El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Monday, October 1st, 2018 - 5:30 p.m.
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Katie Anderson will be participating via teleconference from 231 Canyon Drive, Portola Valley, CA 94028.

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	David Reeder, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Quality Committee Chair		**5:32 – 5:33**
3.	**INTRODUCTIONS**	David Reeder, Quality Committee Chair		**5:33 – 5:34**
4.	**CONSENT CALENDAR ITEMS:** *Any Committee Member or member of the public may pull an item for discussion before a motion is made.*	David Reeder, Quality Committee Chair	*public comment*	**Motion Required 5:33 – 5:36**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (August 6, 2018) b. Minutes of the Open Session of the Quality Committee Meeting (September 5, 2018) ***Information*** c. Patient Story d. FY19 Pacing Plan e. Progress Against FY19 Committee Goals			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	David Reeder, Quality Committee Chair		**Discussion 5:36 – 5:39**
6.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 6**	Mark Adams, MD, CMO		**Discussion 5:39 – 5:54**
7.	**MEDICAL STAFF CREDENTIALING PROCESS** **ATTACHMENT 7**	Mark Adams, MD, CMO		**Discussion 5:54 – 6:14**
8.	**EMERGENCY DEPARTMENT PATIENT SATISFACTION** **ATTACHMENT 8**	Cheryl Reinking, RN, CNO		**Discussion 6:14 – 6:29**
9.	**HOSPITAL UPDATE** **ATTACHMENT 9**	Mark Adams, MD, CMO		**Discussion 6:29 – 6:39**
10.	**PUBLIC COMMUNICATION**	David Reeder, Quality Committee Chair		**Information 6:39 – 6:42**

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**ADJOURN TO CLOSED SESSION**	David Reeder, Quality Committee Chair		**Motion Required 6:42 – 6:43**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Quality Committee Chair		**6:43 – 6:44**
13.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	David Reeder, Quality Committee Chair		**Motion Required 6:44 – 6:47**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (August 6, 2018) b. Minutes of the Closed Session of the Quality Committee Meeting (September 5, 2018) *Health and Safety Code Section 32155.* c. Annual Safety Report ***Information*** d. Quality Council Minutes			
14.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - CMO Report	Mark Adams, MD, CMO		**Discussion 6:47 – 6:57**
15.	*Health and Safety Code Section 32155* for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		**Discussion 6:57 – 7:02**
16.	**ADJOURN TO OPEN SESSION**	David Reeder, Quality Committee Chair		**Motion Required 7:02 – 7:03**
17.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Quality Committee Chair		**7:03 – 7:04**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**ADJOURNMENT**	David Reeder, Quality Committee Chair	*public comment*	**Motion Required 7:04 – 7:05pm**

Upcoming FY19 Meetings: November 5, 2018 | December 3, 2018 | February 4, 2019 | March 4, 2019 | April 1, 2019 | May 6, 2019 | June 3, 2019 || **Board/Committee Educational Gathering:** October 24, 2018 | April 24, 2019

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. **Noes:** None **Abstentions:** None **Absent:** Bauman, Kliger **Excused:** None **Recused:** None	***The open minutes of the June 4, 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.	***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 **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	Dr. Mark Adams, Interim Chief Medical Officer, provided a	***None***

Agenda Item	Comments/Discussion	Approvals/Action
REPORT	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.	
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.***
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

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Meeting of the El Camino Hospital Board
Wednesday September 5, 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; Katie Anderson, And Ina Bauman,	Wendy Ron Julie Kliger Peter Fung, MD and Melora Simon	

** Jeffrey Davis, MD joined via teleconference at 5:30pm*

A quorum was not present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 5th of September, 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 Stephanie Iljin to take a silent roll call. Wendy Ron was absent for the meeting. Jeffrey Davis, MD joined via teleconference.	***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 (August 6, 2018).	***Deferred due to lack of quorum.***
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee. He further announced the placement of Dr. Mark Adams as our permanent Chief Medical Officer, and made special mention of the Board recognition of the Sepsis Team for their Joint Commission Certification.	***None***
6. FY18 QUALITY FINAL RESULTS	Dr. Mark Adams, Chief Medical Officer, provided the final results of nine metrics as they reflect the Hospital's FY18 Quality, Efficiency and Service Goals. He detailed each goal's final standing along with improvement plans for each	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	goal not met for FY19. Dr. Adams noted that there were zero new CAUTIs for June establishing a 3 month trend, one new CLABSI after 6 months with none, and average LOS below FY17 average since February 2018, which continues to improve.	
7. FY19 QUALITY DASHBOARD	Dr. Adams presented on the FY19 Quality Dashboard to the Committee and noted that there were 4 new CAUTIs and zero CLABSI in the month July, and that the Mortality and Readmission Index has been added to the dashboard for review. He further acknowledged the HAI A3 work in FY18 and their accomplishments: CAUTIs were reduced but did not meet goal, CLABSIs were reduced and did meet goal, and C Diff were also reduced and exceeded the goal.	***None***
8. MORTALITY AND READMISSION METRICS (FY19 QUALITY GOALS)	Dr. Adams reviewed two of the key organizational goals, including improving our mortality index and our readmission index. Dr. Adams discussed the importance of the goals, explained the derivation of the goals, and reviewed the work plan to attain the goals. The team evaluated baseline, trend, volatility, how to move the bar, attainability, and level of organizational stretch. Dr. Adams further outlined the quality readmissions and mortality committee structure and charter that includes 60 people with 15 physicians on several teams commissioned to impact a slow change.	***Broader discussion of what is quality to be paced at a future meeting*** ***FY19 dashboard to provide context for each goal not performing at target, change "goal" as currently used on the dashboard to "target," focus on the trend, and highlight outliers outside of the expected trend.***
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Cheryl Reinking, Chief Nursing Officer, provided an overview Patient Care Experience Scores for the Organizational Goals (Nurse Communication, Responsiveness, and Cleanliness) and the current efforts of the teams addressing performance improvement. She shared the Patient Care Experience scores to include the Emergency Department and presented the plan to address the ED patient care experience scores in conjunction with the ED flow work. Mrs. Reinking asked for feedback from the Committee and a brief discussion ensued.	***None***
10. HOSPITAL UPDATE	Dr. Adams provided a brief hospital update to the committee members as further detailed in the packet with the Committee.	***None***
11. PUBLIC COMMUNICATION	None.	***None***
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:38 pm. **Movant:** Anderson **Second:** Bauman **Ayes:** Anderson, Bauman, Davis, and Reeder **Noes:** None **Abstentions:** None **Absent:** Fung, Kliger, Simon and Ron	***Adjourned to closed session @ 6:38pm.***

Agenda Item	Comments/Discussion	Approvals/Action
	Excused: None **Recused:** None	
13. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:02 pm. Chair Reeder disclosed that agenda items 13-17 were discussed in closed session. No actions were taken by the committee.	***None***
14. AGENDA ITEM 19: ADJOURNMENT	The meeting was adjourned at 7:03pm. **Motion:** To adjourn at 7:03 pm. **Movant:** Reeder **Second:** Bauman **Ayes:** Anderson, Bauman, Davis, and Reeder **Noes:** None **Abstentions:** None **Absent:** Fung, Kliger, Simon and Ron **Excused:** None **Recused:** None	***Meeting adjourned @ 7:03pm.***

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

PATIENT STORY – June 7, 2018

I wanted to formally thank you and all of your staff at El Camino Rehabilitation Center. While I don't have an extensive experience with rehabilitation facilities, I can't imagine any better.

The treatment that I received while recuperating was caring and professional. The cheerful and upbeat attitude of every person there was exceptional, while their therapy acumen was amazing.

I think that you were the first person (Physician) I met when I checked in. Your calm, unhurried manner really helped put me and my family at ease and confirmed that we made the right choice.

The nursing staff was also caring and always professional. I was impressed with their responsiveness and appreciated the staffing level on every shift. The occupational and physical therapists were also extremely helpful and encouraging. I learned a lot from them that I will carry over to my everyday life.

While my primary goal was to be able to get on an airplane and return to Oklahoma, I think I am much further ahead because of my stay in your great facility. Though I may have blown my chance at making the line-up of Golden State, I was able to make memories with my 6 year old grandson.

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: 7. Update on Patient and Family Centered Care 8. Mortality and Readmissions Metrics (FY19 Quality Goals) 9. Annual Patient Safety Report ~~10. Delegation of Authority to the Advisory Committees~~ 11. FY18 Quality Dashboard Final Results 12. Pt. Experience (HCAHPS) 13. ED Pt. Satisfaction (Press Ganey)
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 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**, 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 – reviewed FY18 results on 9/5/18; FY20 goals review paced for 3/4/19
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) N/A - Review Medical Staff credentialing process (FY19) – to be reviewed at 10/1/2018 meeting
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 – on track
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 – paced quarterly
5. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals – on the FY19 dashboard

SUBMITTED BY:

Chair: David Reeder
Executive Sponsor: Mark Adams, MD, CMO
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 October 1, 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 September 2018 ECH and ECHD Board Actions	

ECH Board Actions*

1. September 12, 2018 – Approved FY18 Organizational Goal Score

ECHD Board Actions*

1. September 12, 2018 - Approved Re-Branding 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.

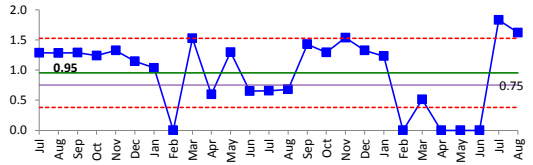
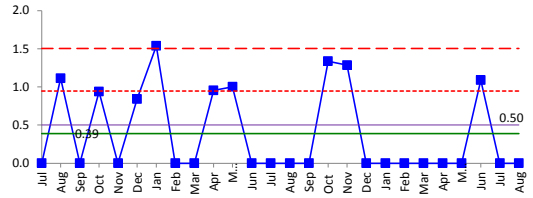
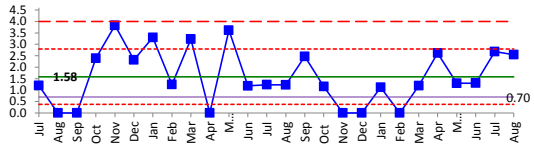
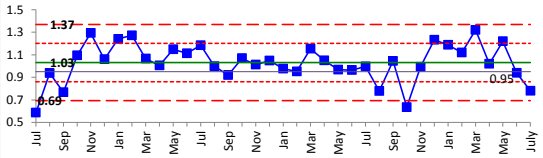
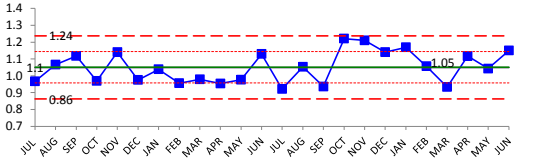
ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	FY19 Quality Dashboard Quality Committee of the Board October 1, 2018
	Responsible party:	Catherine Carson, MPA, BSN, RN, CPHQ; Sr. Director, Quality Improvement and Patient Safety / 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 FY19 Quality, Efficiency, and Service Goals.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: N/A	
	Summary and session objectives : To provide the Committee with a snapshot of the FY19 metrics monthly with trends over time and compared to the actual results from FY18 and the FY19 goals. Annotation is provided to explain actions taken affecting each metric.	
	Suggested discussion items: 1. Two (2) new CAUTIs for August. The number of catheters in place has significantly decreased which is a positive trend. However, any catheter infection then creates a higher SIR illustrated by the increase to 1.72 FYTD because of the 4 CAUTI's. There is an increased risk of CAUTI of 5% per day that the catheter is in place. We have had several justified long term catheters that have become infected. 2. Zero (0) new CLABSI in August. 3. CDI 2.62: 2 new cases as described. Hand washing, contact precautions, and room cleaning all factors needing additional work to prevent spread. (There are normal carriers of C. Diff where screening can be a benefit.) 4. Data for new FY19 Quality goals: Mortality Index & Readmission Index. Ten (10) teams meeting to address issues and barriers for both the Mortality & Readmission Indexes. 5. Four (4) teams supporting work on Hospital-Acquired Infections (HAIs) consolidated into one (1) HAI Team that includes Hand Hygiene, meeting monthly to continue unfinished work and sustain improvements in FY19. 6. New teams and actions to support Service goal in place. Caregiver coaching initiated.	
	Proposed Committee motion, if any: None. This is a discussion item.	
	LIST OF ATTACHMENTS: 1. FY19 Quality Dashboard final results	

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

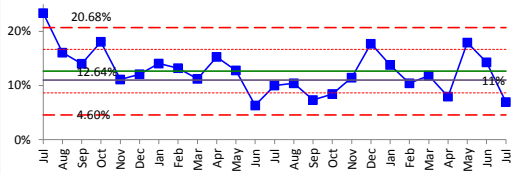
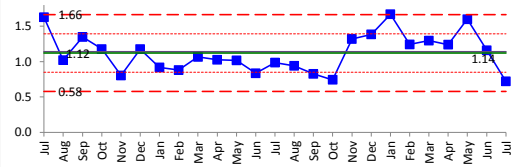
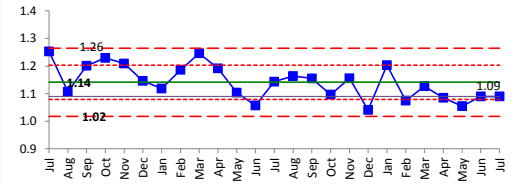
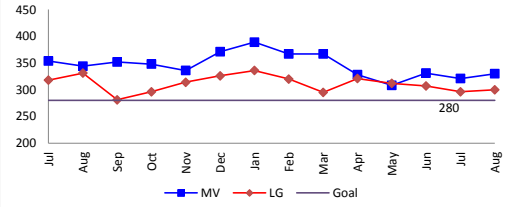
Final Quality Dashboard (August)

Month to Board Quality Committee: October 2018

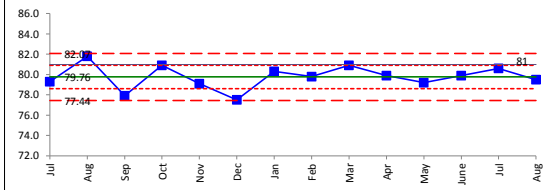
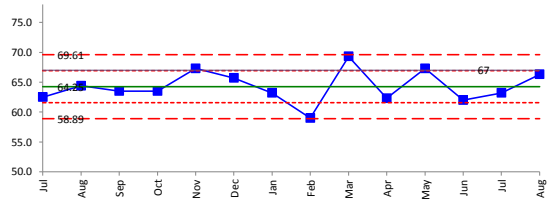
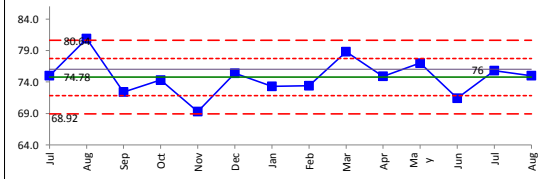
Quality	Performance Month	Performance FYTD	FY18 Actual	FY19 Target	Trend	Comments
			FY18 Actual	FY2019 Target		
1 **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: August 2018* *SIR Goal: <= 0.75*	1.62 (2/1233)	1.72 (4/2324)	0.77 (Improved from 1.09 for FY 2017)	SIR Goal: <= 0.75		2 new CAUTIs in August: 1- Female craniotomy pt., foley inserted in OR, removed postoperatively. Foley re-inserted P.O. Day 2 w/ 2 nurses for retention. Pt became unstable-intubated. Urine culture after 2 days with temp. 2- 85 y/o male w/acute CVA, prior stroke. Pt. unable to void, retention per bladder scan, straight cath done, continued retention - foley inserted. Developed fever, clear CXR, UA ordered.
2 *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: August 2018* *SIR Goal: <= 0.50*	0.0 (0/783)	0.0 (0/1662)	0.23 (improved from 0.56 for FY 2017)	SIR Goal: <= 0.50		Return to zero for CLABSI in August.
3 *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: August 2018* *SIR Goal: <= 0.70*	2.55 (2/7845)	2.62 (4/15295)	1.13 (improved from 1.89 for FY 2017)	SIR Goal: <= 0.70		2 new C.Diff infections: 1-33 y/o female w/amphetamine toxicity, brought to ED to 3AC, no Hx of C.diff, no surveillance on admit. Developed loose stools after 3 days, on 2 ABX total 9 doses, on Pepsid. 2- 69 y/o acute Resp. failure, Metastatic Breast CA with mets had been on steriods & chemo. On 2 ABX x 17 doses, positive C.Diff after 12 days
4 *Organizational Goal* **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: July 2018*	0.78 (1.18%/1.52%)	0.78 (1.18%/1.52%)	1.05 (stable, compared to 1.02 for FY 2017)	0.95		CDI has filled 4 open positions, 1 remains open. Mgr. meeting with physicians to improve documentation. Steady drop in Mortality O/E since May. 3 teams supporting Mortality goal meeting.
5 *Organizational Goal* **Readmission Index (All Patient, All Cause Redmit)** *Observed/Expected* ***Premier Standard Risk Calculation Mode*** Date Period: June 2018	1.15	1.08	1.08 (stable, compared to 1.02 for FY 2017)	1.05		6 teams meeting to support Readmissions Goal, Weekly Readmission Team now includes review of all Medicare and MediCal readmissions. EPIC Cognitive computing tool that predicts risk fo readmission explored and to be part of March 2019 EPIC upgrade.

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**

		Performance			FY19 Target	Trend	Comments
Quality		**Month**	**FYTD**	**FY 2018**	**FY 2019 Target**		
6	**Sepsis Mortality Rate Enterprise** *Date Period: July 2018*	6.94%	6.94%	11.71% (improved from 13.66% for FY 2017)	11%		California's mortality rate for 2017 = 14.9 % while the northern CA (Hospital Council) rate for 2017 is 13.7%. Lower mortality may be related to lower census in July.
7	**Sepsis Mortality Index** *(Observed over Expected)* *Date Period: July 2018*	0.72	0.72	1.19 (1.05 for FY 2017)	1.14		Lower observed deaths than expected, index dropped since May, not yet a trend.
Efficiency		**Month**	**FYTD**	**FY18 Actual**	**FY 2019 Target**		
8	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: July 2018*	1.09	1.09	1.12 (improved from 1.16 for FY 2017)	1.09		Observed/expected LOS at goal for June & July, good trend since March.
9	★Organizational Goal **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: August 2018*	MV: 330 mins LG: 300 mins	MV: 325 mins LG: 298 mins	MV: 350 mins; LG: 314 mins	280 mins		MV: team reviewing MD Order to floor (from ED) weekly with weekly Huddle. LG: Focusing on pulling patients from ED to floor and identifying barriers.

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 Target	Trend	Comments
SERVICE		FY19 Performance Month	FYTD	Q4 2017-Q3 2018	FY 2019 Target		
10	«Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: August 2018*	79.5 (204/257)	80.1 (420/525)	80.0	81.0		Focus in on "Purposeful Rounding" implementation.
11	«Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: August 2018*	66.3 (164/247)	64.7 (323/499)	65.1	67.0		Teams promoting a "No pass Zone," all staff are to not pass a room with a call light on and enter the room to acknowledge the light and then access the appropriate staff. Also setting an objective of addressing each call light w/I 5 minutes and before the call light cycles again.
12	«Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: August 2018*	75.0 (192/256)	75.4 (393/521)	74.5	76.0		Team includes EVS, Facilities, and Nursing to idenify room clutter and debris, and find solutions to limit it.

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**

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Medical Staff Credentialing Process

Mark Adams, MD, CMO

Quality Committee

October 1, 2018

Medical Staff Credentialing Process

Application to include:

- Contact information
- Education
- Work history
- Current CV
- State Licensure
- Board certification
- Malpractice Liability Insurance
- DEA certification

Medical Staff Credentialing Process

Primary Source Verification:

- Verifying training and education through the American Medical Association or the Educational Commission for Foreign Medical Graduates if the applicant was educated outside the United States
- Verifying current medical licensure in the state
- Verifying employment history
- Verifying Medicare sanction information through the OIG sanctions exclusion database
- Querying the National Practitioner Data Bank on closed and settled claims history

Medical Staff Credentialing Process

Primary Source Verification:

- Reviewing any time gaps in education or career
  - If the applicant has more than a six (6) month period of time when they are not enrolled in a program at a medical teaching institution or employed as a physician, the applicant is asked to provide a detailed explanation on the application

- Verifying the status of the applicant's privileges at hospitals and other health care facilities as listed on the application

Medical Staff Credentialing Process

- Criminal Background Check
- Peer References
- Malpractice Claims Review (NPDB)

Medical Staff Credentialing Process

- Does the applicant meet the qualifications for medical staff membership specified in the medical staff bylaws
- If so, next step is consideration of Privileges

Medical Staff Privileges

- Applicant completes privilege request form
- Based on the specialty, this is reviewed by the pertinent department chair
- Core privileges vs specialized privileges considered

Medical Staff Privileging

- Provisional Status
- Focused Professional Practice Evaluation
- Proctoring as needed

Medical Staff Privileging

- Provisional Status changed to Active
- Ongoing Professional Practice Evaluation q 8 months to include core competencies

Core Competencies

- Patient care
- Medical Knowledge
- Professionalism
- Systems-based Practice
- Practice-based Learning
- Interpersonal and Communication Skills

Privileging and Credentialing

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Patient Experience

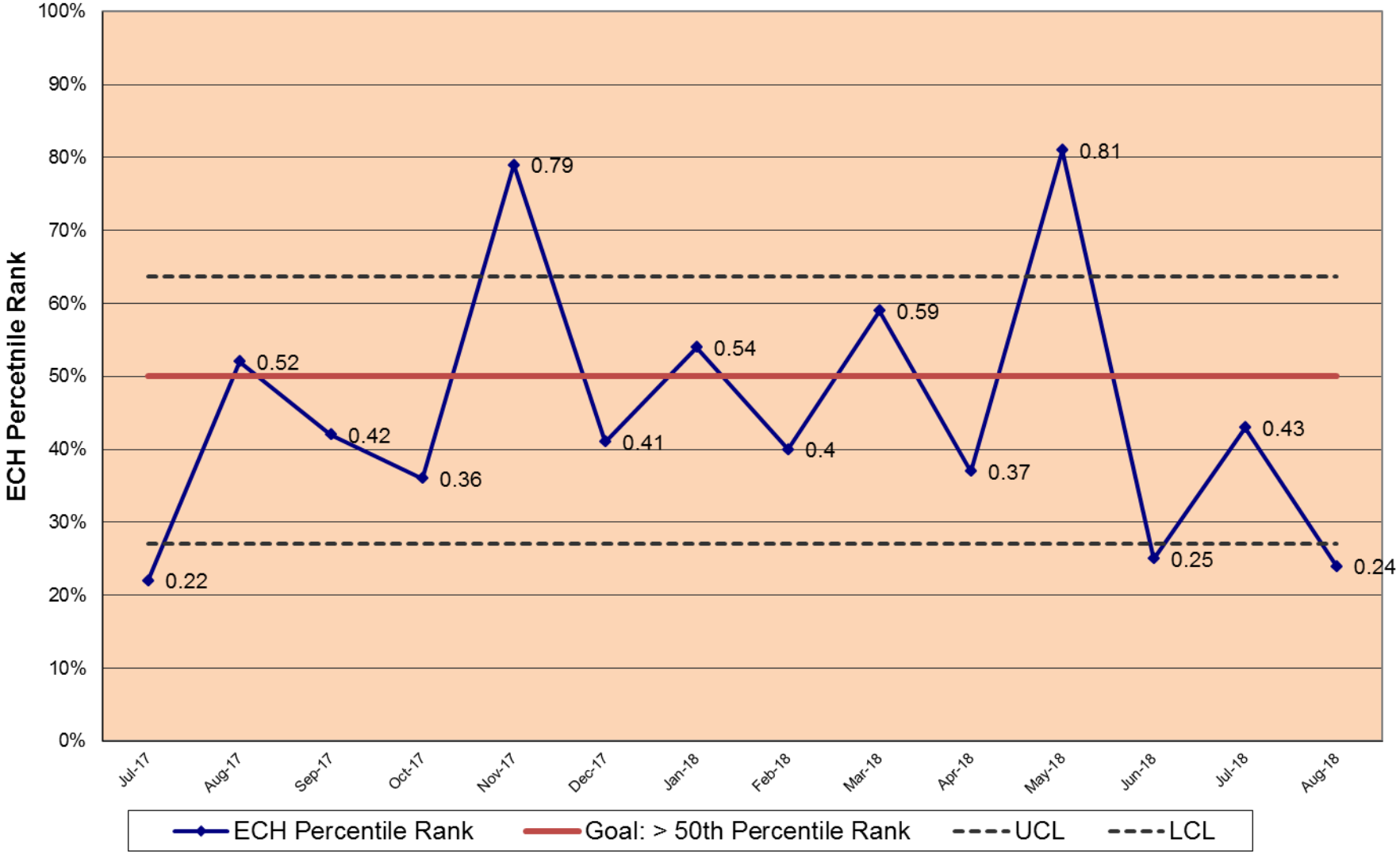
Quality, Patient Care and Patient Experience Committee

Cheryl Reinking, MS, RN, NEA-BC

October 1, 2018

ED Overall

July 2017 - August 2018

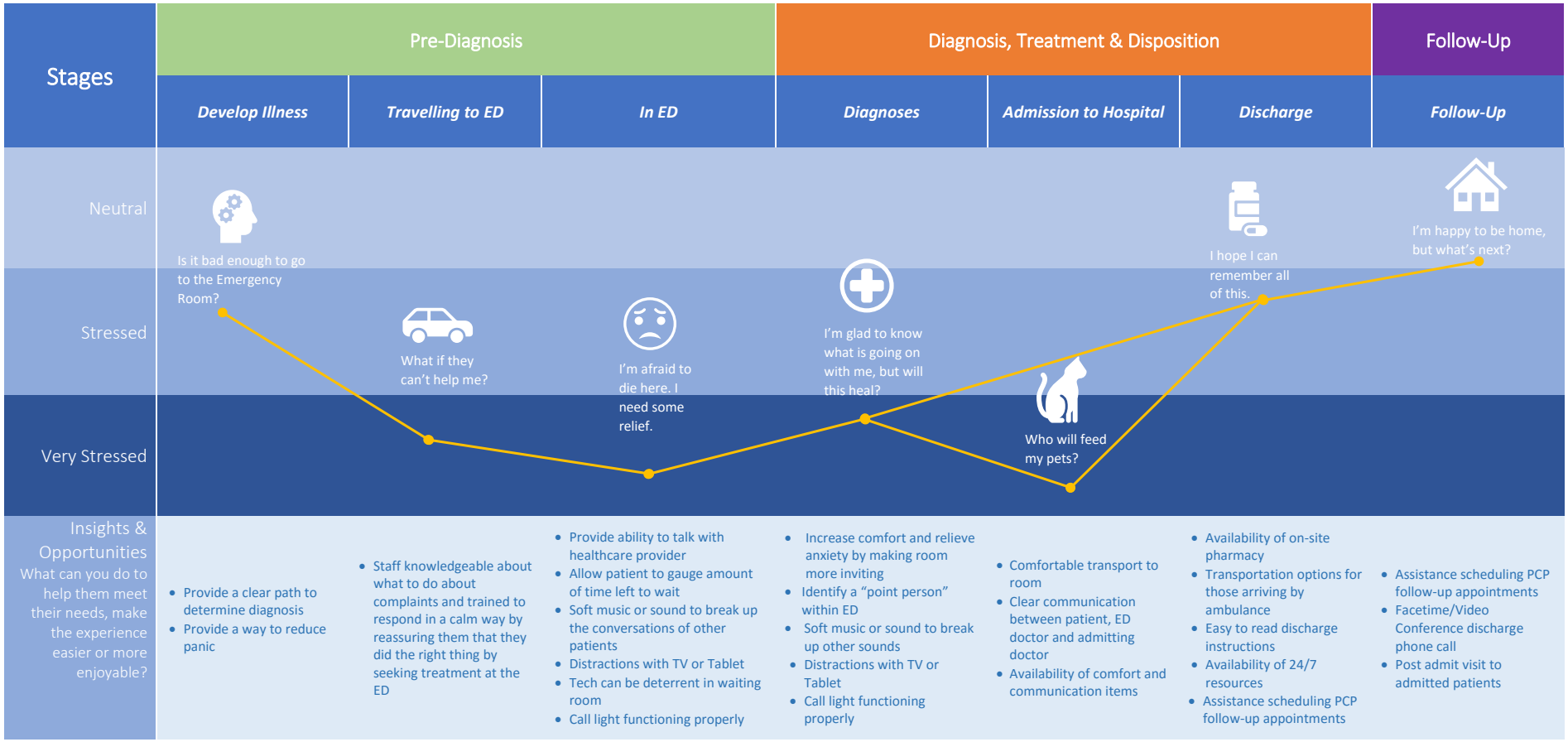


ED Improvement Milestones

September

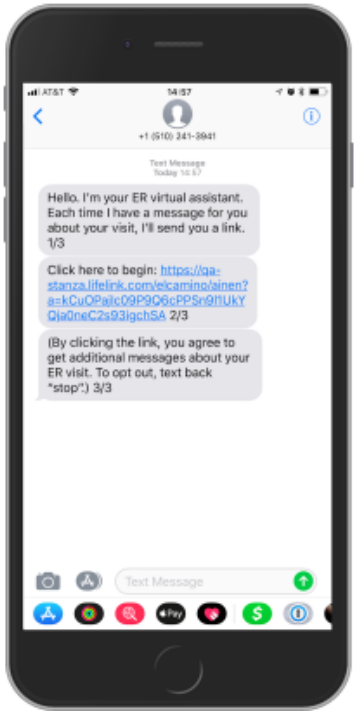
- Physician Coaching
- Patient Journey Observations
- Steering Team Meets Twice A Month
- Patient Experience Champion Group Kicks Off
- Patient ED Focus Group Work Started
- Develop Plan For Waiting Room Rounding
- Expand Post Admit Bedside Visits
- Enhance Current Call Back Process

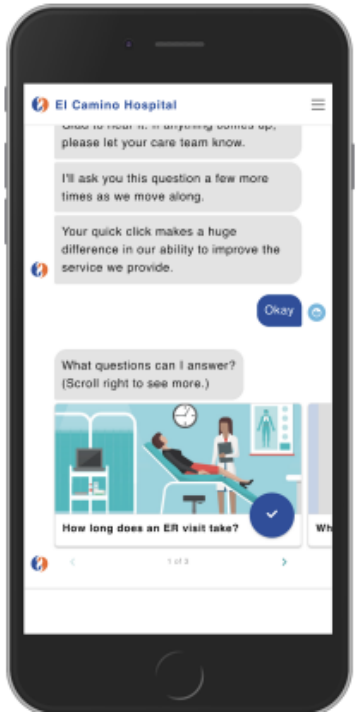
ED Patient Journey Observations



LifeLink—Digital Patient Engagement Platform for ED

- Go live 9/26
- Keeps patients informed and engaged through conversational engagement on their smartphone
- Helps patients understand expectations during ED visit





El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

HOSPITAL UPDATE
October 1, 2018
Mark Adams, MD, CMO

Quality and Safety

The first meeting of the newly constituted Chief Medical Officer Advisory Council (CMOAC) was held on August 22. The CMOAC is comprised of all of our compensated medical directors. This provides a forum to communicate directly with our medical directors to keep them updated on important organizational activities, seek input from them to contribute their expertise toward our clinical programs, enhance their leadership skills, and interact with each other to share learnings and experience. The first meeting was devoted to reviewing our FY19 organizational goals and how we can best align their work with these goals.

Patient Experience

The patient experience improvement work continues to move ahead with zeal. There are numerous stakeholder teams working on Nursing Communication, Responsiveness, and Cleanliness. In addition, there are separate teams addressing ED Patient Satisfaction. There is also a team creating a 3 year road map for the patient experience program at ECH which will be broader and inclusive of all areas of the organization.

Operations

As we reported in April, ECH is reinvigorating its LEAN journey with the objective of embedding Lean principles and processes throughout the entire enterprise. Since April we have made progress in the following areas:

- Designed and implemented Strategy Deployment Room (SDR) and process to monitor progress and escalate issues weekly.
- Rolled out a process whereby organizational and strategic goals have been deployed throughout the organization to front-line work groups.
- Prioritized a list of work to support value-added steps to improve patient flow.
- Management system deployed in the following areas:
  - LG ICU: Improved patient transfer time out of ICU
  - LG Acute Rehab: Improved discharge medication process
  - MV & LG EDs: Improving patient flow from "Door to Floor"
  - MV & LG – multiple nursing departments: Improving patient discharge by noon (note: rate improved by 42% in calendar year 2017)
  - MV CCU: CAUTI rate reduced by 66% during FY18 compared to FY17 (from 9 to 3 cases)
- Trained nine nursing unit coordinators on problem-solving, during which they applied the content to unit-specific issues to support improvement.

Workforce

The new Transit Subsidy Program will be announced in September and, the new East Bay Shuttle pilot will start transporting day shift employees from Fremont and Milpitas to ECH in late September/early October.

New Program

Implementation of the HeartFlow system, a product which provides non- invasive testing via imaging to determine if patient is a candidate for a Cardiac Catheterization, occurred on August 30th with scanning of the first HeartFlow patient by the Radiology Department. The project is sponsored by Dr. Fred St. Goar.

Financial Services

Our cash remains strong. Cash collected in July was $5 million over target of $70 million. Net days in AR remain below target YTD. We have implemented $549,938 in savings against our cost savings initiative of $2.2 Million for the year. To assist new ECMA and clinic providers we have started annual audits of 15 medical records per provider by a HIM professional coder/auditor, revised onboarding process that includes shadowing the providers for the first week, providing real-time onsite support with documentation and coding questions while working with the iCare team to support providers with any additional assistance as needed. We are very proud to have the story of our web based Price Estimator Tool appear in Hospital Access Management in August and Modern Healthcare in July, both national publications.

Marketing and Communications

Our upcoming community education activities include A Healthy Mind series with Fremont Unified High School District, The Women's Health Fair, The Maternal Mental Health Symposium, and Heart & Stroke Walk.

Corporate and Community Health

CONCERN delivered our technology roadmap and new services roadmap to large customers and prospects and identified key accounts to be early adopters for our new Digital Experience platform to pilot in October 2018.

The South Asian Heart Center partnered with the Naatak Group (30 attendees) and the Gujarati Association (50 attendees) to educate the community regarding our programs. We also participated at the Swades (Indian Independence Day) event in Milpitas where we completed 53 biometrics assessments.

The Chinese Health Initiative collaborated with three community service agencies that serve low-income families in Mountain View, Sunnyvale, and Cupertino. On August 22nd, 24th, and 30th, twenty of our CHI volunteers provided Mandarin interpretation for about 325 Chinese seniors who are enrolled in the Challenge Diabetes program and speak limited English.

Silicon Valley Medical Development, LLC

SVMD acquired Direct Urgent Care in Mountain View effective August 13, 2018. Direct Urgent Care, located at 1150 W. El Camino Real, is our second convenient urgent care site, with caring staff committed to getting people better, faster. The Mountain View location will operate under the name Direct Urgent Care, a Silicon Valley Medical Development Service. Our first Direct Urgent Care location opened in Cupertino in May 2018.

Philanthropy

In FY18 the Foundation secured $6,149,592 in gifts, meeting 100% of its fundraising goal. The 23rd annual El Camino Heritage Golf Tournament will take place on Monday October 29th.

Auxiliary

The Auxiliary contributed 6,676 volunteer hours in July 2018.