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

Monday, March 4, 2019 - 5:30 p.m.
El Camino Hospital | Conference Room E&F
2500 Grant Road, Mountain View, CA 94040

Melora Simon will be participating via teleconference from 107 Crescent Ave, Portola Valley, CA 94028

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	Julie Kliger, Quality Committee Chair		**5:30 – 5:32pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**5:32 – 5:33**
3.	**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 (December 3, 2018) b. Minutes of the Open Session of the Quality Committee Meeting (February 4, 2019) ***Information*** c. Patient Story d. FY19 Pacing Plan e. Hospital Update	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required 5:33 – 5:35**
4.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 4**	Julie Kliger, Quality Committee Chair		**Discussion 5:35 – 5:40**
5.	**FY19 QUALITY DASHBOARD** **ATTACHMENT 5**	Mark Adams, MD, CMO		**Discussion 5:40 – 5:50**
6.	**BEHAVIORAL HEALTH SERVICES QUALITY REPORT** **ATTACHMENT 6**	Mark Adams, MD, CMO		**Discussion 5:50 – 6:05**
7.	**SAFETY SURVEY – EMPLOYEE RESULTS** **ATTACHMENT 7**	Mark Adams, MD, CMO		**Discussion 6:05 – 6:20**
8.	**APPOINTMENT OF AD HOC COMMITTEE TO ADDRESS RECRUITMENT OF NEW COMMITTEE MEMBERS** **ATTACHMENT 8**	Julie Kliger, Quality Committee Chair		**Possible Motion 6:20 – 6:35**
9.	**WHAT IS QUALITY** **ATTACHMENT 9**	Julie Kliger, Quality Committee Chair		**Discussion 6:35 – 7:05**

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
10.	**PROPOSED FY20 ORGANIZATIONAL GOALS** **ATTACHMENT 10**	Mark Adams, MD, CMO; Cheryl Reinking, RN, CNO; Jim Griffith, COO		**Possible Motion** **7:05 – 7:25**
11.	**PROPOSED FY20 COMMITTEE GOALS** **ATTACHMENT 11**	Julie Kliger, Quality Committee Chair		**Possible Motion** **7:25 – 7:35**
12.	**PUBLIC COMMUNICATION**	Julie Kliger, Quality Committee Chair		**Information** **7:35 – 7:38**
13.	**ADJOURN TO CLOSED SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required** **7:38 – 7:39**
14.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Julie Kliger, Quality Committee Chair		**7:39 – 7:40**
15.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Julie Kliger, Quality Committee Chair		**Motion Required** **7:40 – 7:42**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (December 3, 2018) b. Minutes of the Closed Session of the Quality Committee Meeting (February 4, 2019) ***Information*** c. Quality Council Minutes			
16.	*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** **7:42 – 7:47**
17.	**ADJOURN TO OPEN SESSION**	Julie Kliger, Quality Committee Chair		**Motion Required** **7:47 – 7:48**
18.	**RECONVENE OPEN SESSION/ REPORT OUT**	Julie Kliger, Quality Committee Chair		**7:48 – 7:49**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
19.	**ADJOURNMENT**	Julie Kliger, Quality Committee Chair	*public comment*	**Motion Required** **7:49 – 7:50pm**

Upcoming FY19 Meetings: April 1, 2019 | May 6, 2019 | June 3, 2019 || **Board/Committee Education:** April 24, 2019

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, December 3, 2018
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present
Katie Anderson
Ina Bauman
Jeffrey Davis, MD
Peter C. Fung, MD
Julie Kliger, Chair
David Reeder
Wendy Ron
Melora Simon

Members Absent

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Chair Kliger. A silent roll call was taken. Ms. Anderson arrived during Agenda Item 4: Report on Board Actions and Ms. Simon arrived during Agenda Item 5: FY19 Quality Dashboard. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (November 5, 2018); and for information: Patient Stories; FY19 Pacing Plan; Progress Against FY19 Committee Goals; and Article of Interest. **Movant:** Davis **Second:** Ron **Ayes:** Bauman, Davis, Fung, Kliger, Ron, Reeder **Noes:** None **Abstentions:** None **Absent:** Anderson, Simon **Recused:** None	***Consent Calendar approved***
4. REPORT ON BOARD ACTIONS	In response to questions, Cindy Murphy, Director of Governance Services, explained that the Board approved the revisions to the Quality Committee Charter that the Committee recommended at its August meeting.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the quality metrics on the Committee's FY19 dashboard and Cheryl Reinking, RN, CNO, reviewed the HCAHPS scores. Ms. Reinking noted that the scores improved significantly in October, but the preliminary data for November is not looking quite as good. Dr. Adams explained that some of the Hospital acquired infections can be explained by a failure to document the infections on admission. The Committee members and staff discussed the importance of instilling a culture of safety throughout the organization that includes careful monitoring of others. The Committee also asked staff to bring the data back plotted quarter by quarter as well as on a rolling -12 month basis.	

6. PSI-90 SCORES	Dr. Adams reported on the AHRQ Patient Safety Indicators for Q1 FY19. He noted that ECH performs better than the Premier Composite mean of 0.90 overall for FY18 and Q1 of FY19, but there is still room for improvement. Dr. Davis suggested that this data would be a good candidate for presentation on a rolling 12-month basis.	
7. THROUGHPUT CASE STUDY	Ms. Reinking reported that it is one of ECH's FY19 Organizational Goals to improve (decrease) the amount of time it takes from the time a patient arrives in the ED until they are admitted to an in-patient unit. She explained that the baseline median was 339 minutes and the goal is to get to 280. Ms. Reinking reported that the staff identified 65 barriers to throughput. One barrier was the time it takes to achieve RN to RN handoff once the physician writes the admission order. Staff is piloting making an appointment for the ED RN to give report to the Unit RN, which is already making some improvement.	
8. READMISSIONS	Dr. Adams reported that the organization is very focused on reducing preventable readmission and the effort is organized around teams composed of a mix of various clinicians and administrators. He explained that ECH is trying to focus efforts on those patients most at risk for readmission and that ECH has developed its own predictor tool and validated it. Teams include a Readmissions Review team, a Care Coordination team, a Palliative Care team, and a CV mortality and Readmissions team.	
9. CUTLURE OF SAFETY SURVEY REPORT	Dr. Adams reviewed themes from the culture of safety survey. Some of the Medical Staff members present commented that members of the Medical Staff report feeling as though hospital administration and the Board do not prioritize the needs of physicians, and need to focus on addressing physician burn-out issues. Dr. Davis asked Dr. Adams to take the lead in defining this problem and bring that back to the Committee and the Board. Chair Kliger requested that this be added to the Committee's Pacing Plan as a topic to revisit.	
10. HOW DOES ECH DEFINE QUALITY	Chair Kliger briefly reviewed the results of the Quality Strategy Maturity Model Survey, noting that 12 of 17 requested participants participated in the survey. She requested that the survey be re-administered to the 5 who did not participate and she also asked Dr. Adams to extend the survey to a broader group of participants. The Committee asked that additional information be provided in the responses that provide evidence that justifies or explains the response. Staff was directed to add this back to the Committee's Pacing Plan for the March 2019 meeting.	
11. HOSPITAL UPDATE	Mark Adams, MD, CMO, answered questions from the Committee members about the hospital update.	
12. PUBLIC COMMUNICATION	There were no comments from the public.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:28pm. **Movant:** Anderson **Second:** Reeder **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Adjourned to closed session at 7:28pm.***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/	Open session was reconvened at 7:38pm. Agenda Items 14-18 were covered in closed session.	

REPORT OUT	During the closed session, the Committee approved the Minutes of the Closed Session of the Quality Committee Meeting (November 5, 2018) a unanimous vote of all members present, (Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon).	
15. AGENDA ITEM 20: ADJOURNMENT	**Motion:** To adjourn at 7:40pm. **Movant:** Anderson **Second:** Reeder **Ayes:** Anderson, Bauman, Davis, Fung, Kliger, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** None **Recused:** None	***Meeting adjourned at 7:40pm***

Attest as to the approval of the foregoing minutes by the Quality, Patient Care and Patient Experience Committee of El Camino Hospital:

_____
Julie Kliger
Chair, Quality Committee

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee
Monday, February 4, 2019
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

Members Present	Members Absent
Ina Bauman**	**Katie Anderson**
Peter C. Fung, MD	**Julie Kliger**, Chair
Wendy Ron	**Jeffrey Davis**, MD
George O. Ting, MD	**Melora Simon**

**via teleconference

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order at 5:30pm by Dr. Fung. A verbal roll call was taken. Ms. Bauman participated via teleconference. Ms. Kliger, Dr. Davis, Ms. Simon and Ms. Anderson were absent. All other Committee members were present at roll call.	
2. POTENTIAL CONFLICT OF INTEREST	Dr. Fung asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.	
3. CONSENT CALENDAR	Dr. Fung asked if any member of the Committee or the public wished to remove an item from the consent calendar. No items were removed. **Due to a lack of quorum, the Committee deferred approval of the meeting minutes to the Committee's March meeting.**	***Approval of the Consent Calendar deferred to the March 4th Meeting***
4. REPORT ON BOARD ACTIONS	There were no questions about the Report on Board Actions.	
5. FY19 QUALITY DASHBOARD	Mark Adams, MD, CMO, reviewed the quality metrics on the Committee's FY19 dashboard and Cheryl Reinking, RN, CNO, reviewed the HCAHPS scores. Dr. Adams commented that the mortality index is improving and that proper documentation of all patients and proper management of terminally ill patients are both important factors in decreasing this measurement. Ms. Reinking reported that the GIP (general inpatient program provides patients assigned to beds within the acute care setting to receive hospice care. These patients that are on hospice are not included in the mortality index measurement. Dr. Adams reported that readmissions have come down below target and staff is gearing up interventions to improve ED throughput as we move into the end of the fiscal year. Dr. Adams reported that there were zero CAUTIs in December and one CLABSI in the last month. The CLABSI was likely due only to a contaminated blood culture, but it still has to be counted. He also reported ECH needs to improve documentation of patients that have a C. Diff infection on admission so the infection does not get attributed to ECH as hospital-acquired. Dr. Adams also commented that there has been a decreasing trend in sepsis mortality over the last two years, but an increase in the number of terminal cancer patients who developed sepsis. He explained that the GIP program will take those patients out of this category. Dr. Fung and the other Committee members requested staff to consider consolidating the information in the dashboard into fewer pages.	

6. UPDATE ON PATIENT CARE EXPERIENCE	Ms. Reinking reported on initiatives to improve patient experience in the ED in both MV and LG including care team coaches (ED physicians and most staff have received coaching) and improved sound barriers between patient bays and providing iPads in the absence of televisions for distraction in the LG ED.	
7. PHYSICIAN BURNOUT	Dr. Adams reported the national suicide rate of physicians is twice the national rate of the population and explained that physician burnout can impact patient safety and satisfaction and decrease the quality of care. He explained that physician burnout is highest in 45-54 year olds, higher in some specialties than others, and the largest contributing factor is too many bureaucratic tasks. Medical staff members commented that some of the EHR modules are very difficult to use and that physicians being asked to continuously improve efficiency creates burnout as well. The staff and Committee members discussed mitigation measures and it was suggested that the Physician Wellness Committee that is being revitalized by the Medical Staff focus on efforts to prevent burnout, not just addressing it when happens.	
8. JOINT COMMISSION SURVEY RESULTS	Dr. Adams reviewed how the Joint Commission's new SAFER matrix used in the Decembers 2018 triennial survey works. He also reviewed the survey findings, noting that there were 4 moderate level findings and 32 low level findings. One of the moderate level findings (absence of documentation of discharge instructions addressing moderate sedation) was found to be "widespread." Actions plans are in place to address all of the findings.	
9. HOSPITAL UPDATE	There were no questions about the hospital update.	
10. PUBLIC COMMUNICATION	There were no comments from the public.	
11. ADJOURN TO CLOSED SESSION	The meeting was adjourned to closed session at 7:14pm.	***Adjourned to closed session at 7:14pm***
12. AGENDA ITEM 17: RECONVENE OPEN SESSION/ REPORT OUT	Open session was reconvened at 7:20pm. Agenda Items 12-16 were covered in closed session. Due to a lack of quorum, the Committee took no actions during the closed session.	
13. AGENDA ITEM 18: ADJOURNMENT	The meeting was adjourned at7:21pm.	***Meeting adjourned at 7:21pm***

Attest as to the approval of the foregoing minutes by the Quality, Patient Care and Patient Experience Committee of El Camino Hospital:

_____

Julie Kliger
Chair, Quality Committee

January 15, 2019

El Camino Hospital
2500 Grant Road
Mt. View, Ca 94040 MS: ECH131

To whom It May Concern:

I am writing this letter regarding my visit to the emergency room on [redacted]

On that date I spent about 15-20 minutes being interviewed, 5 minutes taken to a room, offered a gown and arm band.

When the emergency room doctor came to see me he looked in my ear, did not suggest any tests, a referral to an eye specialist, nor did he prescribe any medications to ease my discomfort and concern. Total time with me about 5-10 minutes.

And, then the nurse came back, and said I could leave. On my way out I saw the doctor at his computer, laughing and talking with staff, and he did not look up as I spoke with him as I passed by.

Probable estimate of total time there 30-35 minutes, When I joined my friend waiting For me she said "are you done already?". We both thought it was not a good example of medical care.

I have visited the emergency room at El Camino Hospital several times over the past few years, as I matured, and have always felt I received excellent attention and care.

I am a 78 year old woman with excellent cognitive, observational and assessment skills. Seniors are grateful for assistance, care, and being treated with respect and patience.

While each hospital has its own system of billing with Medicare and other insurances I do feel my insurances should not be charged $2,243.77 for a nurse asking questions and 5-10 minutes with a doctor who really did not treat my condition or concerns.

I am writing this at the request of [redacted] in your Patient Experience Department.

Sincerely,

[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: 7. Update on Patient and Family Centered Care 8. Mortality and Readmissions Metrics (FY19 Quality Goals) 9. Annual Patient Safety Report 10. FY18 Quality Dashboard Final Results 11. Pt. Experience (HCAHPS) 12. 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. Quarterly Quality and Safety Review 5. Performance Improvement with Physician Management	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 – With FY19 QC Dashboard) 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Culture of Safety Survey Report (Include OR) 6. Q1 FY19 Quality and Safety Review 7. What is Quality? (Maturity Model) 8. Throughput Case Study

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: 7. Q2 FY19 Quality and Safety Review (Q2 Reportable events if any) 8. ~~Physician Survey Results~~Physician Burnout 9. ~~Committee Recruitment~~ 10. Joint Commission Survey Results 11. Update on Patient Care Experience	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.~~1. Proposed FY20 Committee Goals ~~4.~~2. Proposed FY20 Organizational Goals 3. Behavioral Health Services Quality Report 4. Committee Recruitment 5. What is Quality? (Maturity Model)

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 6. Q3 FY19 Quality and Safety Review	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

Hospital Update
March 4, 2019
Mark Adams, MD, CMO

Quality and Safety

We recently ordered a new advanced orthopedic surgical table (base) that, when paired with the Spinal Surgery Top, provides exceptional C-arm and O-arm imaging (x-ray) access during the spine surgery procedure. The table also provides a 360-degree choice of patient rotation that allows the spine surgeon to create the optimal position, tension, and angle when accessing the patient's surgical site for more complex procedures. We have also procured a new head control accessory that helps control the patient's head position, which will enable safer and more accessible anesthesia delivery. We expect to have it operationalized in by mid-February.

Patient Experience

The hospital executed a Homeless Discharge Protocol which addresses all the requirements mandated by the new California state law that went into effect on January 1, 2019. The requirements include providing medical screening exams, referral to appropriate post-acute community service agencies, referrals for follow up medical care, transportation from the hospital, medication prescriptions, a meal before discharge, weather appropriate clothing, and assistance with applying for health care insurance. The Care Coordination Department took the lead working with many other departments across the organization to put the protocol in place.

Workforce

To create a succession pipeline for our future workforce needs and to encourage and support the career and professional development of our ECH employees, a Career Development Fair was held on January 29th with 15 colleges/universities and clinical/technical schools in attendance. Over 250 employees participated in this event.

Twenty department leaders began working with a Press Ganey coach to develop goals and strategies to improve employee engagement in their departments. Additionally, the coach met with employee focus groups to gain additional insight about the department's engagement survey results and inform the specific action plans. We are also set to launch a new mentoring program for nursing staff first, then a second phase will open the program to all employees.

Corporate and Community Health

Community Benefit staff received 103 Midterm Reports from our grant partners that include program narratives, metric performance to target and YTD line item budgets. We released the FY20 Community Benefit grant applications along with a grant guidebook on both the ECH and ECHD websites. Broad notifications to the community accompanied the release. Grant applications and supporting materials are due on February 26th.

One hundred plus community members attended the Mandarin Speaker Bureau workshop "Lung Cancer in Women and Non-Smokers -Misconception, New Diagnostic and Treatment" Attendees learned about the latest research on lung cancer among non-smokers, how new technology can make new diagnostic and treatment for lung cancer possible, and a low dosage CT scan self-pay program which provides an affordable alternative for lung cancer screening when

nonsmokers are not qualified for insurance coverage. The workshop was held in collaboration with the Chinese Health Initiative, Cancer Center and New Hope Chinese Cancer Care Foundation.

Government and Community Relations

The CEO and several members of the Executive team met with the Chiefs of Police of Mountain View, Los Altos and Los Gatos to discuss topics of mutual concern including community emergency response resources and preparation, and hospital campus security. On January 18th, ECH sponsored and staff and board members attended the Silicon Valley Council of Nonprofit's Health & Housing Summit. Board members and staff attended the Los Altos Chamber of Commerce Annual Awards dinner, where outgoing Chamber Board President Cindy Murphy (ECH's Director of Governance Services) was honored for her leadership of the organization in 2018.

Marketing and Communications

After a year in the making, El Camino Hospital was able to share the story of Baby Skai, garnering a 4-minute segment on NBC Bay Area. To date, the story views total about 1.14 million and it has 19,500 social shares and over 156 pieces of coverage.

Philanthropy

As of December 31, 2018, El Camino Hospital Foundation has a secured $7,915,502, 128% of its $6,175,000 FY19 fundraising goal.

Auxiliary

Our dedicated Auxiliary contributed 6,199 volunteer hours in January 2019.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: March 4, 2019
Subject: Report on Board Actions

Purpose:

To keep the Committee informed with regards to actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

Summary:

1. Situation: It is important to keep the Committees informed about Board activity to provide context for Committee work. The list below 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.

2. Authority: This is being brought to the Committees at the request of the Board and the Committees.

3. Background: Since the last Quality Committee Meeting the Hospital Board has met once and the District Board has not met. In addition, the Board has delegated certain authority to the Finance Committee and the Executive Compensation Committee. Going forward, those approvals will also be noted in this report.

A. ECH Board Actions

February 13, 2019

- Approved Revised Women's Hospital Expansion Project Plan and additional $10 million in funding
- Approved a process for the annual review of CEO performance
- Approved funding for SVMD Clinic Site Tenant Improvements (not to exceed $8 million)
- Approved funding for replacement Interventional Services equipment (not to exceed $13 million)
- Approved funding for replacement imaging equipment (not to exceed $16.9 million)
- Approved Resolution 2019-03 approving effectuation of the transaction and funding for SVMD's acquisition and establishment of five multi-specialty clinics

B. Finance Committee Actions

January 30, 2019

- Approved funding for Waste Water Storage Project (not to exceed $3.9 million)
- Approved funding for an additional surgical robot (not-to-exceed $1,550,000 after trade in)
- Approved PAMF Hospitalist Coverage Agreement for unassigned patients.
- Approved unassigned newborn coverage agreement

C. Executive Compensation Committee

January 23, 2019

- Approved FY19 COO Individual Incentive Goals

4. Assessment: N/A

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments: None.

Suggested Committee Discussion Questions: None.

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Catherine Carson, Sr. Director, Quality Improvement and Patient Safety
Date: March 4, 2019
Subject: FY19 Quality Dashboard

Purpose:

To provide updated metrics for current Organization Goals, FY18 Organizational Goals, and additional quality metrics of interest.

Summary:

1. Situation: This report monitors progress toward FY19 Organizational Goals, and sustaining of FY18 Organizational Goals, and metrics monitoring sepsis.

2. Authority: The Quality Committee is responsible for oversight of quality and safety.

3. Background: These twelve metrics were selected for monthly review by this Committee as they reflect the Hospital's FY19 quality, efficiency, and service goals. Annotation is provided to explain actions taken affecting each metric. Committee request to add a rolling 12-month average for each metric included.

4. Assessment: Mortality Index slightly above target level for FYTD. Readmission Index remains at target level for FYTD. Hospital-acquired Infections: Zero CLABSI for Jan. 2019. ALOS/GMLOS continues at or below target level since April 2018.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

FY19 Quality Dashboard (January data unless otherwise specified - final results)

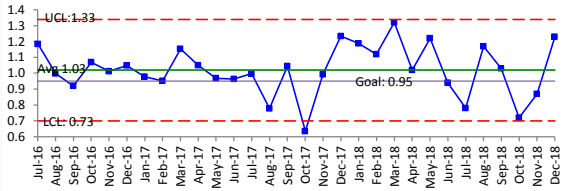
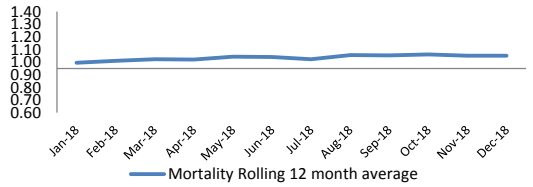
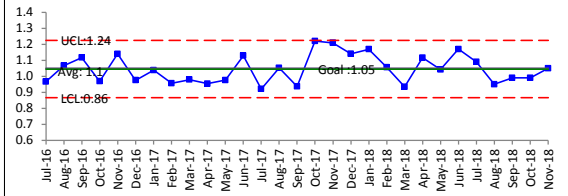
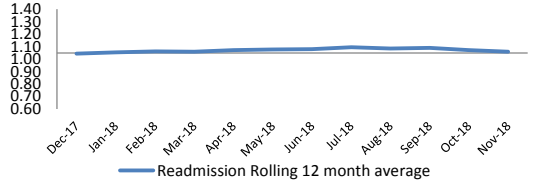
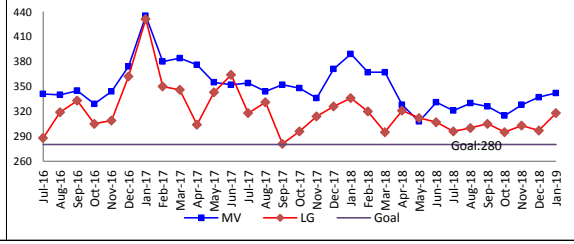
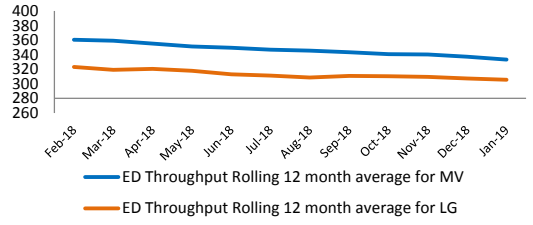
Suggested Committee Discussion Questions: None

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

January 2019 (Unless otherwise specified)

Month to Board Quality Committee: March, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
Quality		**Month**	**FYTD**				
1	* Organizational Goal **Mortality Index** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: December 2018*	1.23 (1.97%/1.60%)	0.97 (1.41%/1.46%)	1.05	0.95		
2	*Organizational Goal **Readmission Index (All Patient, All Cause Readmit)** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Index month: November 2018*	1.05 (7.62%/7.27%)	1.01 (7.06%/6.96%)	1.08	1.05		
3	* Organizational Goal **Patient Throughput-Median minutes from ED Door to Patient Admitted** *(excludes Behavioral Health Inpatients)* *Date Period: January 2019*	MV: 342 mins LG: 318 mins	MV: 327 mins LG: 302 mins	MV: 350 mins LG: 314 mins	280 mins		

Definitions and Additional Information

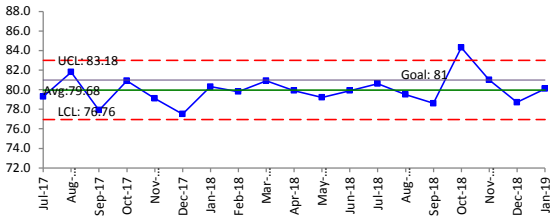
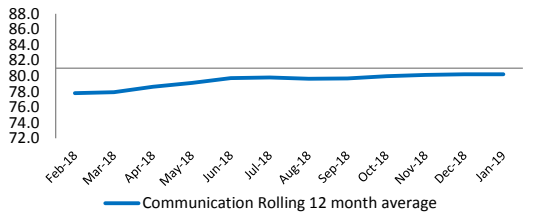
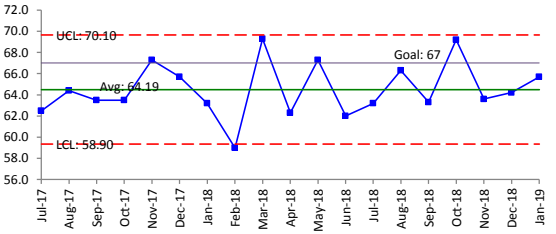
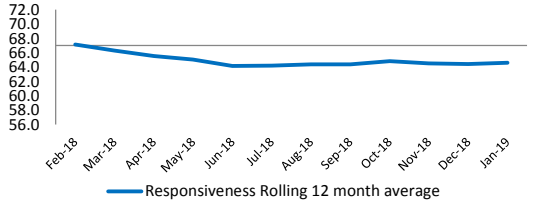
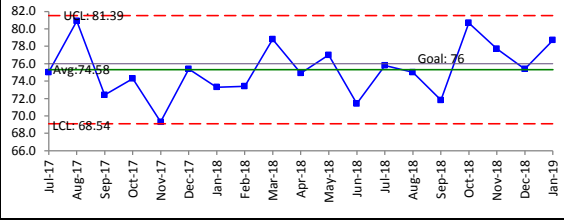
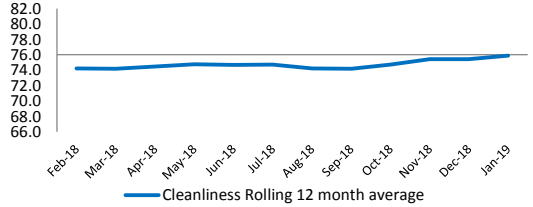
Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Mortality Index (Observed/Expected)	The new rolling 12 month average demonstrates that the mortality index average is above the target goal for the last year. CDI continues to assist physicians in improving clinical documentation so each patient's risk of mortality is captured.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Readmission Index (All Patient, All Cause Readmit) Observed/Expected	The readmission index is back to target with the 12 month rolling average. The CMS QIO (HSAG) Jan. Readmission report for Q4 2017 to Q3 2018 shows that ECH again leads our Region 13 with a readmission rate for this period of 14.3% vs the Region rate of 17.0%	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Patient Throughput- Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients)	In February, ED MDs and hospitalists meet with a physician consultant to explore bridging orders for some ED admissions, and give admitting MDs a "heads-up" on possible admissions. For the Nursing hand off interval, when beds are available, the order to floor interval has improved.	Cheryl Reinking, Michelle Gabriel; Heather Freeman				**iCare Report: ECH ED Arrival to Floor**

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY19 Organizational Goal and Quality Dashboard Update

January 2019 (Unless otherwise specified)

Month to Board Quality Committee: March, 2019

	Service	FY19 Performance Month	FY19 Performance FYTD	HCAHPS Baseline Q4 2017 - Q3 2018	FY19 Target	Trend	Rolling 12 Months Average
4	* Organizational Goal **HCAHPS Nursing Communication Domain** **Top Box Rating of Always** *Date Period: January 2019*	80.1 (178/222)	80.5 (1440/1790)	80.0	81.0		
5	* Organizational Goal **HCAHPS Responsiveness of Staff Domain** **Top Box Rating of Always** *Date Period: January 2019*	65.7 (141/214)	65.1 (1108/1700)	65.1	67.0		
6	* Organizational Goal **HCAHPS Cleanliness of Hospital Environment Question** **Top Box Rating of Always** *Date Period: January 2019*	78.7 (170/216)	76.5 (1354/1771)	74.5	76.0		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
HCAHPS Nursing Communication Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	Efforts addressing Nursing Communication include: Enhanced Interactions: Team prepared videos and HealthStream Module and Care Team Coaching Scheduling Standard Work created.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Communication with Nurse Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples	Efforts addressing Responsiveness include: Call Light Answer and Escalation Standard Work created and Team promoting standard work by attending staff meetings and recognizing the highest scoring and most improved unit.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Response of Hospital Staff Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**
HCAHPS Cleanliness of Hospital Environment Question Top Box Rating of Always, based on Received Date, Adjusted Samples	Efforts addressing Cleanliness include: Smile/ Scan/ Listen/ Act Campaign; Encouraging staff to follow these for steps while engaging with patients, rolling carts are going to units and departments to promote the project and Love your Environment: Clutter Free Challenge: February 6-20th staff took before and after pictures of the cluttered area and received $5 gift card.	Ashley Fontenot Cheryl Reinking	Patient Experience Committee	HCAHPS Rate Cleanliness of Hospital Environment Top Box Rating 9 and 10	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Press Ganey Tool**

El Camino Hospital
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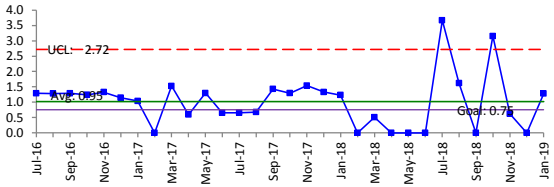
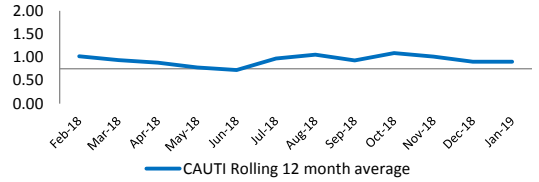
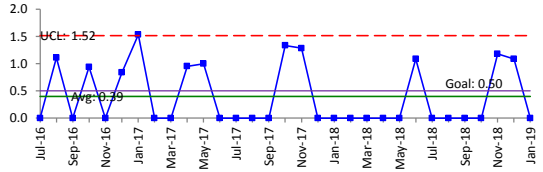
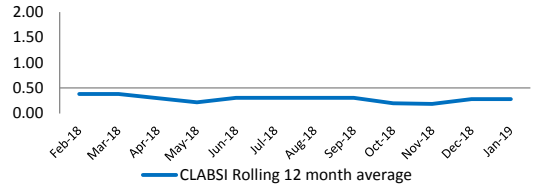
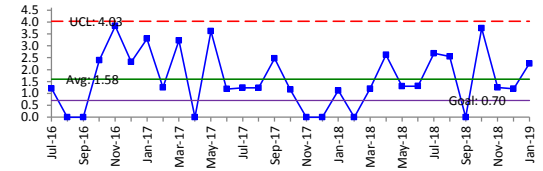
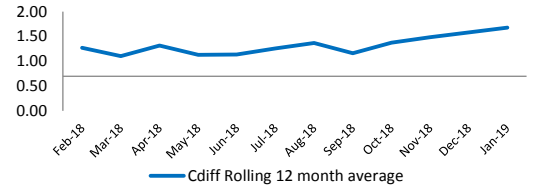
FY19 Organizational Goal and Quality Dashboard Update

January 2019 (Unless otherwise specified)

Month to Board Quality Committee: March, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	
Quality		Month	FYTD				
7	**Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: January 2019*	1.28 (2/1561)	1.40 (13/9300)	0.77	SIR Goal: <= 0.75		
8	*Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: January 2019*	0.00 (0/1121)	0.31 (2/6387)	0.28	SIR Goal: <= 0.50		
9	*Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: January 2019*	2.26 (2/8867)	1.96 (11/56257)	1.13	SIR Goal: <= 0.70		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	2 new CAUTI's in January: 1- MV- normal UA on admission, quadraplegic due to cerical cord CA mets, Foley needed and inserted for urinary retention, UTI due to E.Coli w/stool incontinence. 2- LG Acute Rehab- Post stroke pt admitted w/folley due to urinary retention. CAUTI risk due to disruption of closed urinary drainage system.	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.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	No new CLABSI in January.	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.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	2 new C.Diff infections in January in MV. After review, both due to fmany doses of Antibiotics to address accompanying infections.	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.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	Clin Eff_IC_

El Camino Hospital
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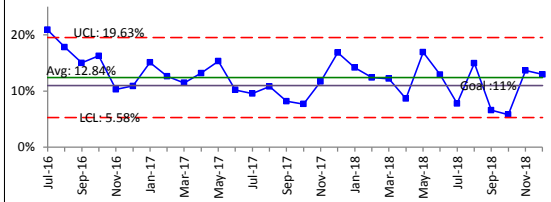
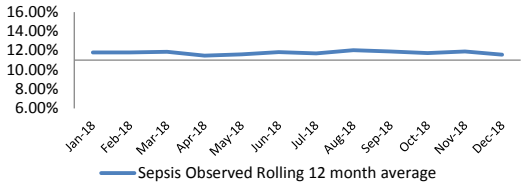
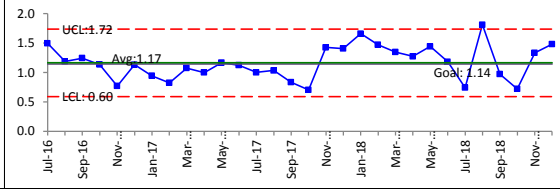
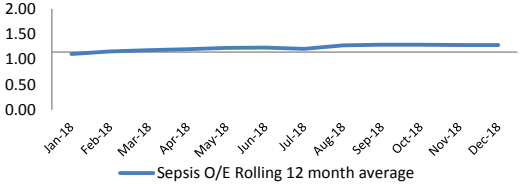
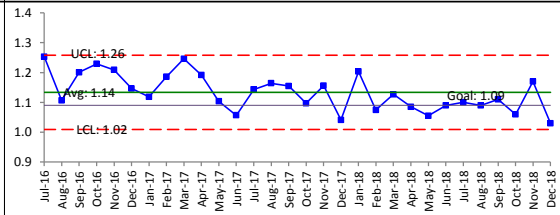
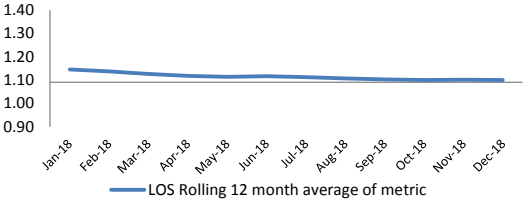
FY19 Organizational Goal and Quality Dashboard Update

January 2019 (Unless otherwise specified)

Month to Board Quality Committee: March, 2019

		FY19 Performance		Baseline FY18 Actual	FY19 Target	Trend	Rolling 12 Months Average
		Month	FYTD				
10	**Sepsis Mortality Observed Rate Enterprise, based on ICD-10 codes** *Date Period: December 2018*	12.94%	10.42%	11.72%	11.00%		
11	**Sepsis Mortality Index, based on ICD 10 codes** *(Observed over Expected)* *Date Period: December 2018*	1.48 (12.94%/8.73%)	1.19	1.22	1.14		
Efficiency							
12	**Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: December 2018*	1.03	1.09	1.12	1.09		

Definitions and Additional Information

Measure Name	Comments	Definition Owner	Work Group	FY 2018 Definition	FY 2019 Definition	Source
Sepsis Mortality Observed Rate Enterprise, based on ICD 10 codes	With this mild flu season, we have not seen the spike in sepsis deaths that we usually experience in December. The rolling average shows that we average just above the target rate., though FYTD we are below target.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Sepsis Mortality Index Observed over Expected, based on ICD 10 codes	The index for December increased due to the increased difference between the documentation of the expected risk of death vs the observed deaths.	Catherine Carson			For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**
Arithmetic Observed LOS Average over Geometric LOS Expected (Medicare definition, MS-CC, Inpatient)	The LOS index continues at our target with the rolling average, and we have not seen the spiked increases this winter as the last.	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.	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. LCL is not visible if value is less than or equal to zero.	**Premier Quality Advisor**

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, CMO
Cheryl Reinking, CNO
Date: March 4, 2019
Subject: Behavioral Health Quality Report

Purpose:

To review with/inform the Committee of the status of behavioral health services.

Summary:

1. Situation: Behavioral Health Services tracks and trends a number of quality metrics.

2. Authority: The Committee requested an update on this topic.

3. Background: The El Camino behavioral health service provides multiple modality therapy and treatments including inpatient and outpatient psychiatric care (adult and adolescent) and Electro Convulsive Treatment (ECT).

4. Assessment: A review of behavioral health quality metrics demonstrates excellent overall performance.

5. Other Reviews: The recent Joint Commission survey of El Camino behavioral health services was exemplary with minimal low risk findings.

6. Outcomes: The program continues to be successful with an expected expansion of service capacity with the opening of the new behavioral health building on campus.

List of Attachments: None

Suggested Committee Discussion Questions: None

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality Committee of the Board
From: Catherine Carson, MPA, BSN, RN, CPHQ
Date: March 4, 2019
Subject: 2018 Culture of Safety Results (as part of Physician & Employee Engagement Survey)

Purpose:

To review inform the Committee of the results of El Camino Hospital's Culture of Safety Survey

Summary:

1. Situation: ECH embedded 19 of the AHRQ Safety Survey questions into the 2018 Press Ganey Employee/Physician Engagement surveys conducted in September-October 2018. This report is specific to the results of the Culture of Safety questions.

2. Authority: ECH Senior Leadership

3. Background: This is the 3rd Culture of Safety Survey done for employees and physicians using the Press Ganey Survey.

4. Assessment: Response rate for Employees: 87% , for Physicians: 19%. For both the Employees and Physicians, the Safety Composite increased over the 2017 survey.

5. Other Reviews:

6. Outcomes: These results help guide ECH Leadership on how to prioritize and address issues regarding both employees and physicians perception of the status of a Safety Culture at ECH.

List of Attachments:

1. 2018 Culture of Safety Survey Results

Suggested Committee Discussion Questions:

1. None

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2018 Culture of Safety Results

Prepared by Sheetal Shah,
Director Risk Management and
Patient Safety

Culture of Safety Survey Results

- 3rd Culture of Safety survey performed with Press Ganey
- Conducted in September-October 2018 along with Engagement/Nursing Excellence
- Surveyed all hospital employees and medical staff
- 19 Questions in Safety Culture Solutions Composite for Employees and Physicians
- Response Rate: 87% Employees, 19% Physicians

Overall Culture of Safety Survey Results

Year	Employee-Safety Composite Score	National HC average-employees	Medical Staff Safety Composite Score	National HC average-physicians
2018 (EE n=2,899, 87%, MS=157, 19%)	4.04 ↑	0.04 above HC avg	3.85 ↑	(0.19 below MD avg)
2017 (EE n=2,419, 79%, MS n=207, 23%)	3.83	0.16 below HC avg	3.81	No data provided

Safety Solution Items – Prevention & Reporting

Prevention & Reporting Item	2018 ECH	% Unfav	% Ntrl	% Fav	Difference From: Natl HC Avg	Difference From: Natl Phys Avg
Mistakes have led to positive changes here. (Slight decrease in MD score from 2017)	**4.05**	**5%**	**15%**	**80%**	**+.01**	**-.04**
Employees will freely speak up if they see something that may negatively affect patient care. (Improvement from 2017)	**4.17**	**6%**	**8%**	**86%**	**+.01**	**+.02**
We are actively doing things to improve patient safety. (Improvement from 2017)	**4.26**	**3%**	**8%**	**88%**	**-.00**	**-.01**
In my work unit, we discuss ways to prevent errors from happening again. (Improvement from 2017)	**4.20**	**5%**	**9%**	**86%**	**-.02**	**-.06**
Where I work, employees and management work together to ensure the safest possible working conditions. (Slight decrease in MD score from 2017)	**4.04**	**7%**	**13%**	**80%**	**-.04**	**-.08**
I feel free to raise workplace safety concerns. (Slight decrease in MD score from 2017)	**4.16**	**5%**	**9%**	**86%**	**-.04**	**-.10**
I can report patient safety mistakes without fear of punishment. (Slight decrease in MD score from 2017)	**4.14**	**5%**	**11%**	**84%**	**-.06**	**-.13**
When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person. (Slight decrease in MD score from 2017)	**3.79**	**12%**	**19%**	**69%**	**-.08**	**-.10**
Prevention & Reporting	**4.10**	**6%**	**11%**	**82%**	**-.03**	**-.06**

Safety Solution Items – Pride & Reputation

					Difference from:	
Pride & Reputation Item	2018 ECH	% Unfav	% Ntrl	% Fav	Natl HC Avg	Natl Phys Avg
I would recommend this organization to family and friends who need care. (Improvement from 2017)	**4.38**	**2%**	**7%**	**91%**	**+.11**	**+.14**
This organization provides high-quality care and service.. (Improvement from 2017)	**4.36**	**2%**	**6%**	**92%**	**+.09**	**+.11**
This organization makes every effort to deliver safe, error-free care to patients.(Improvement from 2017)	**4.33**	**3%**	**6%**	**91%**	**+.06**	**+.09**
Senior management provides a climate that promotes patient safety. (Slight decrease in MD score from 2017)	**4.09**	**6%**	**12%**	**82%**	**+.02**	**+.02**
Pride & Reputation	**4.29**	**3%**	**8%**	**89%**	**+.07**	**+.09**

Safety Solution Items – Resources & Teamwork

					Difference from:	
Resources & Teamwork Item	2018 ECH	% Unfav	% Ntrl	% Fav	Natl HC Avg	Natl Phys Avg
My work unit is adequately staffed. Slight decrease in MD score from 2017)	**3.50**	**21%**	**20%**	**59%**	**+.21**	**+.21**
The amount of job stress I feel is reasonable. (Improvement from 2017)	**3.66**	**14%**	**20%**	**66%**	**+.16**	**+.21**
Communication between work units is effective in this organization. Slight decrease in MD score from 2017)	**3.75**	**11%**	**21%**	**68%**	**+.12**	**+.07**
Different work units work well together at this organization. Slight decrease in MD score from 2017)	**3.83**	**8%**	**22%**	**70%**	**+.08**	**-.01**
Communication between physicians, nurses, and other medical personnel is good in this organization. Slight decrease in MD score from 2017)	**3.82**	**9%**	**21%**	**71%**	**+.05**	**-.07**
There is effective teamwork between physicians and nurses at this hospital. Slight decrease in MD score from 2017)	**3.92**	**6%**	**18%**	**75%**	**+.00**	**-.24**
My work unit works well together. (Improvement from 2017)	**4.11**	**7%**	**12%**	**81%**	**-.07**	**-.14**
Resources & Teamwork	**3.80**	**11%**	**19%**	**70%**	**+.08**	**+.01**

Summary

- **High Performing Areas:**
  - Pride and Reputation theme scored significantly above National benchmarks
  - Resources and Teamwork theme scored significantly above the National Healthcare Average

- **Areas of Focus:**
  - The Preventing and Reporting theme scored significantly below the National Physician Average with two items scoring significantly below both averages
  - Communication between physicians/nurses/ medical personnel, teamwork between nurses and physicians, and teamwork within departments scored significantly below the National physician average

EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Cindy Murphy, Director of Governance Services
Date: March 4, 2019
Subject: Appointment of Ad Hoc Committee to Address Recruitment of new Members

Recommendation(s): To appoint Committee members _____ and _____ to an Ad hoc Committee to address the recruitment of new members.

Summary:

1. Situation: Pursuant to its Charter, in addition to Board members "the Quality Committee may also include no more than nine (9) external (non-Hospital Board member) members with expertise in in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient." Over the last year or so, several subject matter experts have resigned from membership on the Committee, leaving at least some of these competencies unrepresented.

2. Authority: In accordance with the attached Hospital Board Advisory Committee Nomination and Selection Policy and Hospital Board Advisory Committee Nomination and Selection Procedures, the Committee has the authority to appoint and Ad hoc Committee to begin the recruitment process.

3. Background: N/A

4. Assessment: N/A

5. Other Reviews: Committee Chair Julie Kliger, RN, and Executive Sponsor Mark Adams, MD, CMO, have expressed a desire to add additional members to the Committee.

6. Outcomes: N/A

List of Attachments:

1. Hospital Board Advisory Committee Nomination and Selection Policy & Procedures

Suggested Committee Discussion Questions:

1. Which members of the Committee shall be appointed to the Ad hoc Committee?
2. What are the most important competencies missing from the Committee at this time?

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION POLICY

XX.XX HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION POLICY

A. Coverage:

El Camino Hospital Board Advisory Committees

B. Adopted:

June 12, 2013;

C. Policy:

It is the policy of ECH that appointment of Hospital Board Advisory Committee Members to vacant or newly created positions follow the procedure set forth in the attached Document entitled:

Hospital Board Advisory Committee Member Nomination and Selection Procedure

1. Length of Service and Term Limits for Committee Members

As provided in the Committee Charters, Committee Members will serve a term of one (1) year, renewable annually.

D. Reviewed:

Governance Committee March 31, 2015
ECH Board Approved April 8, 2015

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

EL CAMINO HOSPITAL
HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION PROCEDURES
Adopted February 12, 2014
Revised (Approved) April 8, 2015

01.07 HOSPITAL BOARD ADVISORY COMMITTEE MEMBER NOMINATION AND SELECTION PROCEDURES

A. Coverage:

El Camino Hospital Board Advisory Committees

B. Adopted:

2/12/2014

C. Procedure Summary:

The nomination and selection of each Hospital Board Advisory Committee (Advisory Committee) member (Member) shall follow the procedures below.

D. Procedure for Nominating and Appointing an Advisory Committee Member:

1. Eligibility and Qualifications

Each Advisory Committee shall determine minimum qualifications and competencies for its Members. In addition, the Governance Committee will periodically conduct a strategic assessment of the respective Advisory Committee's membership needs and ensure that it evolves with the Hospital's strategy.

2. Nomination and Declaration

a. Nominations for Advisory Committee membership may be received from any source.
b. The Board Liaison will notify the Board, the Advisory Committee members, the Executive Leadership Team and the public of all vacancies for which new Advisory Committee Members are being recruited.
c. A candidate shall submit an application to the Board Liaison that includes reason(s) the candidate wishes to serve, the candidate's relevant experience and qualifications,

potential conflicts of interest including any personal or professional connections to ECH, a release to permit ECH Human Resources to conduct a background check, and specifies which Advisory Committees that the candidate wishes to be considered for.

d. If the interested candidate is currently serving on another Advisory Committee at ECH, the candidate shall notify the Chair(s) of the Advisory Committee with a vacancy and the Advisory Committee on which they are serving. The interested candidate shall also notify the Board Liaison, provide all application materials, and be subject to all other requirements of this procedure.
e. All candidates will be considered in the candidate due diligence process.
f. In the event that no qualified candidates can be found through the routine recruitment procedures of the Hospital, the Board may, in its discretion, obtain the services of a recruiting firm to identify qualified candidates.

3. **Review of Candidates and Selection of New Members.**

a. The Board Liaison will forward the names and resumes of all applicants to the Chair of the Advisory Committee with any vacancy or, if appointed by the Committee, to the members of an Ad hoc Committee for review.
b. At the request of the Chair of the Advisory Committee, current Advisory Committee Members, and the Advisory Committee Chair shall select and interview the final slate of candidates and will recommend the top finalist(s) to the Board.
c. The Board shall appoint the Advisory Committee Member in accordance with the Hospital Bylaws.

4. **Obtaining Approval to Increase the number of Members of an Advisory Committee**

a. If an Advisory Committee Chair proposes to increase the number of Members of such Chair's Advisory Committee, then the Advisory Committee Chair must submit a brief description of the need (e.g., gap in skill-set) for an increase in membership to the Governance Committee.
b. Upon review of the request, the Governance Committee shall make a recommendation to the Board whether the membership of such Advisory Committee should be increased.

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EL CAMINO HOSPITAL
COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Mark Adams, MD, CMO
Date: March, 4, 2019
Subject: What is Quality?

Purpose:

To continue the discussion we began at our November 5, 2018 and December 3, 2018 meetings regarding how to define quality.

Summary:

1. Situation: At the Committee's November 5th meeting, we introduced this topic and indicated it was something we would continue to discuss during upcoming meetings.

2. Authority: N/A

3. Background: At a previous meeting, we distributed a "Healthcare Quality Strategy Maturity Model" and asked the Committee members, as well as staff and members of the Medical Staff who regularly attend the Committee meeting to participate in a related survey. Initially, we received responses from 12 of 17 requested participants and asked those who had not responded to please respond. Since that time we also asked the other Members of the Board Directors to respond to the survey. In total, we received eight additional responses.

4. Assessment: For each domain in the survey there was a fairly wide range of responses (2 -4 with one outlier of 5 and 3 outliers of 1). The range of averages for all domains was 2.64 – 3.28 and the average of the averages was 2.99. As noted in the attachment, a response of 3 ("Defined") means activities/behaviors are formally defined and moderately managed (activities/behaviors followed 70-80% of the time). There was no discernable trend based on the type of survey respondent (physician, leader, Committee member, Board member), at least in part because the number of survey participants was low. One Committee member commented that in many instances his/her rating based on a sense of what is happening or bits and pieces that is learned at Committee meetings. Or, there were some qualities, but not all, as defined on the grid, he/she knew about for a certain rating. This Committee member noted that it would be helpful to see evidence to justify the ratings.

5. Other Reviews: N/A

6. Outcomes: N/A

List of Attachments:

1. Healthcare Quality Strategy Maturity Model
2. Survey Data

Suggested Committee Discussion Questions:

1. What do the survey results tell us about the maturity of ECH's quality strategy?
2. Is it possible the results tell us more about perceptions than actual maturity?

Alvarez & Marsal's Healthcare Quality Strategy Maturity Model

Dimension	Description	INITIAL [1]	MANAGED [2]	DEFINED [3]	QUANTITATIVELY MANAGED [4]	OPTIMIZED [5]
		Activities/behaviors are not defined	**Activities/behaviors are commonly performed but in an adhoc and reactive manner with large variation**	**Activities/behaviors are formally defined and moderately managed (activities/behaviors followed 70-80% of the time)**	**Activities/behaviors are proactively managed and measured according to defined standards (activities/behaviors followed 80%+ of time)**	**A consistent process exists where activities and behaviors are reviewed and improved upon. Innovation occurs to establish new frontiers**
Leadership and Culture	• Role(s) of Leader(s) is/are clear to others. • Leader has set clear objectives to align the organization to its vision, mission, strategy and core values in quality **Key Themes:** • Vision/Mission/Strategy/Core values • Communication of quality goals • Priority of creating a quality plan • Quality defined	• No organizational vision, mission, strategy and core values related to quality • Quality is not a top priority • Leadership communication on quality performance does not exist • No common definition of quality exists	• Inconsistent organizational vision, mission, strategy and core values related to quality • Quality is only a priority when there are problems with reputation, funding, accreditation, or resource requests (single item issues and not strategic items) • Leadership communication on quality performance is inconsistent/adhoc • Varying views exist of what quality means in the organization	• Vision, mission, strategy and core values on quality are established and the organization is aware • Quality is a priority but no plan exists for an organization-wide quality program • Leadership communication on quality is delivered on a need basis • Organization is in alignment with the definition of quality	• Vision, mission, strategy and core values on quality are routinely communicated and goals are established related to the vision • Quality is a leadership priority, a plan is in place, and measurements are being used to determine efficacy of quality • Leadership communication on quality is consistently delivered and measured for effectiveness (surveys, open rates, adoption rates, etc...) •Organization understands the drivers of quality improvement and leaders hold the organization accountable to quality	• Vision, mission, strategy, and core values on quality are revisited on a predetermined time horizon • Results from measuring quality plan are used to identify improvements • Communication is altered to adapt to staff preferences and changing needs • Definition of quality is revisited to ensure it is relevant to the organization's vision, mission, strategy, and core values
Organizational Integration	• Shared governance of clinical activities across all Physicians, Nurses and other Service Lines • Vertical and horizontal accountability • Physician Alignment with organization's goals **Key Themes:** • Collaboration/ shared goals around quality measures • Transparency and accountability • Decision making (linked and aligned work streams)	• Collaboration is not encouraged and staff do not engage others in decision making or sharing best practices in delivering quality • No forum for collaboration exists at a department/unit/service line or organization/system-wide level	• Ad hoc collaboration takes place (hallway conversations), but drive minimal improvements • Discussions exist across services lines but with no defined follow-through • Department/unit/service line discussions on quality exists inconsistently and only on a need basis	• Pockets of collaboration exists (e.g., some clinical pathways, high performing units) • Just developing organization-wide view of shared responsibilities and sharing of best practices exist in achieving positive outcomes. • Formal department/unit/service line meetings are established and consistently held to drive improvements in quality	• Formal collaboration meetings are held department/unit/service line- wide, as well as organization-wide and yielding measurable improvements in quality	• Leadership reviews output from collaboration meetings and makes needed changes to improve quality across all lines of service • Leadership uses collaboration meetings to spur new ideas and innovation
Performance Improvement Methodology	• Common view (mental model) and operational model for executing change across organization. • Process of creating a ongoing practice of improving quality across the organization **Key Themes:** • Methodology for ongoing improvements	• Performance improvement methodologies do not exist • Staff make no efforts at improvements and performance improvement has a negative connotation	• Performance improvement methodologies are not widely known or understood • Improvement efforts are made ad hoc based on immediate needs • Some unit-based improvement efforts exist but are not consistently enforced or followed	• Leadership committed to an organization-wide approach and has set organization-wide goals • Performance methodologies are defined, deployed and managed across the organization	• Performance methodologies adoption and effectiveness are tracked • Feedback and best practice sharing is encouraged on performance improvement methodology • Policy and protocol deviation evaluated • Feedback about performance and continuing education	• Consistent review process for performance improvement methodologies are in place and changes are made where necessary or new methodologies are incorporated in the practice • Metrics are used to help improve the practice
Policy and Procedure Management	• A defined, executed and measured series of actions to deliver clinical quality through the management of clinical policies and protocols **Key Themes:** • Define, create accountability and measure for clinical quality policy and procedures	• There is no standardization or automation of processes (e.g., clinical pathways) • No policies and procedures exist or they exist and no knows where to find them, or not followed • Staff is left to determine their own method • No accountability for use or non-use of P&P	• There are some standardization and automation of processes but there is an adhoc approach to execution or adoption • Policies and procedures exist but poor adoption • Little accountability for staff to follow policies and procedures • Individuals who are held responsible lack the appropriate authority	• Processes are generally standardized and adhered to • Policies and procedures are well defined documented and followed throughout the organization • People are held accountable to policies and procedures • The appropriate people are held responsible and have appropriate authority	• Breaks in standards or possible deviations from standards are tracked and evaluated for revision root cause analysis and possible policy revision • Policies and procedures are routinely reviewed and evaluated for alignment with best practice • Process automation exists throughout the organization	• Based on best practices, lessons learned and outcomes, processes are revised and improved upon • A formal process is in place for process revision, ownership, testing and execution • All deviations evaluated with positive deviance deeply understood
Training and Learning	• Necessary training and learning opportunities delivered to aid in effective delivery of quality **Key Themes:** • Formal education/training/learning	• No training and learning opportunities exist	• Training and learning opportunities exist but quality varies and inconsistently used or organization does not provide the time for staff to take training	• Training and learning opportunities are available and valued as a skill development resource • Training is delivered to the appropriate service lines • Training supports strong adoption of quality performance drivers • Reinforcement training provided on a continual basis • Tools (guides, aids, etc…) are provided to support the training	• Continuous learning and education are in place to ensure most current evidence based practices are occurring • Training participation and achievements are tracked • Surveys or assessments are created for staff to gauge the effectiveness of training and learning opportunities • Follow-up and reinforcement training provided on a consistent basis	• Metrics are tracked and used on a regular basis to improve overall training and yield innovative approaches and improvements to quality • Materials and learning opportunities are reviewed, updated and continuously improved upon
Data Measures and Management	• Collecting, tracking and use of metrics to drive improvements • Managing data to advance quality **Key Themes:** • Data Timing • Data Type • Data Use • Data Stakeholders • Data Integrity	• Little to no data are used to inform or drive improvements • Data that are used are not defined or relevant in driving strategic goals or improvements in quality and lacking insight (i.e., lagging indicators) • Front-line staff or physicians are not informed of important stats/metrics (e.g., LWBS, sepsis rates) • Poor quality/integrity to the data. data are not believed ("my patients are sicker" mindset) • Industry performance benchmarks are not being met	• Data are generated on demand and are used for regulatory purposes only (external) • Data delivery method has an inconsistent format providing an incomplete picture • Appropriate stakeholders are not always updated on the metrics • Industry performance benchmarks are being inconsistently met for some elements	• Data generation is managed and aligns to the strategy • Data have a consistent format and delivery schedule • Stakeholders are regularly provided metrics • Industry performance benchmarks are being mostly met and showing continuous improvements in multiple benchmarks	• Data generate relevant information that is easily tailored to interest areas of stakeholders • Data are insightful with leading indicators to help in decision making or a course of action • Data are used to drive improvements • Industry performance benchmarks are being met in all categories	• Process is in place to review data to ensure it is relevant with any changes in the industry, and modifications are made if necessary '• Input and feedback is continuously obtained from stakeholders to ensure that reporting meets stakeholder needs. • Industry performance benchmarks are consistently being met in all categories year over year

Definition of Quality:
IOM- Lowering Mortality • Effectiveness • Safety • Equity • Efficiency • Patient Centered
Triple Aim- Patient Centered • Population Health • Lower Cost
Rate of Improvement- Improving Externally Reporting Metrics • Innovative • Reputation/ Name Recognition

Responses to Quality Maturity Model Survey

20 of 24 Requested Participants

Mix of Board Members, Committee Members, Physicians and ECH Leadership Responded

Rating	1	1.25	1.5	1.75	2	2.25	2.5	2.75	3	3.25	3.5	3.75	4	4.25	4.5	4.75	5	Average
Domain																		
Leadership and Culture	1				2		1		7		2	1	6					3.16
Organizational Integration	1				2		2		12		2		1					2.70
Performance Improvement Methodology					3			1	7		2		6				1	3.27
Policy and Procedure Management					6		1	1	6		1		5					2.94
Training and Learning	1				5	1	2		5		1		4					2.64
Data Measures and Management					1	1	1		8		2	1	6					3.28

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Prepared: 2/6/2019

FY19 Organizational Goals

Organizational Goals FY19	Benchmark	Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY19 through January
Organizational Goals								
Patient Throughput ED Door to Patient Floor - LG & MV	Internal Benchmark *Based on CMS Core Measure Data*	Minutes - 339	306	280	270	30%	Q4	314
HCAHPS Service Metric Nurse Communication 10%	External Benchmark *PG-HCAHPS Adjusted/Received*	Nurse Comm - 80	80.5	81	82	10%	Q4	80.5
HCAHPS Service Metric Responsiveness 10%	External Benchmark *PG-HCAHPS Adjusted/Received*	Responsiveness - 65.1	65.6	67	68.5	10%	Q4	65.2
HCAHPS Service Metric Cleanliness 10%	External Benchmark *PG-HCAHPS Adjusted/Received*	Cleanliness - 74.5	75	76	77	10%	Q4	76.5
Quality Metrics* Mortality Index - All Patients 10%	External Benchmark *Premier Quality Advisor Top Quartile*	Mortality 1.02	1.00	0.95	0.90	10%	FY	0.90
Quality Metrics** Readmissions Index - All Patients 10%	External Benchmark *Premier Quality Advisor Top Quartile*	Readmission 1.08	1.07	1.05	1.03	10%	FY	1.00
People *(Management Employees)* Employee Engagement	External Benchmark *Press Ganey*	4.09	4.09	4.14	4.17	20%	FY	4.27
People *(Non-Management Employees)* Participation in Employee Voice (Engagement) Survey	External Benchmark *Press Ganey*	79%	79%	80%	82%	20%	FY	87%
Threshold Goals								
Budgeted Operating Margin***	Internal *95%*	Achieved FY18 Budget	95% of Budgeted Operating Margin			Threshold	FY	Met

* This metric is available through November 2018 only.

** This metric is available through October 2018 only.

HCAHPS Q4FY17 - Q3 FY18
Employment Engagement FY18 Press Ganey Overall Engagement Indicator Score
Baseline Measurement Period: Q4 FY 17- Q3 FY 18 (one year)
Benchmark: Top Quartile =276 Minutes. Target set just below top quartile, but max set above top quartile.

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

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

4. People
Employee Engagement Survey

Non Management:
Press Ganey's Average Participation is 75%
Press Ganey's Top Decile for participation rate is 83%
This is based on a database of 4900 facilities that use the Press Ganey survey

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 initial review on 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) – COMPLETE - 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, reviewed at every meeting.

SUBMITTED BY:**Chair**: David Reeder
Executive Sponsor: Mark Adams, MD, CMO
Approved by the El Camino Hospital Board on June 13, 2018