SPECIAL AGENDA

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

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

Jeff Davis will be participating via teleconference from 4100 Lake Tahoe Blvd, South Lake Tahoe, CA 96150

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER**	Dave Reeder, Quality Committee Chair		**5:30 – 5:31pm**
2.	**ROLL CALL**	Dave Reeder, Quality Committee Chair		**5:31 – 5:32**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**5:32 – 5:33**
4.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.* ***Approval*** a. Minutes of the Open Session of the Quality Committee Meeting (August 6, 2018) ***Information*** b. Patient Story c. FY19 Pacing Plan d. Progress Against FY 2019 Committee Goals	Dave Reeder, Quality Committee Chair	*public comment*	**Motion Required** **5:33 – 5:36**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion** **5:36 – 5:39**
6.	**FY18 QUALITY DASHBOARD FINAL RESULTS** **ATTACHMENT 6**	Mark Adams, MD Chief Medical Officer		**Motion Required** **5:39 – 5:59**
7.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 7**	Mark Adams, MD Chief Medical Officer		**Discussion** **5:59 – 6:09**
8.	**MORTALITY AND READMISSION METRICS (FY19 QUALITY GOALS)** **ATTACHMENT 8**	Mark Adams, MD Chief Medical Officer		**Discussion** **6:09 – 6:29**
9.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE** **ATTACHMENT 9**	Cheryl Reinking, RN, Chief Nursing Officer		**Discussion** **6:29 – 6:39**
10.	**HOSPITAL UPDATE** **ATTACHMENT 10**	Mark Adams, MD Chief Medical Officer		**Discussion** **6:39 – 6:49**
11.	**PUBLIC COMMUNICATION**	Dave Reeder, Quality Committee Chair		**Information** **6:49 – 6:52**

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
12. ADJOURN TO CLOSED SESSION	Dave Reeder, Quality Committee Chair		**Motion Required 6:52 – 6:53**
13. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Dave Reeder, Quality Committee Chair		**6:53 – 6:54**
14. CONSENT CALENDAR *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required 6:54 – 6:57**
Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (August 6, 2018)			
15. ANNUAL PATIENT SAFETY REPORT	Mark Adams, MD Chief Medical Officer		**Motion Required 6:57 – 7:17**
16. CMO REPORT	Mark Adams, MD Chief Medical Officer		**Motion Required 7:17 – 7:22**
17. ADJOURN TO OPEN SESSION	Dave Reeder, Quality Committee Chair		**Motion Required 7:22 – 7:23**
18. RECONVENE OPEN SESSION/REPORT OUT	Dave Reeder, Quality Committee Chair		**7:23 – 7:24**
To report any required disclosures regarding permissible actions taken during Closed Session.			
19. ADJOURNMENT	Dave Reeder, Quality Committee Chair		**Motion Required 7:24 – 7:25pm**

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Meeting of the El Camino Hospital Board
Monday, August 6, 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, Mikele Epperly, Wendy Ron and Melora Simon.	Ina Bauman, Julie Kliger	

**Mikele Epperly joined via teleconference at 5:52pm*

**Mikele Epperly left the conference at 6:57pm*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 6th of August, 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 5:52 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Ina Bauman and Julie Kliger was absent for the meeting. Mikele Epperly joined via teleconference. Chair Reeder gave a brief introduction to Erica Osborne, who is a consultant attending 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 (June 4, 2018). **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Davis, Epperly, Fung, Reeder, Ron, and Simon.	***The open minutes of the June 4, 2018 Quality Committee were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Noes: None **Abstentions:** None **Absent:** Bauman, Kliger **Excused:** None **Recused:** None	
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee.	***None***
6. FY18 QUALITY RESULTS	Dr. Mark Adams, Interim Chief Medical Officer, provided an overview of the nine metrics as they reflect the Hospital's FY18 Quality, Efficiency and Service Goals. Zero new CAUTIs for June, one new CLABSI after 6 months with none, and average LOS below FY17 average since February 2018, which continues to improve. Data for July is still pending to complete the fiscal year report. So far, goal achievement is assured for CLABSI, CDI, Sepsis IVF bolus. Goal achievement is close for ALOS/GMLOS and HCAHPS Rate Hospital. CAUTI, SEP-1, Falls, and Mortality Index did not meet goal. Mortality Index was the only metric showing a declining trend.	***None***
7. FY19 QUALITY DASHBOARD	Dr. Adams presented on the FY19 Quality Dashboard to the Committee, noting the Sepsis metric has been changed to Sepsis Mortality Index. Data presented for trends over time, Dashboard is effective with July 2018 data. Dr. Adams reviewed over the HAI A3 work in FY18 and their accomplishments: CAUTI were reduced but did not meet goal, CLABSI were reduced and did meet goal, and C Diff were also reduced and exceeded the goal.	
8. APPROVE COMMITTEE CHARTER	Chair Reeder reviewed over the revised Committee Charter with the Committee members. Dr. Adams noted the two additions under Specific Duties: Review and approve an annual "Quality Dashboard" for tracking purpose and Physician Satisfaction Surveys. **Motion:** To approve the Committee Charter **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Davis, Epperly, Fung, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None	

Agenda Item	Comments/Discussion	Approvals/Action
	Absent: Bauman, Kliger **Excused:** None **Recused:** None	
9. CULTURE OF SAFETY DISCUSSION	Dr. Adams provided an overview of the culture of safety as defined by AHRQ to the Committee. He explained current state and reviewed our progress toward becoming a high reliability organization. He requested the engagement of the Committee to support ECH's advancement in our culture of safety. Dr. Adams asked for feedback and questions from the Committee and a robust discussion ensued.	
10. LEAN PROGRESS REPORT	Dr. Mark Adams, Interim Chief Medical Officer, provided a progress report on the application of lean management by noting specific examples of lean management in action: Auditing of ED standard work supporting flow, Analysis of EVS transport data, Defining target process metrics for Door to Floor, and Analysis of ED operational data. Afterwards, he gave a brief tour of the Strategic Deployment room located in the administration suite.	***None***
11. HOSPITAL UPDATE	Chair Reeder asked the committee members if they had any questions on the Hospital Update and none was noted. He stated that further details were provided in the packet.	***None***
12. PUBLIC COMMUNICATION	Former patient expressed her concerns to the Committee regarding her hospital stay at El Camino Hospital. She stated that she asked for a patient advocate/care coordinator while admitted to the unit but never got one. She felt she was wrongly discharged and disappointed with our Patient Experience Department on handling her complaint.	***Committee will follow up on her concern.***
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:32 pm. **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Davis, Fung, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** Bauman, Epperly, Kliger **Excused:** None **Recused:** None	***Adjourned to closed session at 7:32 pm.***

Agenda Item	Comments/Discussion	Approvals/Action
14. AGENDA ITEM 20: ADJOURNMENT	The meeting was adjourned at 7:37pm. **Motion:** To adjourn at 7:37 pm. **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Davis, Fung, Reeder, Ron, and Simon. **Noes:** None **Abstentions:** None **Absent:** Bauman, Epperly, Kliger **Excused:** None **Recused:** None	***Meeting adjourned at 7:37 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

Dear Minchie, Words cannot express our thanks for the kindness and concern that you have shown my father. In the last days of his life I have never seen such a complete and utter change in his personality as when you walked into his room and called him [redacted]. His face goes from a somber mask of trepidation to one of smiles. His voice immediately becomes stronger and his old personality comes roaring back to life. If I had not witnessed it with my own eyes I would have thought of it as an exaggeration. But I did see it, and it has been one of the most beautiful and most blessed things that I have seen in a lifetime. Thank you for treating him like a normal human being that is simply in the hospital to get better and then go home. Thank you for taking him away from his troubles and distracting him from what he knows is short to come. Thank you for providing an example to us, to be more upbeat and positive. It is so important for all patients no matter what their condition to experience even just a little of that love, that hope , that momentary distraction. Certainly all of the things that the doctors and your fellow nurses have done have prolonged his life and kept him around for another week or so so that we could have the most important opportunity to express our love and thanks to him and eventually to say goodbye. But what you did as a newcomer into my fathers and my family's lives was nothing short of a miracle. You brought something that I thought our family would never experience again with my father, you brought love and laughter back into all of our lives for a few precious times while visiting El Camino Hospital. Thank You, Thank You from the bottom of all of our hearts for giving us this Most Important and Unanticipated Gift. Enclosed is a very small token of our appreciation and cannot come close to the value of the services that you have provided for my father and my family. You are an Angel and we have been so fortunate to make your acquaintance. May God Bless You and Keep You. May All Good Things Come Your Way. You are one of El Camino Hospitals Most Valuable Assets and I am forwarding a copy of this letter to the highest possible authority of El Camino Hospital and the President of its Board Of Directors. El Camino Hospital needs to know what a treasure they have in their midst and you deserve all of the recognition due and more. I think it is important that your example be followed in all institutions of healthcare. LOVE and true Empathy Is The Best Medicine of All. Once again Thank You on behalf of my family, [redacted]

Blessings To You !

[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

FY19 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital 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 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**, Interim Chief Medical Officer (Executive Sponsor)

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 and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	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 quality	- FY18 Achievement and Metrics for FY19 (Q1 FY19) - FY20 Goals (Q3 – Q4)	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	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 reports and dashboards	- FY19 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals

SUBMITTED BY:

Chair: David Reeder
Executive Sponsor: Mark Adams, MD

Approved by the El Camino Hospital Board on June 13, 2018

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality, Patient Care and Patient Experience Committee September 5, 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 August 2018 ECH Board Actions	

ECH Board Actions*

1. August 15, 2018
    a. Resolution 2018-08 Recognizing the Sepsis Team for Joint Commission Gold Seal of Approval Award
    b. FY18 Year End Financials
    c. FY19 Base Salary for Chief Medical Officer Mark Adams, MD
    d. FY19 CEO Salary Range and Base Salary
    e. Second Amendment to Executive (CEO) Employment Agreement extending Mortgage Assistance benefit for additional 12 months
    f. Approval of ReBranding Using New Brand Architecture (El Camino Health)

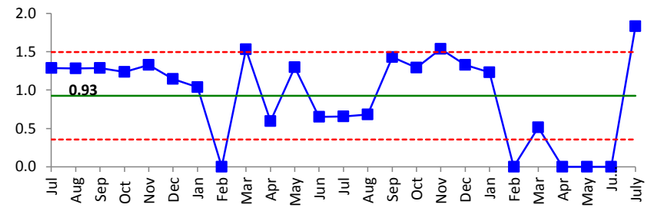
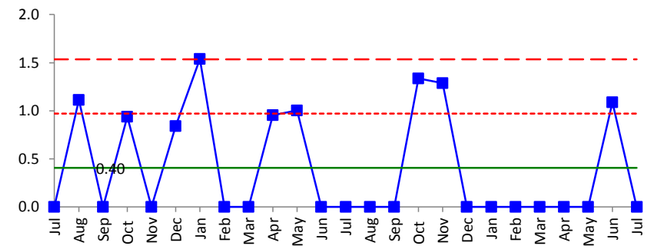
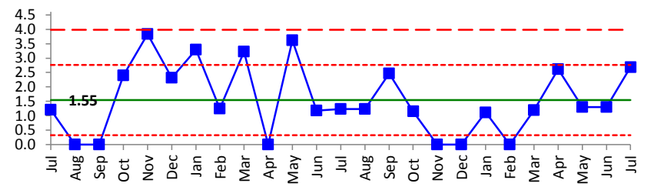
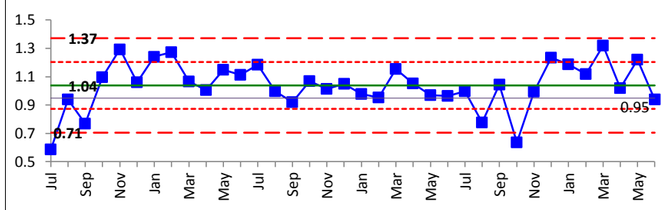
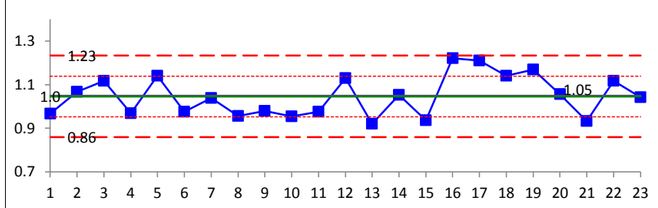
*This list is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	FY18 Quality Dashboard Final Results Quality Committee of the Board Meeting Date: Sept. 5, 2018
	Responsible party:	Mark Adams, MD, CMO Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director Quality
	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. 4 teams supporting work on HAIs consolidate into 1 HAI Team that includes Hand Hygiene, meeting monthly to continue unfinished work and sustain improvements in FY19	
	Proposed Committee motion, if any: Recommend approval of the FY18 Organizational Goal Achievement	
	LIST OF ATTACHMENTS: FY18 Quality Dashboard Final Results	

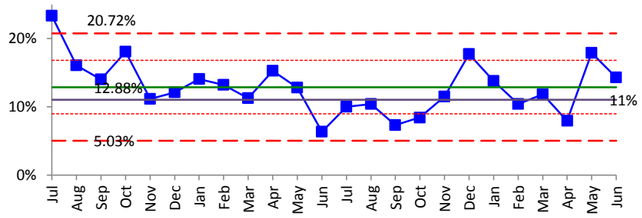
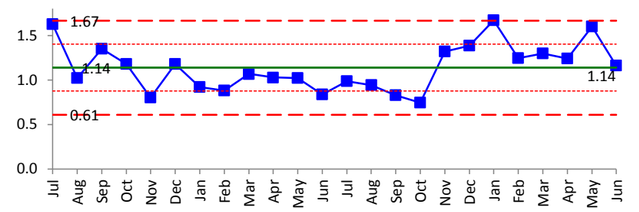
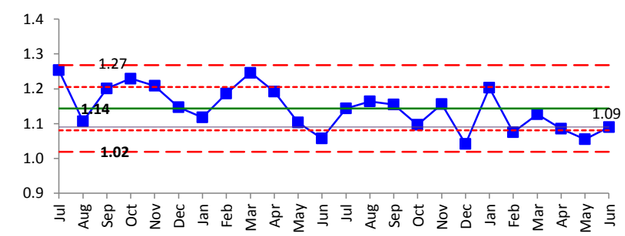
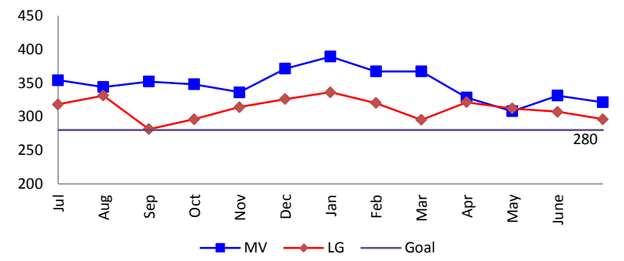
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Final Quality and Safety Dashboard (July)

		Performance		Baseline	FY19 Goal	Trend	Comments
Quality		Month	FYTD	FY2018 Actual	FY2019 Goal		
1	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: July 2018* *SIR Goal: <= 0.75*	1.83 (2/1091)	1.83 (2/1091)	0.77 (Improved from 1.09 for FY 2017)	SIR Goal: <= 0.75		Spike in July w/4 new CAUTIs: 3 in 3AC, 1-3C. 1-63 y/o male coded in ED, emergent foley insertion probable cause, 2- 63 y/o female w/TB, with trach. Poss cross contamination from trach by pt, same organism, 27 total foley days, 3 -77 y/o male post cranioplasty, MD ordered Urine culture w/o UA first - to prompt culture if neeeded, staff educated to not use axillary temp., 4- 61 y/o male w/ 35 foley days due to retention.
2	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: July 2018* *SIR Goal: <= 0.50*	0.0 (0/879)	0.0 (0/879)	0.23 (improved from 0.56 for FY 2017)	SIR Goal: <= 0.50		Return to zero for CLABSI in July. For FY19 on HAIs, one new team for CAUTI, CLABSI, Hand Hygiene is meeting monthly to complete unfinished work of the FY18 HAI teams. After Infection Prevention review all possibel HAIs with the IC Medical Director, an intensive analysis is done with the nursing unit mgr/staff, then the HAI is reviewed with this team to take action if more education, training or new procedures are needed, and to distribute the information to the hosptial.
3	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: July 2018* *SIR Goal: <= 0.70*	2.68 (2/7450)	2.68 (2/7450)	1.13 (improved from 1.89 for FY 2017)	SIR Goal: <= 0.70		2 new C.Dff HAIs, 1- very ill male w/necrotizing pancreatitis, on Antibiotics x5 + Protonics, developed C. Diff 14 days post admission, expired in August, 2 - 22 y/p female re-admitted after days days home, no diarrhea w/necrotizing pancreatitis, Antibiotics x2, protonics, develope C.Diff 18 days post admission.
4	***Organizational Goal** **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: June 2018*	0.94 (1.35%/1.43%)	1.05 (1.67/1.59)	1.05 (stable, compared to 1.02 for FY 2017)	0.95		CDI has filled 3 open positions, only 2 inplace. Mgr.meeting with HVI physicians weekly to address documentation and risk of mortality. Mortality review committee will include risk of mortality in weekly reviews, and provide feedback to physicians. Additonal teams formed to support organization's mortality goal.
5	***Organizational Goal** **Readmission Index (All Patient, All Cause Redmit)** *Observed/Expected* ***Premier Standard Risk Calculation Mode*** Date Period: May 2018	1.04	1.08	1.02	1.05		6 teams have been formed to support the organization' Readmission Quality Goal. Inlcuded are Chronic Respiratory team, Weekly Readmission Review, Care Coordination Readmission team, Chronic Disease Mgmt team, Discharge Teaching team, and Palliative Care Team. The Weekly Readmission Review team will expand cases to imclude MediCal as well as Medicare Readmissions to address the "all patient" index.

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**

		FY18 Performance		Baseline	FY19 Goal	Trend	Comments
Quality		Month	FYTD	FY 2018	FY 2019		
6	**Sepsis Mortality Rate Enterprise** *Date Period: June 2018*	14.29%	11.71%	11.71% (improved from 13.66% for FY 2017)	11%		CMS recntly posted on Hospital Compare the Sep-1 compliance and mortality rate. California's mortality rate for 2017 = 14.9 % while the northern CA (Hospital Council) rate for 2017 is 13.7%.
7	**Sepsis Mortality Index** *(Observed over Expected)* *Date Period: June 2018*	1.16	1.19	1.19 (1.05 for FY 2017)	1.14		Sepsis deaths are part of the Clinical Effectiveness mortality review, the Sepsis Committee will begin to review deaths, focused on the Risk of mortality.
Efficiency		Performance Month	FYTD	FY18 Actual	FY 2019 Goal		
8	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: June 2018*	1.09	1.12	1.12 (improved from 1.16 for FY 2017)	1.09		Trend of lower ALOS/GMLOS contines since February 2018, with achievement of O/E goal in 4th qtr. FY18. GMLOS (expected LOS) is provided to nursing/providers in EPIC for each inpt. 2 days after admission, and this is revised with additional provider documentation.
9	★Organizational Goal **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: July 2018*	MV: 321 mins LG: 296 mins	MV: 321 mins LG: 296 mins	MV: 350 mins; LG: 314 mins	280 mins		Process targets have been set for door to consult, consult to admit order and admit order to floor and communicated them to the inpatient units and a provider workgroup. In Mountain View,a standard form has been establishd to capture daily data on admits from the ED for inpatient units to track further discreet process metrics and barriers that explain delays. The plan is to do the same for the ED and Assistant Hospital Managers. LG will work to spread the data capture piece to start identifying their issues as well. A weekly flow huddle will be started to share previous week's performance and learnings across units.

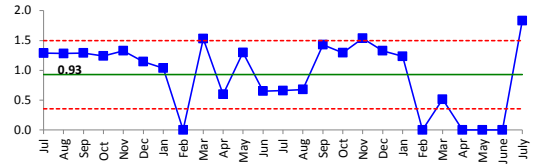
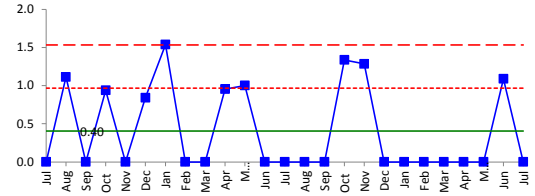
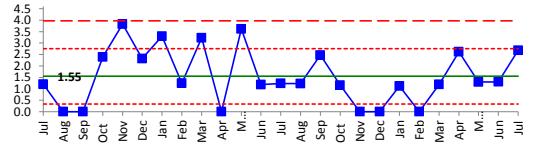
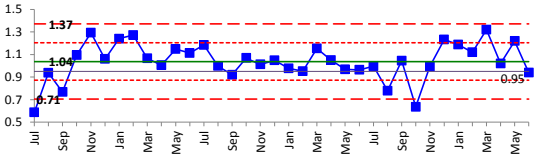
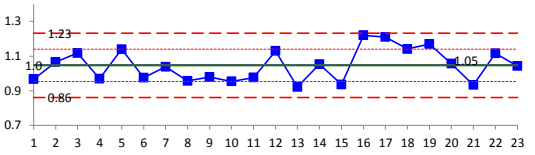
Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Rate Enterprise	Catherine Carson				**Premier Quality Advisor**
Sepsis Mortality Index Observed over Expected	Catherine Carson				**Premier Quality Advisor**
Arithmetic Observed LOS Average over Geometric LOS Expected.	Cheryl Reinking Catherine Carson (Cornel Delogramatic)		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)	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**EPIC**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	FY 19 Quality Dashboard Quality Committee of the Board Meeting Date: Sept. 5, 2018
	Responsible party:	Mark Adams, MD, CMO Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director Quality
	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 FY2018 and the FY 2019 goals. • Annotation is provided to explain actions taken affecting each metric.	
	Suggested discussion questions: 1. 4 new CAUTIs for July, see annotation. 2. Zero new CLABSI in July. 3. Data for new FY 19 Quality goals: Mortality Index & Readmission Index. 4. 4 teams supporting work on HAIs consolidated into 1 HAI Team that includes Hand Hygiene, meeting monthly to continue unfinished work and sustain improvements in FY19. 5. New teams and actions to support Service goal in place.	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: FY19 Quality Dashboard final results	

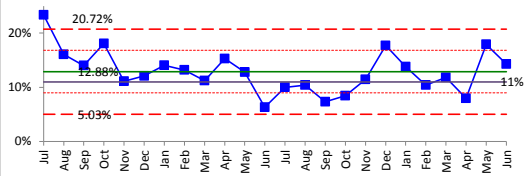
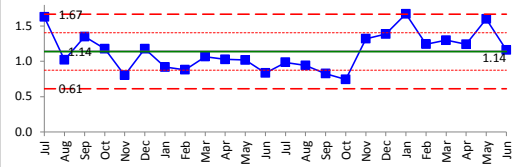
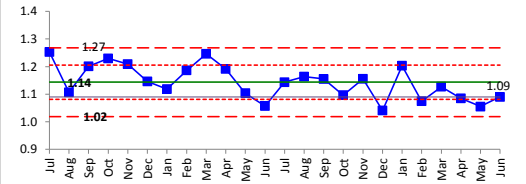
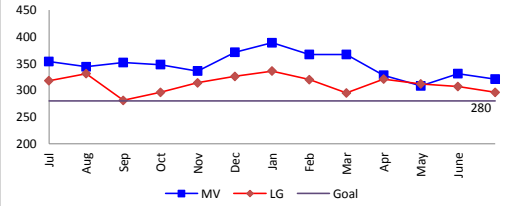
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Final Quality and Safety Dashboard (July)

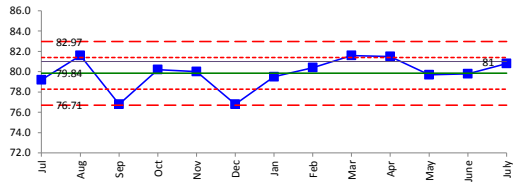
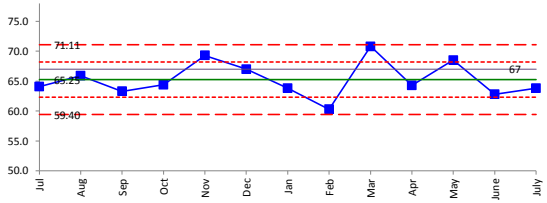
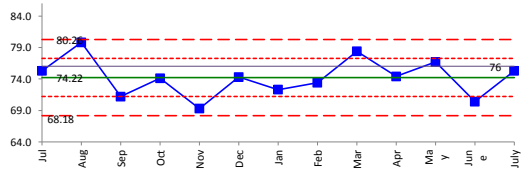
	Quality	Performance Month	Performance FYTD	Baseline FY2018 Actual	FY19 Goal FY2019 Goal	Trend	Comments
1	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: July 2018* *SIR Goal: <= 0.75*	1.83 (2/1091)	1.83 (2/1091)	0.77 (Improved from 1.09 for FY 2017)	SIR Goal: <= 0.75		Spike in July w/4 new CAUTIs: 3 in 3AC, 1-3C. 1-63 y/o male coded in ED, emergent foley insertion probable cause, 2- 63 y/o female w/TB, with trach. Poss cross contaimination from trach by pt, same organism, 27 total foley days, 3 -77 y/o male post cranioplasty, MD ordered Urine culture w/o UA first - to prompt culture if neeeded, staff educated to not use axillary temp., 4- 61 y/o male w/ 35 foley days due to retention.
2	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: July 2018* *SIR Goal: <= 0.50*	0.0 (0/879)	0.0 (0/879)	0.23 (improved from 0.56 for FY 2017)	SIR Goal: <= 0.50		Return to zero for CLABSI in July. For FY19 on HAIs, one new team for CAUTI, CLABSI, Hand Hygiene is meeting monthly to complete unfinished work of the FY18 HAI teams. After Infection Prevention review all possibel HAIs with the IC Medical Director, an intensive analysis is done with the nursing unit mgr/staff, then the HAI is reviewed with this team to take action if more education, training or new procedures are needed, and to distribute the information to the hosptial.
3	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: July 2018* *SIR Goal: <= 0.70*	2.68 (2/7450)	2.68 (2/7450)	1.13 (improved from 1.89 for FY 2017)	SIR Goal: <= 0.70		2 new C.Dff HAIs, 1- very ill male w/necrotizing pancreatitis, on Antibiotics x5 + Protonics, developed C. Diff 14 days post admission, expired in August, 2 - 22 y/p female re-admitted after days days home, no diarrhea w/necrotizing pancreatitis, Antibiotics x2, protonics, develope C.Diff 18 days post admission
4	*Organizational Goal* **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: June 2018*	0.94 (1.35%/1.43%)	1.05 (1.67/1.59)	1.05 (stable, compared to 1.02 for FY 2017)	0.95		CDI has filled 3 open positions, only 2 inplace. Mgr.meeting with HVI physicians weekly to address documentation and risk of mortality. Mortality review committee will include risk of mortality in weekly reviews, and provide feedback to physicians. Additonal teams formed to support organization's mortality goal.
5	*Organizational Goal* **Readmission Index (All Patient, All Cause Redmit)** *Observed/Expected* ***Premier Standard Risk Calculation Mode*** Date Period: May 2018	1.04	1.08	1.02	1.05		6 teams have been formed to support the organization' Readmission Quality Goal. Inlcuded are Chronic Respiratory team, Weekly Readmission Review, Care Coordination Readmission team, Chronic Disease Mgmt team, Discharge Teaching team, and Palliative Care Team. The Weekly Readmission Review team will expand cases to imclude MediCal as well as Medicare Readmissions to address the "all patient" index.

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**

		FY18 Performance		Baseline	FY19 Goal	Trend	Comments
Quality		Month	FYTD	FY 2018	FY 2019		
6	**Sepsis Mortality Rate Enterprise** *Date Period: June 2018*	14.29%	11.71%	11.71% (improved from 13.66% for FY 2017)	11%		CMS recntly posted on Hospital Compare the Sep-1 compliance and mortality rate. California's mortality rate for 2017 = 14.9 % while the northern CA (Hospital Council) rate for 2017 is 13.7%.
7	**Sepsis Mortality Index** *(Observed over Expected)* *Date Period: June 2018*	1.16	1.19	1.19 (1.05 for FY 2017)	1.14		Sepsis deaths are part of the Clinical Effectiveness mortality review, the Sepsis Committee will begin to review deaths, focused on the Risk of mortality.
Efficiency		Performance Month	FYTD	FY18 Actual	FY 2019 Goal		
8	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: June 2018*	1.09	1.12	1.12 (improved from 1.16 for FY 2017)	1.09		Trend of lower ALOS/GMLOS contines since February 2018, with achievement of O/E goal in 4th qtr. FY18. GMLOS (expected LOS) is provided to nursing/providers in EPIC for each inpt. 2 days after admission, and this is revised with additional provider documentation.
9	★Organizational Goal **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: July 2018*	MV: 321 mins LG: 296 mins	MV: 321 mins LG: 296 mins	MV: 350 mins; LG: 314 mins	280 mins		Process targets have been set for door to consult, consult to admit order and admit order to floor and communicated them to the inpatient units and a provider workgroup. In Mountain View,a standard form has been establishd to capture daily data on admits from the ED for inpatient units to track further discreet process metrics and barriers that explain delays. The plan is to do the same for the ED and Assistant Hospital Managers. LG will work to spread the data capture piece to start identifying their issues as well. A weekly flow huddle will be started to share previous week's performance and learnings across units.

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 (Cornel Delogramatic)		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)	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**EPIC**

				Baseline	FY19 Goal	Trend	Comments
SERVICE		FY19 Performance Month	FYTD	FY 2018	FY 2019 Goal		
10	«Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: July 2018*	80.8 (217/268)	80.8 (217/268)	79.8	81.0		For Service goal FY19: • Work groups formed for each measure with frontline staff, management, patient and family advisors, and patient experience dept. • Monthly education to all staff via newsletter • Working with all three workgroups on purposeful rounding and how each measure can support the proper execution of purposeful rounding. For Nursing Communication: Doing observations on the nursing units to map out RN and CNA responsibilities.
11	«Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: July 2018*	63.8 (161/252)	63.8 (161/252)	70.1	67.0		Currently: Process mapping of call light system and identifying roadblocks
12	«Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: July 2018*	75.3 (217/288)	75.3 (217/288)	75.4	76.0		Currently: Looking at issues with facilities (temperature, bathroom, etc.)

Measure Name	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always	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	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10		**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always	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:	Mortality and Readmission Metrics (FY19 Quality Goals) Quality Committee of the Board Meeting Date: September 5, 2018
	Responsible party:	Mark Adams, MD, CMO Catherine Carson, MPA, BSN, RN, CPHQ Sr. Director Quality
	Action requested:	For Discussion
	Background: Two of the key organizational goals include improving our mortality index and our readmission index	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Discuss the importance of the goals • Explain the derivation of the goals • Review the workplan to attain the goals	
	Suggested discussion questions: 1. How does this work intersect with other organizational efforts, e.g., lean management? 2. How would the committee prefer to track progress toward the goals given the lag in data reporting?	
	Proposed Committee motion, if any: Discussion	
	LIST OF ATTACHMENTS: Mortality and Readmission Metrics (FY19 Quality Goals) Mortality and Readmission work plan	

El Camino Hospital
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Quality Readmission and Mortality Committee Structure

Mark Adams

Cheryl Reinking
Dan Shin
Shreyas Mallur
Grace Benlice
Meriam Signo
Catherine Carson
Michelle Pezzani
Craig Joseph
Suann Schutt
Amy Maher

Meeting Time: First Tuesday of the month
3:30pm-4:30pm

Chronic Respiratory Team

* Current Assessment tools
* Pneumnoia Criteria
* GOLD Guidelines for COPD
* CHEST Prevention of Acute Exacerbations
* COPD Foundation Screening tool
* NICE COPD Guideline

Lead: Jolie Fournet

Members:
* Chandin Saw, MD
* SJ Salfin, MD
*Jessica Foreman-Starks
* James Canfield
* Julee Arbuckle
* Estella Ayala, MD

Meeting Time
2nd and 4th Wednesdys
10am-11am
Respiratory Care Office

Weekly Readmit Review Team

Review previous week's readmits Refer Med. Complications

* Identify issues and develop strategies
* COPD/PNA/AMI/HF /Palliative
* CHF Home contract/teaching
* Educate MD/ Observation Pts

***Lead: Michelle Pezzani,* Anne Marie Strebel**

Members:
* Shreyas Mallur, MD
* Heather Freeman
* James Canfield
* Kim Nguyen
* Kelly Nguyen
* HVI- CNS
* Jeffery Jair
* Grace Benlice
* Chief Team Health
* ED/MD?

Meeting Time
Fridays 1-2pm
Admin Conference Room #2

Care Coordination Readmission Team

* EPIC Risk Tool – BNA
* Post-discharge appointments- Non PAMF
* Post-D/C follow up care, meds, nutrition
* BOOST
* Post Discharge Syndrome
* Hospitalist Rounding
* Transition Visits

Lead: Grace Benlice

Members:
* Bruce Harrison-
* Craig Joseph, MD
* Michelle Pezzani, MD
* Inna Yaskin, MD
* Team Health
* Barbara Chang
* Julia Stoner
* Margaret Magee
* Mae Dizon
* Maritza /Ketul- Ad Hoc

Meeting Time
1st and 3rd Wednesday
10-11am
Conference Room B
Sept. 5th

Chronic Disease Management Team

* Review readmissions with medical complications and all readmits w/I 7 days of D/C
* Consider premature D/C & quality of care issues
* Develop assessment tool (EPIC risk tool?)

Lead: Dan Shin, MD

Members:
* Jolie Fournet
* Jeffrey Yoon MD
* Helen Conaghan
* Kaye Jaramillo
* Sherril Hopper
* Evelyn Taverna
* Grant Hochstein, MD

Meeting Time
2X Month

Discharge Teaching Team

* Implement Teach Back across Enterprise
* Address quality of D/C teaching materials
* Meds to Beds - Pharmacy phone consult

Lead: Beth Willy

Members:
* Pharmacist/Ketul Patel
* Valerie Llavore
* Edward Mamaril
* HVI- CNS
* Mari Joy Rasco
* Jackie Keane
* Athena Lendvay
* Christine Andrade
* Kim Nguyen - ad hoc
* Julia Stonner

Meeting Time
2nd and 4th
Tuesdays 1:45-2:45pm
Conference Room

Palliative Care Team

* Initiate Palliative care trigger tool/screening
* Implement GIP
* Tracking with POLST and MD F/U
* Identify Patients &Track opioid use
* Utilization of Palliative Care
* Med Safety Team:
*T rack readmission of Previous DC'd Pallative Care patients

Lead: Channin Daugherty

Members:
* Shreyes Mallur
* Cheryl Reinking (Ad-Hoc for GIP)
* S. Chelamkuri, MD
* Jessica Chi Pharm D.
* Grace Benlice?
* CDI specialist –
* Corneliu D.
* Lackshmy Menon
* Heather Roorda

Meeting Time
2nd & 4th Wednesday 10-11
Conference Room A

Mortality Review

* Review all deaths after screen
* Identify Quality issues
* Deaths with treatable causes
* Peer Review
* Risk of Mortality documentation, extraction form?

Lead: S. Mallur & D. Shin

Members:
* D. Mattapally
* Charlene Boggs
* Bonnie Gebheart
* Jane Truscott
* Sheetal Shah

Meeting Time
2X Month

Cardiovascular Mortality & Readmissions Team

* Review all deaths
* Review all HVI deaths
* Utilize predictive risk tools
* Utilize registry data
* Meet per registry submission quarterly
* Premiere data trended and pushed to EPIC dashboard?

Lead: F. St Goar

Members:
* Amy Maher
* Lynn Taylor
* Shuwen Chen
* Evelyn Taverna
* Kaye Jaramillo
* Pei Tsau, MD
* Geoffery Yoon, MD
* Chad Rammohan, MD

Meeting Time
2X Month

CDI Steering Committee

* Report from CDI
* Monthly expected mortality
* Issues with MD documentation
* MCC-CC capture (AMI,CABG, HF,Non-PCI, PCI)

Lead: C. Delogramatic

Members:
* Iftikhar Hussain
* Catherine Carson
* Frank Kuzil
* Jackie Meza
* Shreyas Mallur, MD
* Dan Shin, MD
* Mark Adams, MD
* Team Health Chief: Priti Dave, MD / Daniel Jo, MD
* Ben Chang, MD

Meeting Time
Monthly
August 20th 11am-12nn
to be updated

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Patient and Family Centered Care: Grievance Update Quality, Patient Care and Patient Experience Committee September 5, 2018
	Responsible party:	Cheryl Reinking, RN Chief Nursing Officer
	Action requested:	For Discussion
	Background: Improving the Patient Experience is an essential activity at ECH that is pursued at all levels of the enterprise.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide an overview of the Patient Care Experience Scores for the Organizational Goals (Nurse Communication, Responsiveness, and Cleanliness) and the current efforts of the teams addressing performance improvement. • Expand sharing of Patient Care Experience scores to include the Emergency Department. • Present the plan developed to address the Emergency Department Patient Care Experience scores in conjunction with the ED flow work.	
	Suggested discussion questions: 1. Do you think the team effort to approach the improvement work is adequate? 2. Do you think the ED Patient Care Experience Plan is comprehensive? 3. What are your thoughts regarding the patient journey mapping?	
	Proposed Committee motion, if any: None. This is a Discussion item.	
	LIST OF ATTACHMENTS: 1. Patient Care Experience data and plans.	

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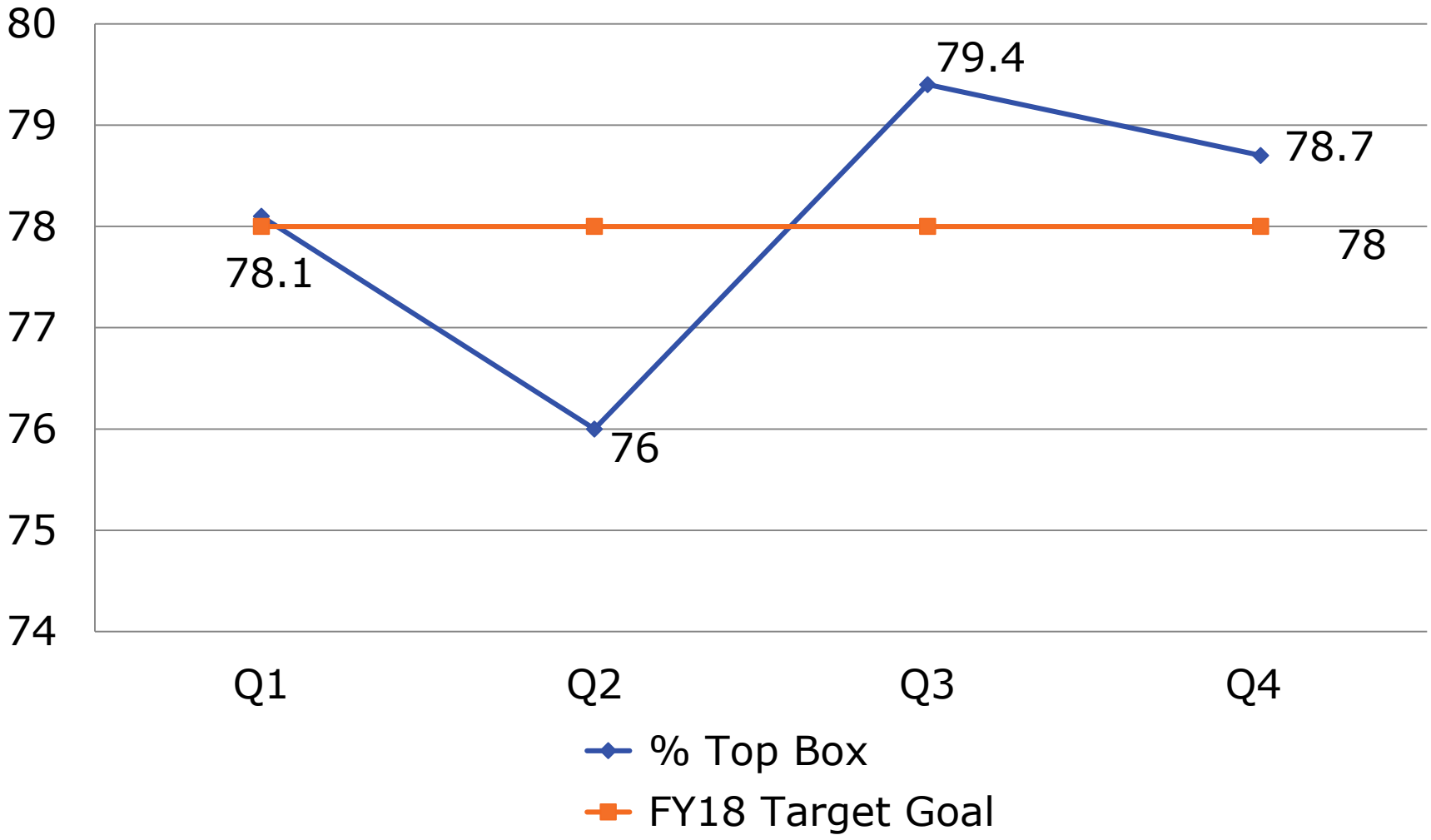
Patient Experience Updates

Cheryl Reinking, MSN, RN, NEA-BC

Rate the Hospital 0-10 FY18 Org Goal
FYTD 2018 Data—Discharge Date



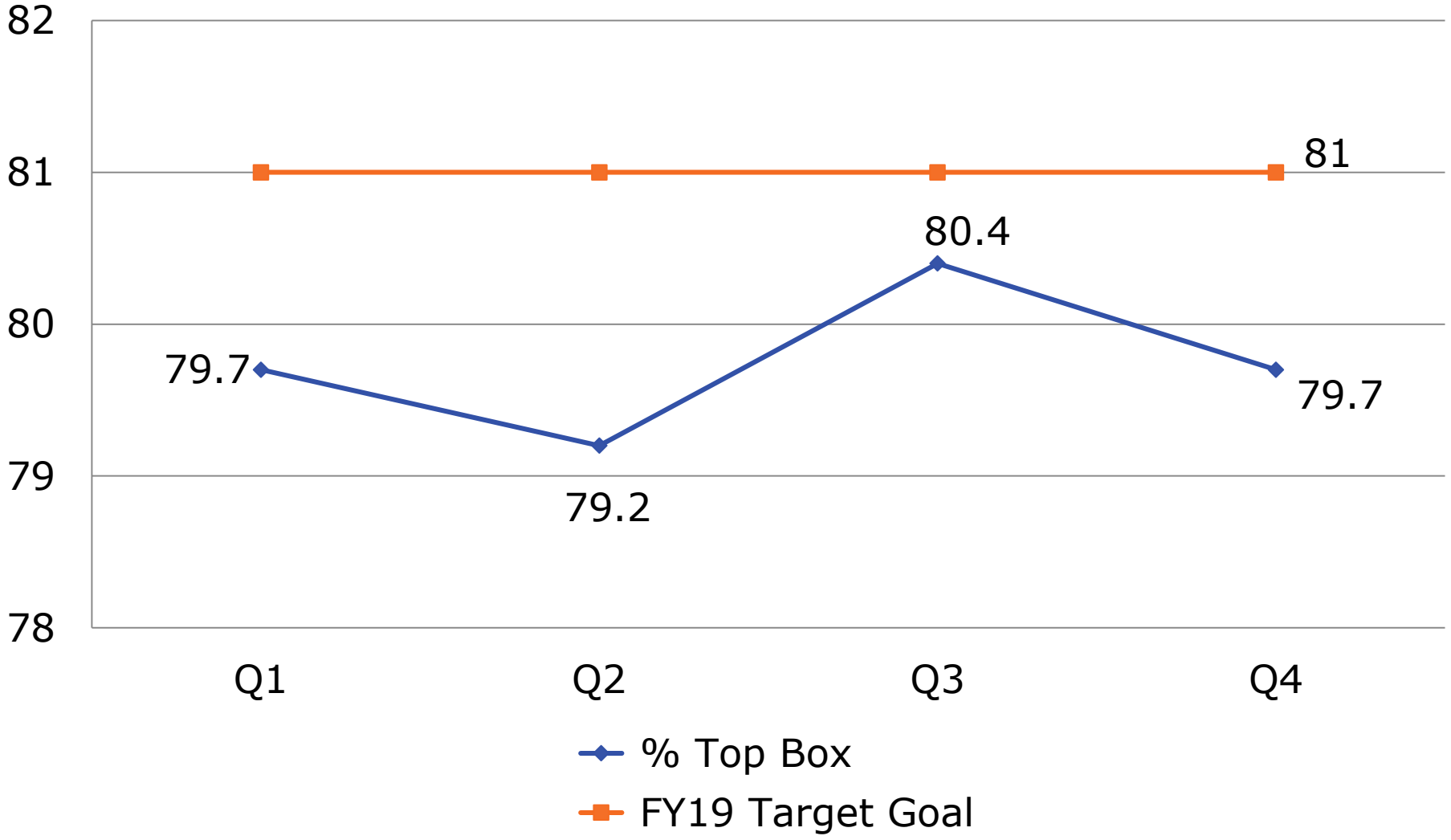
FY19 Organizational Goals and Plan

	Nursing Communication	Cleanliness	Responsiveness
Baseline	80.0	74.5	65.1
FY18 Average	79.7	74.7	64.2
FY19 Min/Target/Max Goal	80.5/81/82	75/76/77	65.6/67/68.5

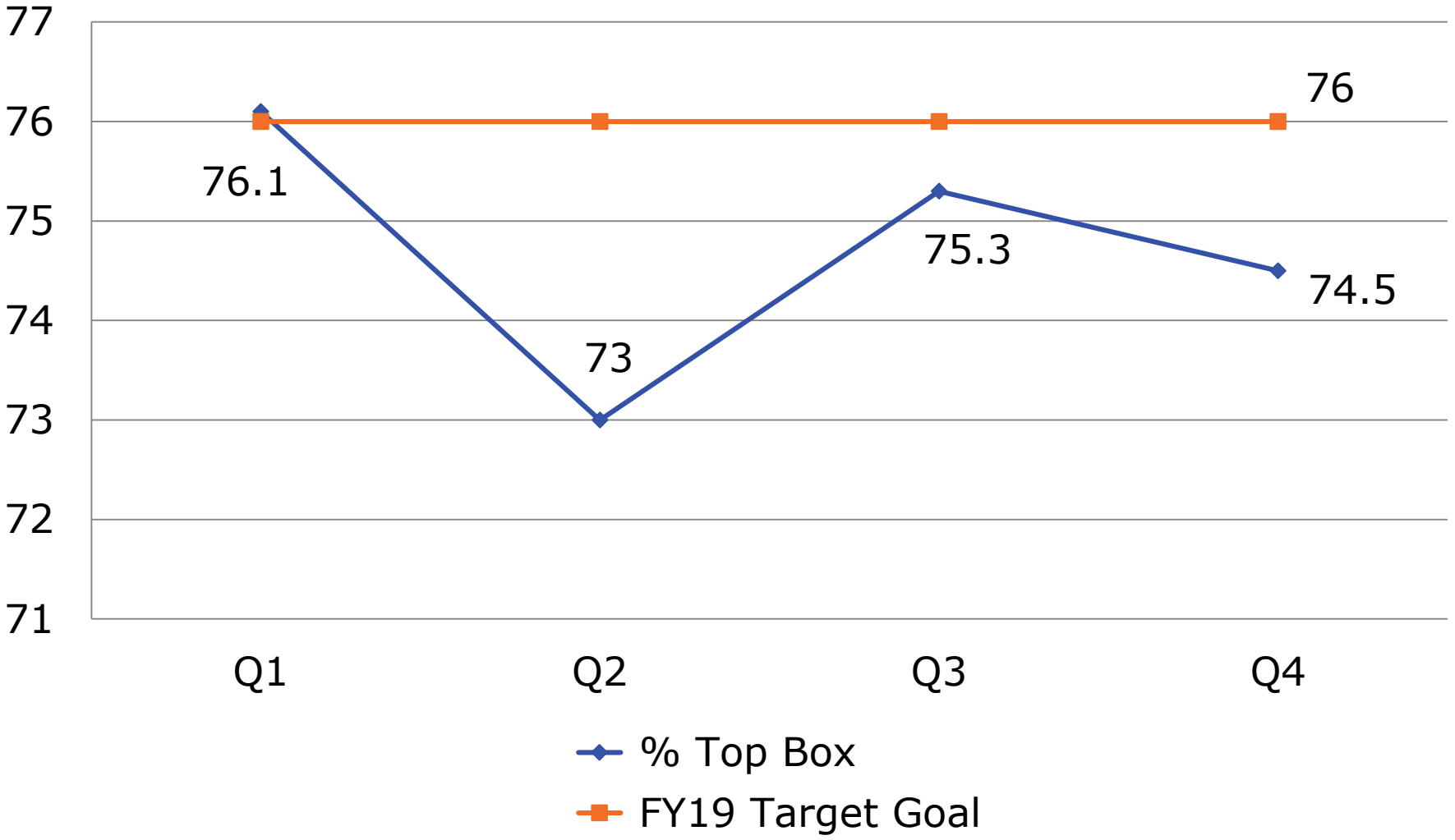
*All numbers are top box %

- Have expanded the multi-disciplinary process improvement workgroups to implement processes and monitor progress. Teams have begun meeting to identify best practices.
- During the social media crisis, resources were diverted for 3-4 weeks, resulting in a slight delay of project implementation.

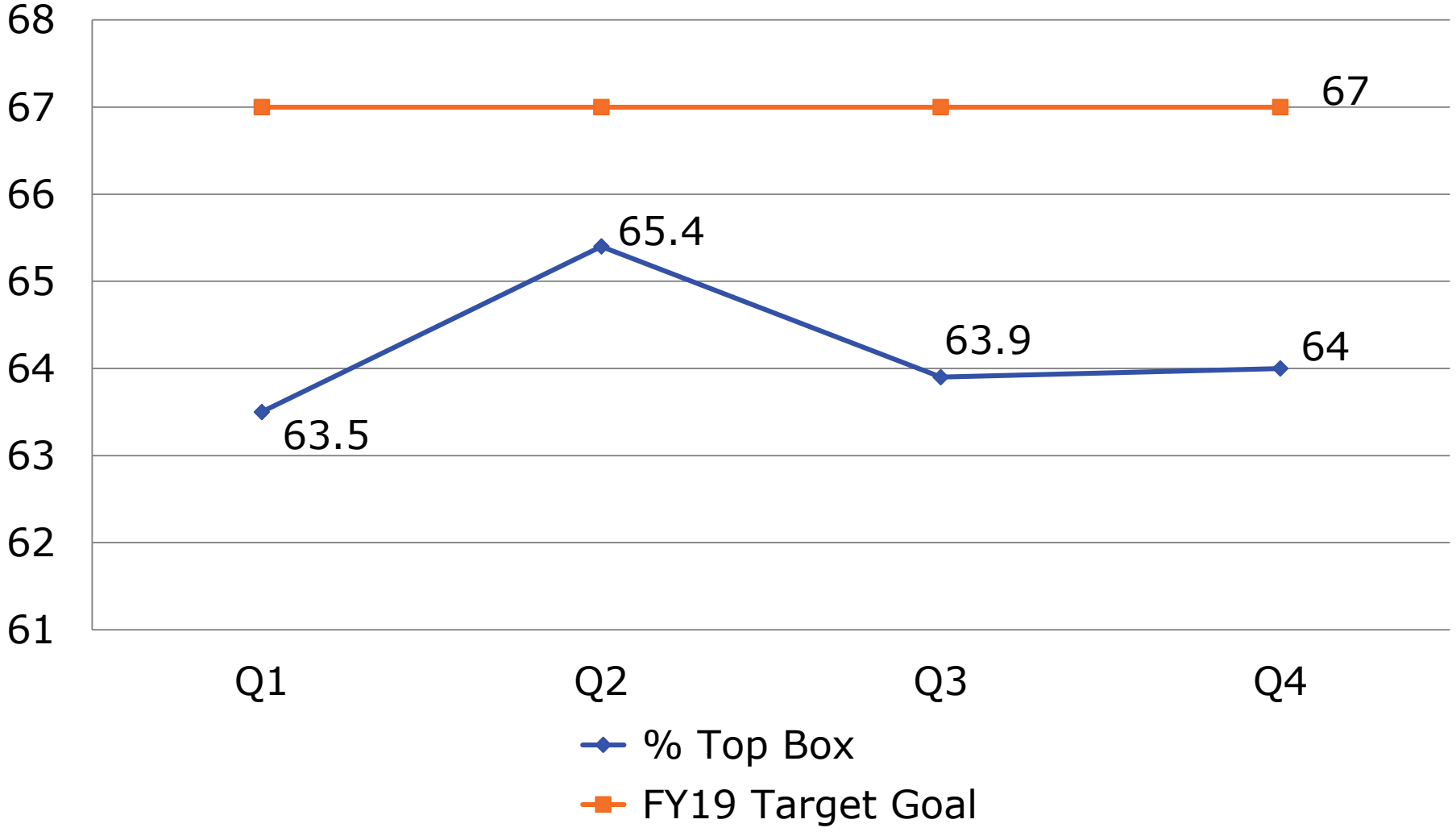
Nursing Communication FY19 Org Goal
FYTD 2018 Data—Received Date



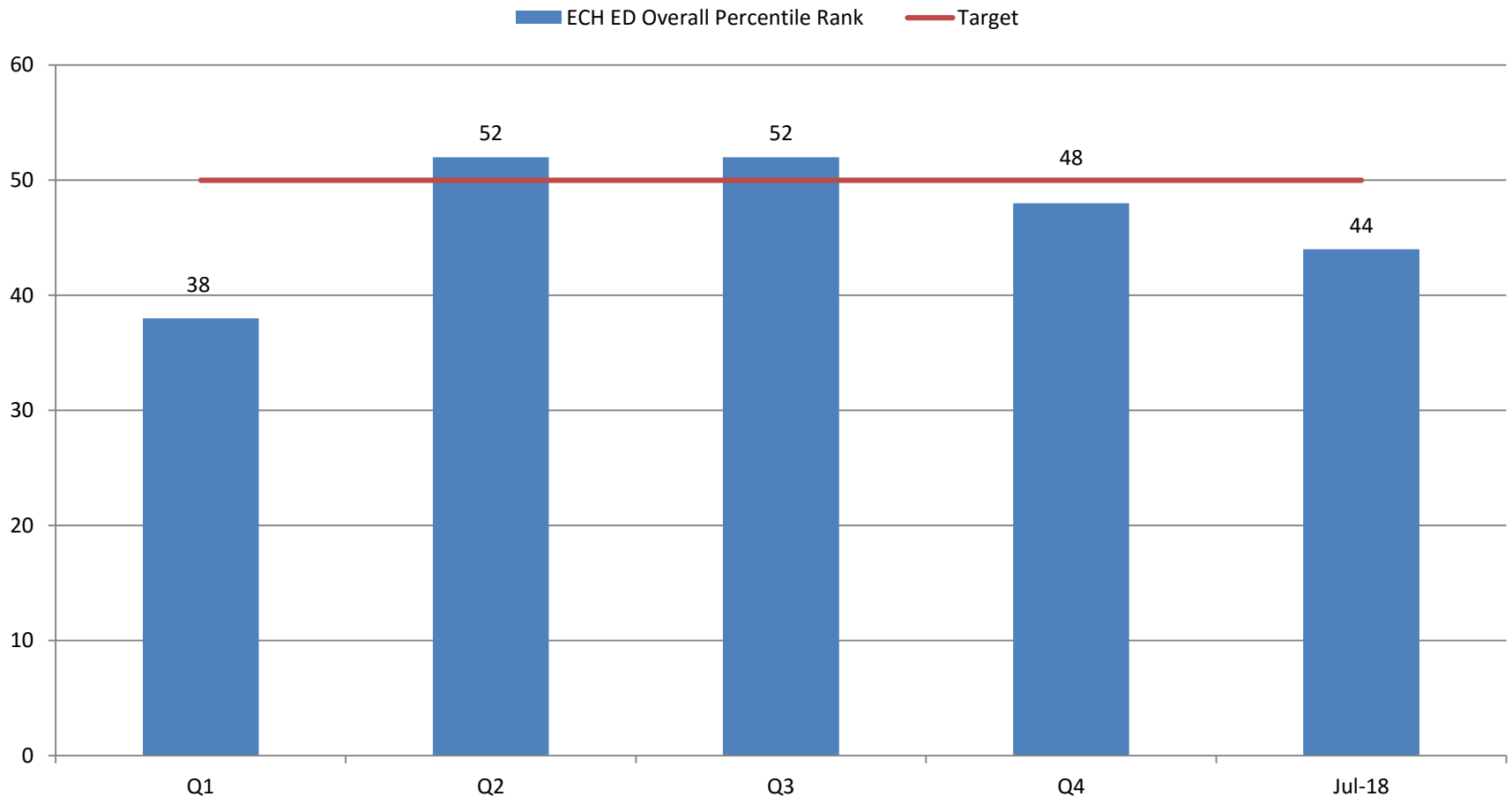
Cleanliness FY19 Org Goal
FYTD 2018 Data—Received Date



Responsiveness FY19 Org Goal
FYTD 2018 Data—Received Date



ED Overall
FY19 Goal: Above 50th Percentile Rank (National)



FY 2019 ED Patient Experience Road Map Priorities

Patients

- Seek PFAC input on ED experience & "Wow" factors, reconfirm aspects of wait time, seeing a doctor, comfort in waiting room, belongings process, renaming "waiting room"
- Inquire of past PFAC members with ED specific experiences
- **Perform Patient Journey Observations**
- **Seek patients and family members to potentially serve on PX Champions group**
- **Convene an ED specific PFAC or a ED Focus group, or a diversity advisory council**

Processes

Perform throughput project for FY 2019 goal

Identify metrics and goals for initiatives to track progress

Expand use and monitor use of Patient Passport

Create patient advocate or ambassador program - specially trained volunteers round on patients and even accompany patients throughout their journey

Ensure consistent adoption of practice by which physicians meeting patients in triage

Begin Post-Discharge Phone Calls to d/c patients & visits to admitted patients

Staff & Physicians

Offer Care Team Coaching for physicians and nurses by DTA coaches

Create PX Champions group – interdisciplinary team (physicians, nurses, techs, security, coordinators/admin support, social work) to determine improvements

Design and deliver training modules on biggest aspects of ED experience lacking - with input from PX Champions and patients

Diversity & Inclusion training

Follow this workshop with Care Team Coaching for every team member

Feedback

Align all paper surveys to ED CAHPS & ensure adequate volume

Review patient comments to validate themes & look for "Wow" factors

Begin leader rounding in waiting room, in ED, & on patients admitted from ED to inpatient units (not just ED leaders)

Institute a text survey to provide greater volume of patient voices, sooner and in a more modern mode

Amenities & Technology

Evaluate TV/entertainment on demand for patient rooms

Consider providing iPads or tablets for patient use in check in and time management

Regardless of which mode (TV or iPad), incorporate interactive technology which allows for electronic care board for staff identification, plan of care, and patient journey tracking

Incorporate other ideas per patient and PFAC input and PX Champions group

Resources

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Hospital UPDATE
September 5, 2018
Mark Adams, CMO

Quality and Safety

We established a new patient safety task force to enhance our focus on this vital area. Following two clinical summits with a multidisciplinary team of physicians, nurses, pharmacists, and management, we initiated an extensive work plan to address our organizational quality goals to reduce mortality and readmissions. The Joint Commission (TJC) preparation continues. Weekly follow-up on action items identified through the mock survey is conducted. The window for TJC survey is now open and they could arrive any week between now and January 2019.

Patient Experience

We developed a Patient Experience Plan to achieve our FY19 strategic and organizational goals related to patient experience improvements. Of note, in June we began a weekly meeting focused in specific initiatives related to communication improvements in our ED that are being initiated. These include care team coaching for all physicians and other communication techniques that will improve expectation and experience for our patients. We await our final survey to determine how we performed on our Patient Experience FY18 goals.

Operations

High Performance Organization Team: Strategy Deployment Update - During Q4 of FY18, members of the ECH leadership team focused significant efforts on deploying Lean management throughout the enterprise, including a value stream analysis with a multidisciplinary team of roughly 30 clinical and administrative personnel, covering the Patient Flow initiative from ED arrival until the patient's "head in bed." As a result, 18 performance improvement teams are being organized with specific goals and objectives to accomplish during Q1 of FY19.

Workforce

Our Employee Alternative Transportation Strategy Task Force continues to work on creating alternative transportation options for employees commuting to/from ECH each day. In the next two months we will prepare to launch a Transit Pass Subsidy program. If ridership is sufficient to substantiate the expense, we will launch an East Bay Shuttle pilot later this fall. The Enterprise Resource Planning (ERP) Initiative is targeted for a formal launch September 1, 2018. On September 17th, we will begin our combined Employee and Physician Engagement, Culture of Safety, and Nursing Excellence survey.

Cohort 5 (8 students) began their New RN Graduate Program journey with us this summer and Cohort 6 (7 students) will begin on September 25. This program will build our pipeline of ECH nurses as we mitigate nursing staff vacancies due to retirements, a national nursing shortage, and local housing and traffic barriers.

We achieved ANCC (American Nurses Credential Center) Accreditation for our Practice Transition Program (training program for new graduates and change of specialty RNs). This is a new requirement for our 4th Magnet Designation application.

Financial Services

The Revenue Cycle Team achieved outstanding results in FY18. Our cash collection was $882 million exceeding our target by $50 million, up front collections were $4.1 million achieving $1 million more than target, and insurance denial recoveries in FY18 was $27.9 million. In FY19, we are going to increase our focus on preventing avoidable denials and work closely with our Departments and Service Lines to achieve this.

Our cost initiative for FY19 is $2,200,000. As of July 26, 2018 we have implemented $310,351 in savings.

To avoid interruption in dictation/transcription capabilities, we completed the dual transcription platform project with iMedx as the secondary vendor providing redundancy for these services. This aligns with physician integration supporting an excellent environment for physician practice at El Camino.

Marketing and Communications

The marketing team is heavily engaged in consumer research planning, implementation and reporting for multiple studies as well as working towards enhancing our consumers' experience online via upgrading and rebuilding our website in FY19. They are also providing help with overall marketing strategy for SVMD and marketing support for its clinic openings. The annual Men's Health Fair at our Los Gatos Campus enabled three hundred community members to connect with more than 20 physician specialties.

Information Services

Implementation of a new PACs system is on track for activation by early 2019 and ePrescribing of controlled substances is available to improve the medication ordering process.

The Physician Efficiency Initiative focused upon the Winchester Clinic to provide training, workflow improvements, Epic software enhancements, and personalization with physician efficiency improvement measures. The two ambulatory physicians demonstrated a 16.9% and 0.4% increase in efficiency saving between 75 and 110 minutes per day for the physicians. A physician onboarding and data conversion plan is in process to improve physician efficiency when transitioning to Epic from a paper or EMR based system.

Registration staff have iPads to assist patients with enrollment in MyChart during registration process. Over 200 employees signed up for MyChart last month and overall patient enrollment is at 12% for June 2018. We are meeting with Ambulatory Clinics and departments to review department specific statistics and determine plan to increase numbers to reach the 50% goal.

Progress on the MyChart Bedside project continues with plans to bring the initially identified departments live with MyChart Bedside on a mounted iPad for each patient by the end of this calendar year.

Corporate and Community Health (CONCERN and Community Benefit)

In June, the Community Benefit Sponsorship Program provided support to a Silicon Valley YWCA event to address domestic violence, the Sunnyvale Police Athletic League's Kick, Lead and Dream Camp for underserved youth, and Los Gatos Lions Club event to address youth mental health.

The South Asian Heart Center partnered with India Community Center on a health and wellness event "Cracking the Wellness Code" attended by over 600 members of the community and with MayView Community Health center to conduct a nutrition workshop for underserved patients.

The LG Health Librarian provided information about ECH's involvement in the Health Equality Index during the week of June 18th through June 22nd to visitors and staff. This included information regarding ECH's commitment to supporting the LGBTQ Community in a culturally competent manner. LGBTQ Community resource flyers and information on staff CEU training resources were distributed.

The Chinese Health Initiative surpassed all the goals of its new diabetes prevention and education program (funded by the ECH Foundation). They provided culturally tailored educational materials, screening, and dietitian consultations to help Chinese community members who are at high risk for diabetes make positive life styles changes. The Foundation approved a second year of grant funding.

Silicon Valley Medical Development, LLC

SVMD is rapidly filling out its administrative infrastructure and has its administrative office with Concern:EAP in Mountain View. The new Melchor Clinic was opened with support by the IT Department to enable technology and the Epic platform for Dr. Gussous and Dr. Prabhu who joined ECMA this summer.

Philanthropy

The El Camino Hospital Foundation achieved 100% of its FY18 fundraising goal by the end of the fiscal year. During the month of June, the Foundation secured $410,768 which brought its annual total to $6,149,592. Giving from Foundation Board members totaled $414,420.

Auxiliary

The Auxiliary contributed 7,059 volunteer hours in May and 6,522 hours on June 2018.