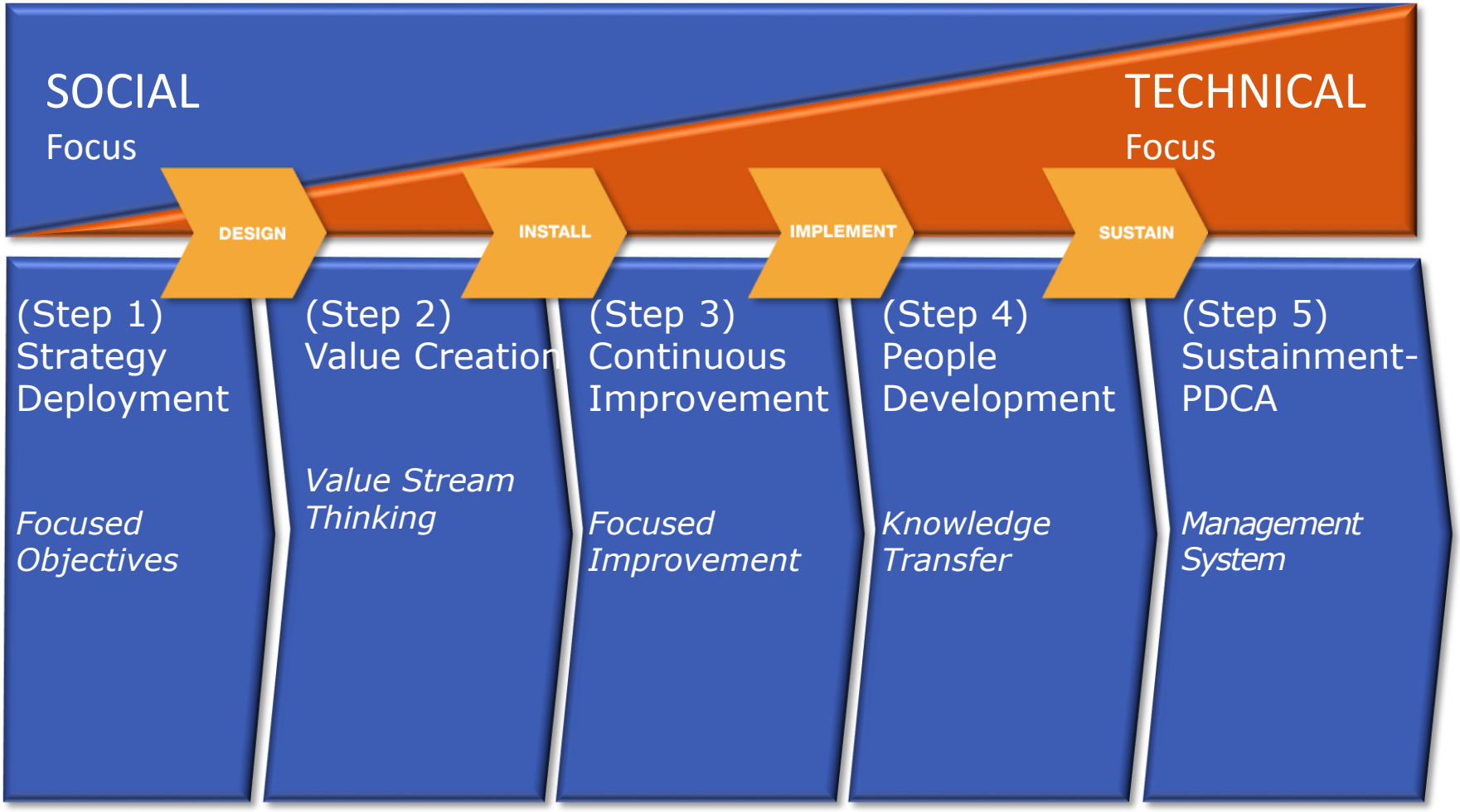
Embedding A Lean Management Culture Progress Report Quality Committee

August 6th, 2018

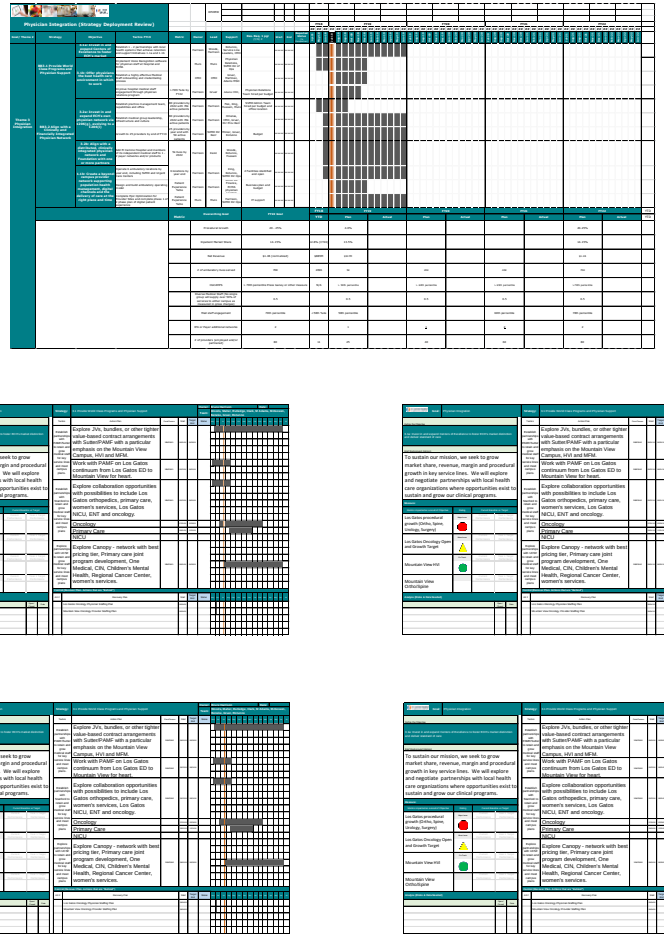
Dr. Mark Adams, Interim CMO
Cheryl Reinking, CNO

EMBED A LEAN MANAGEMENT SYSTEM

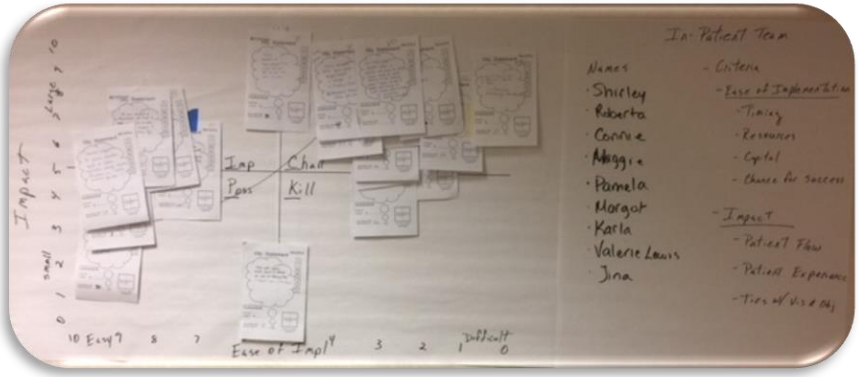


Step 1 – Strategy Deployment

- Bimonthly executive team review of progress on FY19 tactics
- Venue for tactical owners to escalate issues needing support to stay on track



Step 2 – Value Creation / "Value Stream Thinking"



Step 3 – Continuous Improvement

- Completed
  - Flow Value Stream Analysis and recommendations for improvement
- In Progress
  - Auditing of ED Standard Work supporting flow
  - Analysis of EVS transport data
  - Defining target process metrics for Door to Floor
  - Analysis of ED operational data
- Planning
  - RPIW on Direct Admissions
  - Design workshop for setting process metrics from order to floor and capturing barriers to achieving targets

Draft Flow Improvement Plan (MV)

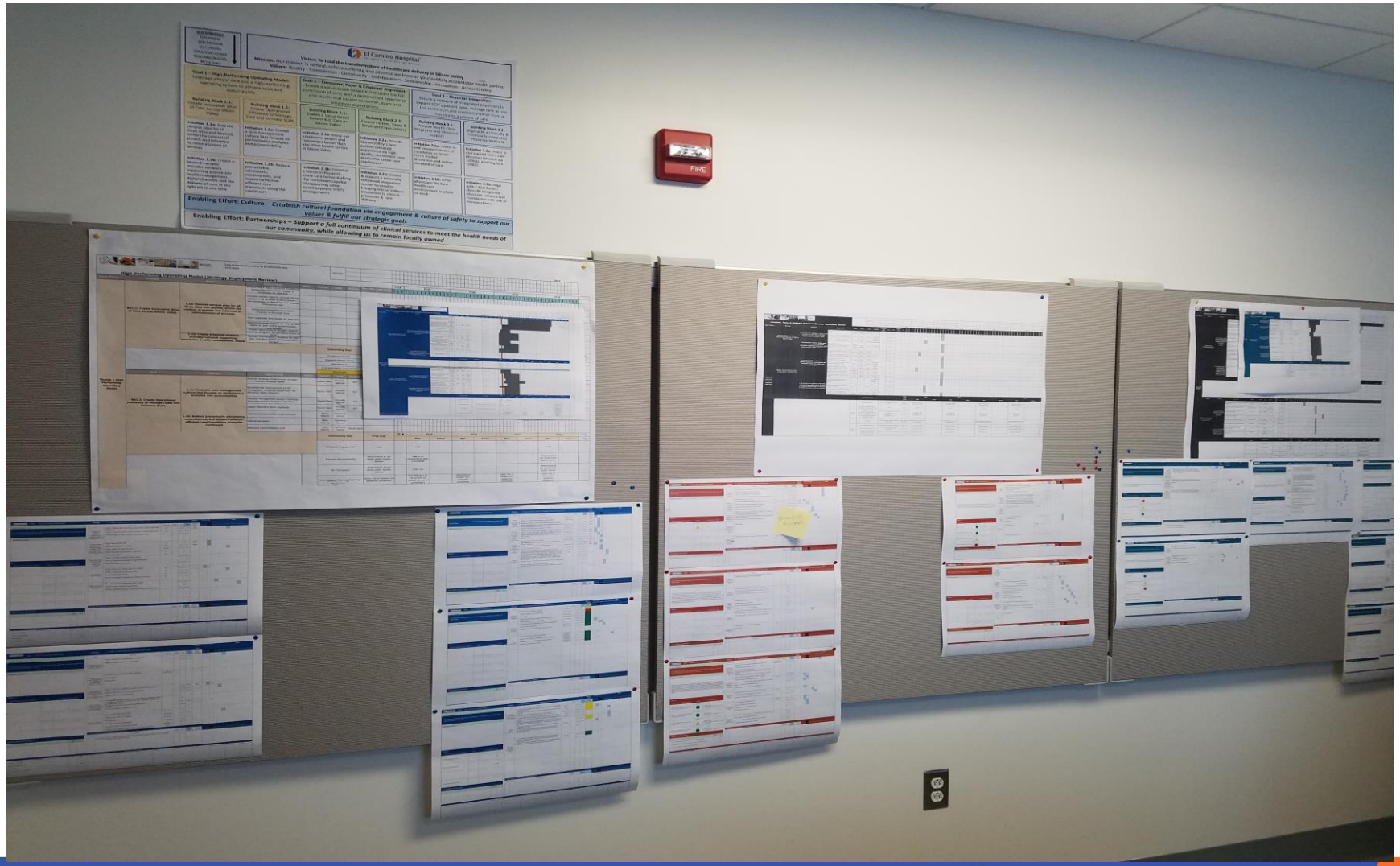
Type	July	August	Sept
RPIW		- Direct Admissions	- Disposition to Head in Bed Standard Work
Fast Track		- Develop process for monitoring performance against process targets - Standard Work Instruction for transferring patients in iCare to Cath Lab	- Standards for Discharge Rounding (PAMF) - Standards for Discharge Rounding (Team Health)
Just Do It	- Audit Standard Work in ED - Define target process goals - EVS transport analysis - Build online structure for flow repository - Analyze data from ED operations reports	- Demand and capacity analysis for Hospitalists for Admissions from ED - Establish Patient Flow Oversight Committee	

Draft Flow Improvement Plan (MV)

Type	Oct	Nov	Dec
RPIW	- Door to Triage and Triage to Room Standard Work	- MD Eval to Dispo Standard Work	- Kanban process for ED gurneys and wheelchairs
Fast Track	- ED Standard Work Instructions for locating patients - ED Standard Work Instruction to prepare patient for CT	- Establish turnaround times for specialty consults for Team Health	
Just Do It			

Lean Management

Lean Management



Lean Management

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Hospital Update
August 6, 2018
Mark Adams, MD, Interim CMO

Organizational Goal Update Through February 2018 (SIR) and May (Others) 2018

Organizational Goals FY18	Benchmark	2017 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY18 through May	
Quality, Patient Safety & iCare									
Arithmetic Observed LOS Average / Geometric LOS Expected for Medicare Population (ALOS /GMLOS)	External: Expected via Epic Methodology	FY 2016: 1.21 (ALOS 4.86/GMLOS 4.00) FY 2017 YTD April: **1.18** (4.81/4.08)	1.12	1.11	1.09	34%	4Q FY18		1.11
HCHAPS Service Metric: Rate Hospital	External Benchmark	HCAHPs Baseline: 10/2016-12/2016: **75.5%** 1/2017-3/2017: **75.1%**	77%	78%	79%	33%	4Q FY18		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: **0.525**
Threshold Goals									
Budgeted Operating Margin**	95% Threshold	Achieved Budget	95% of Budgeted			Threshold	FY 18		Met

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

Quality and Safety

Urologists at our Los Gatos campus are the first in the nation to utilize aquablation to treat symptomatic benign prostatic hypertrophy. This treatment is as effective as the traditional trans urethral resection of the prostate (TURP), but has significantly fewer side effects.

Preparation and planning for the El Camino Comprehensive Stroke Center program is continuing with work to establish 24/7 critical care intensivist availability with Emergency Neurological Life Support (ENLS) training and 24/7 neurosurgical coverage.

Patient Experience

We continue to hit the maximum of the HCHAPS overall patient experience goal at 80.9. Many activities are in process as we continue our efforts to improve the patient experience including care team coaching, nurses listening tool kit, and leader rounding.

The MyChart Bedside project implementation plan is in progress with immediate focus upon selecting the pilot unit and determining the location of the iPad in the patient room. A patient representative has been added to the MyChart Steering Committee. We plan to go-live on a pilot unit by December 2018.

We are introducing e-prescribing for controlled medications as a convenience for doctors and patients. Prescribers will be required to check the CURES database used by California to track opiate prescriptions to reduce overdose risks.

Operations

We implemented some additional physician-friendly changes to the OR scheduling process in Los Gatos and will increase the number of pre- and post-operative beds from 9 to 15 to be utilized by patients being observed and treated during pre- and post-surgical procedures (scheduled to be complete in September 2018).

Implementation of plans to execute against our commitment to embedding LEAN management at all levels of the organization is well underway. The patient flow execution plan is moving

forward with a number of tactics being completed to ensure continued improvement with patient flow beginning in the Emergency Department, *e.g.*, staff are participating in various organizational development and training activities, value stream exercises are being rolled out (*i.e.*, identifying key processes and training the relevant staff on specific actions associated with problem-solving, information management, and physical transformation associated with patient flow), and executive sponsors are educating and training direct reports regarding key processes, outcomes, and accountabilities.

The Magnet application for the ECH's 4th Designation was sent to the American Nurses Credentialing Center on June 1st. The full set of documents with sources of evidence indicating that we meet the 2019 standards is due on June 3, 2019.

Financial Services

We implemented a new A/P payment system that will enable us to pay enrolled vendors each night at a discounted amount due to immediate payment. We expect there to be growth in adding vendors to this program resulting in savings to ECH at a minimum of $500,000 per year.

Our cost initiative goal has been achieved. As of May 25, 2018 we have implemented $5.3M savings of our $4.8M challenge and cost avoidance of $330,000. We have already begun work on our savings goals for FY19. Financial Services will be working with both groups to ensure correct decisions and cost savings are achieved.

Marketing and Communications

The Marketing Team is developing an ethnic population-focused healthcare survey as well as a survey of Cancer Center patients. Recent ECH news releases focused on the opening of the new outpatient pharmacy on the Mountain View campus and the Norma Melchor Heart & Vascular Institute's American College of Cardiology's NCDR ACTION Registry Platinum Performance Achievement Award. We led and implemented activities for Hospital Week and a robotics symposium for staff, local high school robotic programs, and the broader community. There was also lots of activity in support of the Auxiliary's Annual General Meeting, the Foundation's "Spring Forward" gala, and Mental Health Awareness Month. We are currently engaged in planning for the annual Men's Health Fair and summer "Jazz on the Plazz" concert series in Los Gatos. The team also launched an audit and planning for upgrading the website platform in FY19.

Information Services

Approximately 130 physicians received EPIC training. Based on physician feedback, over 25 enhancement improvements were built in Epic with 45% of the hospital physicians now rating themselves as mature Epic users, saving an average of 6 minutes per patient. Ambulatory physicians demonstrated an 11.8% increase in efficiency, saving over 22 minutes per patient. Next steps include developing a data conversion plan to improve physician efficiency when transitioning to Epic from a paper or another EMR-based system. Our employee enrollment campaign for MyChart began in April in coordination with improved patient enrollment opportunities at registration. Weekly enrollment reports are monitored for progress towards reaching the 50% patient enrollment goal by December 2018.

Corporate and Community Health (CONCERN and Community Benefit)

CONCERN provided critical incident response support to a large tech company after a traumatic event on campus. We provided 300 hours of counseling support over 30 days at eight sites. We have also developed a clickable prototype and video to describe our new digital platform that will significantly enhance the EAP user experience, which we will share with a number of customers over the next several months.

El Camino Hospital/El Camino Healthcare District provided support to the 10 following organizations through the sponsorship program:

- BAWSI: Evening at the Olympics
- Cystic Fibrosis Foundation: Great Strides Walk
- Sunnyvale Rotary Foundation/Sunnyvale School District/ Sunnyvale Community Services: Our Kids Our Community
- Pacific Stroke Association Conference
- Child Advocates of Silicon Valley: Flower Run
- Jenny's Light Run – overcoming perinatal mood disorders
- Alzheimer's Association/Chinese American Forum
- Aging Services Collaborative: Caregivers Conference
- Preeclampsia Foundation: Promise Walk Bay Area
- City of Mountain View Senior Center: Mountain View Senior Center Fair

The South Asian Heart Center graduated another group of patients in STOP-Diabetes program; average improvement in A1C = 13.2% and average weight loss was 4.9% equivalent to 7.9lbs.

El Camino Hospital eldercare consultants presented at the Mountain View Senior Resource Fair about ECH eldercare services. Topics included Medicare coverage, in-home caregiving versus home health care, dementia symptoms and care, and transportation options with an emphasis on RoadRunners.

The Chinese Health Initiative (CHI) collaborated with 3 Community Services Agencies (Mountain View, Cupertino, and Sunnyvale) to provide culturally appropriate health education to their Chinese members enrolled in Challenge Diabetes, a program funded by El Camino Hospital. CHI recruited 18 bilingual volunteers and provided interpretation to the Chinese clients. The volunteers assisted with completion of forms and communication with phlebotomists and dietitians. Around 275 Chinese clients were served by our volunteers.

Government and Community Relations

Brenda Taussig and Dan Woods visited County Supervisor Mike Wasserman to discuss hospital services and new construction. Brenda Taussig and Joan Kezic met with Assemblymember Ash Kalra about his bill, AB 3087, held in the Assembly Appropriations Committee, which would create a state commission to set commercial insurance payments to hospitals, doctors, and other healthcare providers. ECH opposed the bill, but appreciates Assemblymember Kalra's invitation to discuss payor relations and cost reduction with him. Rate regulation legislation is likely to return next year. ECH has closely followed SB 1152, a bill that mandates a process for discharging homeless patients. Staff is working on this important issue from both a government relations and hospital operations perspective. ECH staff joined a new homeless patient discharge task force to share best practices and improve linkages between local hospitals, social service, and housing agencies.

ECH was awarded "2018 LGBTQ Healthcare Equality Leader" status by the Human Rights Commission, the result of extensive work done by a multidisciplinary ECH staff committee. In June, as part of recommended staff education, ECH will host internationally-renowned surgeon Dr. Marci Bowers speaking on understanding and addressing the healthcare needs of transgender patients.

Silicon Valley Medical Development, LLC

El Camino Hospital affiliate Silicon Valley Medical Development, LLC purchased the assets of Atlas Urgent Care in Cupertino. It has reopened as "Direct Urgent Care, a service of SVMD" and we began seeing patients May 7th.

We have enabled technology including Epic for 5 ECMA physicians at the Winchester Clinic with 2 new additional physicians joining ECMA by July for a total of 7. Currently, 5 independent physicians use Epic in their practices as part of the Community Connect program with a 5-physician practice (Cardiology, Nephrology) expected to sign a contract this month.

Philanthropy

During the month of April, El Camino Hospital Foundation secured $473,186, bringing the total raised by close of period 10 to $5,432,351, which is 88% of the FY18 fundraising goal. Replacing the Sapphire Soiree, the Foundation launched a new gala in support of mental health services at El Camino Hospital: Spring Forward on Saturday, May 5, 2018. The revenue expected is in the range of $350,000 for this first-time event.

Auxiliary

The Auxiliary contributed 7,052 volunteer hours in April 2018**.**