Gilchrist

Quality and Patient Safety Plan

FY2018

Plan Overview

Each element of the FY2018 Gilchrist Quality Plan is intended to guide hospice and end-of-life care performance in accordance with the CMS Quality Strategy for hospice and the GBMC "Quadruple" AIM: Better Health, Better Care, Least Waste and More Joy.

The ultimate goal of hospice care is to help the patient and family receive care aligned with their preferences, while improving quality of life as death nears. Defining and measuring the quality of hospice care is challenging given its strong ties to patient preferences, the terminal health status of patients, and the challenges of an interdisciplinary team delivering services in various settings, including patients' homes and residential care settings. National data gathering and public reporting are in their initial stages and as a result the consumer currently has limited information about the quality of hospice care to help them select a provider.

Efforts to reach consensus on defining hospice quality –including the National Consensus Project for Quality Palliative Care – has generated the measures currently implemented in The Centers for Medicare and Medicaid Services (CMS) Hospice Quality Reporting Program.

The first of these CMS measures is the Hospice Item Set (HIS), a patient-level instrument administered as part of the hospice admissions process. It is used to gather data on seven quality measures. These measures include management of; pain, shortness of breath, bowel function, patient preferences regarding life-sustaining treatment and spiritual concerns. The second measure is the Consumers Assessment of Healthcare Providers and Systems (CAHPS) that was recently implemented. Information from post-death surveys are used to provide a retrospective understanding of the patient and family experience of care.

The above CMS measures are in the "pay-for-reporting" phase. We anticipate CMS implementation of the "pay-for-performance phase" in the near future which can yield either financial benefit or penalty. The reporting phase puts 2% of our revenues at risk annually. This is equivalent to a total of $2,200,000 per year.

CMS is also focused on understanding the number and types of visits performed by hospice staff in the patient's final 7 days, and final 3 days of life. The expectation is that visits will increase during this critical time, and CMS suspects that the emphasis in the last 3 days of life will shift from a clinical focus to more psych-social interventions. Hospices are required to report this data on their discharge HIS. There has not been any comparative data available by hospice to date so that hospices can determine how they rank in comparison to others. CMS is also analyzing the number of patients discharged live from hospice and the number of revocations (voluntary withdrawal) from service shortly after admission. This may signal that the hospices admission staff are not adequately describing the care a patient receives, causing them to withdraw from hospice shortly after admission. Gilchrist will begin collecting this data for internal review in preparation for further CMS action.

Gilchrist was awarded a Medicare Innovation grant that began in January 2016. The program allows Gilchrist to offer persons seeking hospice care the ability to receive curative treatments while also receiving hospice care. Commercial carriers have already learned that this approach results in overall cost savings and improved patient and family satisfaction. We suspect that this program may be more aligned with the minority populations preference to continue curative treatments longer than their Caucasian counterparts. To learn more about this, we have added three measures this year that will monitor the use of this program by minority populations. The specific measures are: (1) the number of minority patients admitted to the new Medicare Care Choices program, (2) the number of minority patients admitted to hospice, and, (3) the sum of the two. There is no improvement goal associated with these measures. We are simply interested in monitoring the results.

The CMS CAHPS measures and the HIS measures have external benchmarks. The CAHPS measures have national benchmarks available from the vendor (Deyta) collecting this data from hundreds of hospices. Most of the CAHPS goals have been set at or slightly above the 75 percentile. CMS has published the first national data. Gilchrist currently exceeds all national benchmarks except the one associated with pain assessments. We will be targeting this area for improvement this year.

In addition to collecting the CMS measures described above and in keeping with the GBMC- Quadruple AIM, Gilchrist will maintain a strong focus on safety through reporting, analysis, and rapid tests of change. Using the existing Process Owner Improvement Program (developed in Fall of 2016), as well as an updated practice of LDM as a workbench for improvement, Gilchrist will continue to focus on the following internal metrics:

Better Care:

1) Eliminating Adverse Events
2) Unsafe Oxygen Use
3) Reducing Terminal Falls (G+)
4) Reducing Falls with Injury
5) Increased reporting of Patient Care Concerns

Better Health:

1) Decreasing Medication Errors
2) Monitoring the presence of Interdisciplinary Team Notes every 14 days
3) Referral Source Satisfaction

Least Waste:

1) Reducing RN and AIDE Agency Use in our Centers

More Joy:

1) Reducing Employee Injuries
2) Engaging Staff in Stay Interviews
3) Employee Engagement

These metrics do not have external benchmarks associated with them. The goals associated with these items are reductions in incidents of patient harm from the prior year.

In addition, Gilchrist will maximize the use of Gemba Boards as improvement tools in order to; 1. Create sustained improvement as measured by the number of graduated metrics, 2. Increase improvement learning accountability of all staff. 3. Provide Leaders and line staff regular, scheduled interactions on safety issues. Leaders will focus on; guiding GEMBA discussions toward problem-solving using “5 Whys”, and encourage each team to implement quick tests of change, always measuring results. Unit Leaders are encouraged to select team metrics for their boards from CAHPS measures, Quadruple AIM metrics, and other improvement metrics that can be solved by the team. Currently, Gilchrist has 22 GEMBA boards representing almost 70 metrics. Additional boards planned for FY18 include; *Business Development, Health Information Management, and others.* In addition to these metrics, Gilchrist will use the data collected from its referral source survey. The results and comments from the Employee Engagement Survey are also used to initiate further improvement activities.

Finally, Gilchrist will enhance its patient engagement learning through the development of a Patient Family Advisory Council (PFAC). PFAC members will collaborate with Gilchrist staff with the goal of providing the highest level of care and service to our patients and families. Through this partnership, we will seek to better understand the needs and desires of our patients and families in order to yield the most patient- and family-specific care experience possible. The goals of PFAC include: the creation of a recurring forum that fosters frank and meaningful discussion among both community and Gilchrist members, the documentation, testing, and appropriate implementation of new or improved elements of care based on PFAC feedback and recommendations, and the advancement of the patient and family experience of care. Patient Family Advisors (PFAs) will be selected following a nomination and application/interview process. All PFAs will be asked to share personal experiences, opinions and ideas in a constructive way to effectively improve the Gilchrist patient experience.

In summary, Gilchrist will be monitoring 45 discreet measures of quality. All members of the leadership team have an active role in meeting or exceeding these goals.

CMS - Dollars at Risk - Some National Benchmarks Available

Gilchrist FY18 Improvement Dashboard	FY15 Actual	FY16 Actual	FY17 Actual	FY18 Goal	Nat'l. Ave.	Desired Change	Desired Outcome
Hospice CAHPS Domains & Global Questions **Domain Measurement New in FY18**							
Team Communications (Qs 6, 8, 9, 14, 35)	--	78.0%	81.2%	85.0%	81.1%	3.8%	**Higher**
Getting Timely Care (Qs 5, 7)	--	73.0%	76.3%	79.2%	77.0%	2.9%	
Treating Family Member with Respect (Qs 11, 12)	--	88.7%	91.8%	95.5%	91.0%	3.7%	
Providing Emotional Support (Qs 37, 38)	--	88.2%	89.9%	95.8%	92.4%	5.9%	
Support for Religious and Spiritual Beliefs (Q36)	--	92.2%	91.1%	100.0%	94.0%	8.9%	
Getting Help for Symptoms (Qs 16, 22, 25, 27)	--	68.8%	70.0%	78.1%	75.8%	8.1%	
Information Continuity (Q10)	--	83.0%	88.4%	92.6%	87.6%	4.2%	
Understanding Side Effects of Pain Medication (Q18)	--	75.5%	71.6%	76.0%	74.4%	4.4%	
Teaching How to Care for Patient at Home (Qs 19, 20, 23, 29)	--	68.0%	67.5%	75.5%	71.7%	8.0%	
Overall Rating of Hospice (Q39)	--	81.8%	81.7%	88.2%	84.7%	6.5%	
Likelihood to Recommend (Q40)	--	82.4%	86.5%	90.5%	86.5%	4.0%	
Hospice Item Set (HIS)							
HIS Acceptance Rate	--	99.9%	95.6%	99.5%	--	3.9%	**Higher**
Treatment Preferences	--	--	99.8%	99.9%	98.5%	0.1%	
Beliefs/Values	--	--	98.2%	99.5%	94.1%	1.3%	
Pain Screening	--	--	99.2%	99.9%	94.4%	0.7%	
Pain Assessment (w/I 1 day of positive screen)	--	--	65.1%	85.0%	79.3%	19.9%	
Dypsnea Screening	--	--	99.0%	99.5%	97.5%	0.5%	
Dypsnea Treatment	--	--	98.5%	99.5%	95.1%	1.0%	
Bowel Regiment	--	--	99.2%	99.5%	93.5%	0.3%	
Discharge HIS: # of Visits in Final 3 Days of Life (O5010) **New in FY18**	--	--	--	--	--	--	**Monitor (Higher)**
Discharge HIS: # of Visits in Final 7 Days of Life (O5020) **New in FY18**	--	--	--	--	--	--	

	Pain Management w/i 18 hours (IPU)	N/A	98%	99%	99%	--	+	Higher
	Pain Management w/i 24 hours (FBC+HC)	97%	96%	95%	98%	--	+	
	Hospice Revocation w/I 15 Days of Admission **New in FY18**	--	--	--	TBD	--	--	Monitor (Lower)
	# of Hospitalizations in the last 7 days of life **New in FY18**	--	--	--	TBD	--	--	
	# of Live Discharges **New in FY18**	--	--	--	TBD	--	--	
	CMS Care Choices (GCC)							
	# African American population admitted to Care Choices Program **New in FY18**	0	2	26	--	--	+	Monitor (Higher)
	# African American population admitted to Gilchrist Hospice **New in FY18**	1012	986	883	--	--	+	
	# African American population admitted to Care Choices and then Gilchrist Hospice **New in FY18**	TBD	TBD	TBD	--	--	+	
AIM - Better Care	**Adverse Events**	0	0	0	2 or less	--	--	Lower
	O2 Safety Compliance (HC only)	79%	92%	88%	95%	--	+ 7%	Higher
	Terminal Falls (G+) - IPU **New in FY18**	0	5	0	1	--	1	Lower
	Terminal Falls (G+) FBC **New in FY18**	12	18	13	8	--	-4	Lower
	Falls with Injury	434	501	553	498	--	0	Lower
	IPU	26	30	28	25	--		
	FBC	218	271	284	256	--		
	HC - includes kids	190	200	221	199	--		
	Patient Care Concerns	3864	4276	2914	5120	--	+2206	Higher
AIM - Better	**Medication Errors**	135	104	79	74	--	-5	Lower

	Referral Source Engagement: Likelihood to Recommend this Hospice	4.61 (FY14)	--	TBD	N/A	N/A	FY19	**Higher**
	IDT Note Compliance	--	78%	87.7%	90%	--	+2.3%	**Higher**
AIM - Least Waste	**Inpatient Unit Agency Use (in dollars). New in FY18 Leadership GEMBA Board**	--	--	--	TBD	--	-	**Lower**
AIM - More Joy	**Stay Interview Compliance**	54%	29%	76%	88%	--	+12%	**Higher**
	Job Vacancy Time-to-Fill (in days) New in FY18	--	--	--	TBD	--	+	**Lower**
	Employee Injuries: Motor vehicle related	14	25	1	22	--	-3	**Lower**
	Employee Injuries: Non - motor vehicle related	8	6	6	4	--	-2	
	Overall employee engagement	--	4.15	4.25	4.28	--	+0.03	**Higher**

Glossary

Adverse Event: An Adverse Event is defined by Gilchrist as an unintended patient safety event that reaches a patient, and results in; severe, permanent harm, intervention required to sustain life, or unexpected death. An event will not be considered for adverse categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).

APU: Annual Payment Update

CHAP: Community Health Accreditation Partner. Gilchrists' accrediting body.

Employee injury: An injury as defined by the GBMC Employee Health/HR/System.

Falls with Injury: When a patient moves downward without control from a higher to a lower level and incurs an injury in the following categories:

E: A fall event that increased the need for intervention, and caused temporary harm

F: A fall event that contributed to or resulted in temporary harm and the patient is temporarily hospitalized

Terminal (G+) Fall: **G:** A fall event that contributed to or resulted in permanent harm. Gilchrist defines "permanent" as any event that will prevent the patient from returning to his/her prior level of function.

H: A fall event that required intervention to sustain life.

I: A fall event that directly contributed to or resulted in death not due to disease progression.

When a patient being cared for moves downward without control from a higher to a lower level and incurs an injury defined by the following severity categories G: A fall event that contributed to or resulted in permanent harm. Gilchrist defines "permanent" as any event that will prevent the patient from returning to his/her prior level of function. H: A fall event that required intervention to sustain life. I: A fall event that directly contributed to or resulted in death not due to disease progression. An event will not be considered for G+ categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).

HIS Measures:

Acceptance Rate: CMS portal report yields the # Populated (all measures)/Total number of admissions

Quality Measure #1: **Discharge HIS # of visits in final 3 days of life:** The percentage of patients who were visited at least once by either an MD, NP, RN, or PA in the last 3 days of life.

Quality Measure #2: **Discharge HIS # of visits in final 7 days of life:** The percentage of patients who were visited at least twice by a Medical Social Worker, Chaplain or Spiritual Counselor, LPN or Hospice Aide in the last 7 days of life.

Hospice CAHPS:

The CMS developed post-death family caregiver survey intended to systematically assess patient and family experiences with hospice care. The survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) family of surveys and is officially designated by CMS as the CAHPS® Hospice survey.

The survey is 47 questions long, and includes 6 composite members, 3 single item measures, and 2 global measures.

Hospice Revocation w/i 15 Days of Admission: The number of patients and families who leave hospice within 15 days of admission in order to pursue another provider option.

Hospitalizations in the last 7 days of life:

The number of hospice patients who choose to be hospitalized within the last 7 days of life.

IDT Note Compliance:

Based a census review of IDT notes, the percentage calculation is scored by the following two elements; 1. How many of the 4 disciplines (Nurse, Hospice Aide, SW, Chaplain) documented, or X/120 per month, and 2. % plans with descriptive plan, or X/24 per month. Note must contain more than "continue plan of care". Goal: 92% or for 1. 110/month and for 2. 22/month

Inpatient Unit Agency Use:

The total number of hours worked by non-Gilchrist nurses due to position vacancies.

# of Live Discharges: The number of patients who are alive at discharge.

Medicare Care Choices Model: Medicare insurance coverage for patients who want to receive concurrent care; both curative and hospice.

Medication Error: As identified in Quantros, this is an instance during the reporting month where the Patient/family/caregiver does not follow physician orders, or nurse instructions in administering medications; e.g. titration of IV opiates outside of physician ordered titration parameters. PRN medications being administered consistently at regularly scheduled intervals. Wrong medication, wrong, time, wrong dose, wrong route of administration, or extra dose, omission of ordered drug as the result of nursing intervention. Missing a scheduled administration of sub-cutaneous, intra-muscular, or intravenous medication, or nay form of medication for any reason; e.g. staffing difficulties, equipment or supply failure. Prescription dispensed incorrectly/incorrectly labeled. (any pharmacy order).

Oxygen Safety: **Requires an oxygen order be present in the care plan as well as an oxygen contract.**

Pain Management: Percentage based on a comparison of EPIC note documented time of pain management compared to the documented start of pain protocol.

Patient Care Concerns: The total number of Quantros events entered during the reporting month. This number includes Triage and Tell Line calls.

Pay-for-Reporting: CMS releases or withholds Medicare dollars based on reporting on a quality item without regard for scoring.

Pay-for-Performance: CMS releases or withholds Medicare dollars based on nationally compared scoring on the quality item.

Position Vacancy Time-to-Fill: The average number of days between the publication of a job and getting an offer accepted.

Public Reporting: CMS posts organization-specific HQRP data on an open website
Most probably to be called “Hospice Compare”

Supervisory/Stay Visit Compliance: Based a census review of IDT notes, the percentage calculation is scored by the following two elements; 1. How many of the 4 disciplines (Nurse, Hospice Aide, SW, Chaplain) documented, or X/120 per month, and 2. % plans with descriptive plan, or X/24 per month. Note must contain more than "continue plan of care". Goal: 92% or for 1. 110/month and for 2. 22/month

Stakeholder Satisfaction: Self-reported approval of partnership with Gilchrist. Research conducted by Press Ganey who calculates average mean score on a 5-point scale with "5" being the best possible response.

Star Rating: Medicare uses a Star Rating System to measure how well hospices perform, and to translate the actual scoring into a rating system easily understood by consumers and referrers. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score.

Gilchrist

Quality, Safety and Staff Development Plan

FY2019

Plan Summary

Each element of the FY2019 Gilchrist Quality Plan is intended to guide our performance and alignment with the CMS Quality Strategy for hospice and the GBMC "Quadruple" AIM: Better Health, Better Care, Least Waste and More Joy.

The goal of high quality serious and end of life care is assuring the person and family receive care that is congruent with their preferences, while enhancing their quality of life as death nears. Defining and measuring the quality of hospice care is challenging given its strong ties to individual person preferences, their declining and/or terminal health, and the challenges of an interdisciplinary team delivering services in various settings, including private residences, residential care settings and our own inpatient units.

Efforts to reach consensus on defining quality in serious and end of life care –including the National Consensus Project for Quality Palliative Care – has generated the measures currently implemented in The Centers for Medicare and Medicaid Services (CMS) Hospice Quality Reporting Program.

The current CMS quality measures include; the Hospice Item Set (HIS), a patient-level instrument administered as part of the hospice admissions and discharge process. The HIS gathers data on seven quality measures. These measures include the assessment and management of; pain, shortness of breath, bowel function, patient preferences regarding life-sustaining treatment and spiritual concerns. The HIS reporting also includes a requirement for us to report the number and types of visits performed by hospice staff in the patient's final 7 and final 3 days of life. CMS believes that visits should increase during this critical time, with visits shifting from a clinical focus to increased psychosocial interventions during the last 3 days of life. A report by RTI International indicated that 92.4% of all persons received at least one skilled nursing visit in their last 7 days and 45.6% received at least one visit by a medical social worker. 6% of all persons received zero visits of any kind in the last in the last three days of life. 10% received 7 or more leading CMS to believe that this variation could be a significant and meaningful differentiator among hospices. A recent addition to the HIS reporting has been the calculation by CMS and reporting of a Composite HIS Score. It allows consumers to look at the single composite score to evaluate hospices.

CMS is evaluating a replacement set of measures for the HIS called the HEART measure which is being pilot tested now. It stands for the Hospice Evaluation and Assessment Reporting Tool. It is a comprehensive assessment tool that looks at close to 40 treatment attributes and preferences upon admission. It is like the current home health tool; OASIS. While an implementation date has not yet been released hospices are being told that it could be as early as October 2018.

The second CMS focus measure is the Consumers Assessment of Healthcare Providers and Systems (CAHPS). These measures gather information from post-death surveys and are used to provide a retrospective understanding of the "family" experience of care.

The Pepper Report tracks various utilization measures including the number of patients discharged live from hospice, number of revocations (voluntary withdrawal) from service shortly after admission, length of stay and others.

The above CMS measures continue to be in the "pay-for-reporting" phase meaning that penalties are levied to organizations who fail to report. We expect CMS to move to Phase 2, "pay-for-performance" in the next year where actual performance will drive incentive payments or penalties. The dollars at risk currently for reporting is 2% of annual revenues or $2,200,000. We anticipate the same level of penalty/incentive dollars when we move to phase 2.

Comparative data on HIS/CAHPS performance is available on a public facing web site, Hospice Compare.gov.

Planning considerations for FY 2019:

- Current HIS scores for Gilchrist exceed all national benchmarks except the one associated with pain assessments. We will be targeting this area again in FY19 for improvement.

- CAHPS goals for FY 2019 are based on the following:
  - All CAHPS domain scoring goals have been set at the 75th percentile.
  - The process improvement work will focus on each CAHPS domain, and each domain will be managed by a dedicated Process Owner/Executive Sponsor. This is a change from FY18 where singular questions were selected for improvement testing based on the strength of their relationship to likelihood to recommend Gilchrist.
  - The Gilchrist Data Analytics team will create a priority analysis of all CAHPS behaviors that is specific to the Gilchrist population.
  - Gilchrist will interview the Healthcare Quality Data Vendor Strategic Health Partners to understand if utilizing their reporting structure will support faster, more meaningful improvements.
  - Gilchrist will implement three modules of the Language of Caring program which focuses on "communication" training and coaching solutions for staff and physicians. The modules include Heart, Head, Heart Communications, Blameless Apology and Say It Again with Heart.
  - To better track the impact of our rapid cycle improvements, the team will create a calendar that lists and cross references; 1. Sample month (date of discharge), 2. Last date of survey return that CMS will count individual responses in the CAHPS data set (within 42 days of receipt), and 3. The date that CAHPS data will show on HospiceCompare.gov, CMS' public reporting site.

Medicare Care Choices Program:
In FY19 Gilchrist will continue work on the Medicare Care Choices Program that allows persons seeking hospice care the ability to receive curative treatments while also receiving hospice care. This model is designed to increase access to supportive care services provided by hospice, improve quality of life and patient/family satisfaction, and inform new payment systems for the Medicare and Medicaid programs. Commercial carriers have already learned that this model results in overall cost savings and improved patient and family satisfaction. Additionally, this option appears to improve the health equity for minorities.
We will be measuring the use of this program by minorities compared to the use of overall hospice care.

LEAN Weekly Management:
In addition, Gilchrist will use Lean Weekly Management (LWM) Boards as improvement tools to; 1. Create sustained improvement as measured by the number of graduated metrics, 2. Increase improvement learning accountability of all staff. 3. Provide Leaders and line staff regular, scheduled interactions on safety issues. Leaders will focus on; guiding LWM discussions toward problem-solving using "5 Whys" and the PDSA cycle of improvement model, and encourage each team to implement quick tests of change, always measuring results. Team Clinical Leaders are encouraged to select metrics for their boards from CAHPS measures, Quadruple AIM metrics, and other improvement metrics that can be solved by the team. Currently, Gilchrist has 22 boards representing almost 70 metrics. Additional boards planned for FY19 include; *Business Development, Health Information Management, and others.*

In addition to collecting the CMS measures described above and in keeping with the GBMC- Quadruple AIM, Gilchrist will maintain a strong focus on safety through reporting, analysis, and rapid tests of change. Using the existing Process Owner Improvement Program (developed in Fall of 2016), as well as an updated practice of LWM as a workbench for improvement, Gilchrist will continue to focus on the following internal metrics:[1]

I. Better Care:

1) Eliminating Adverse Events
2) Reducing Unsafe Oxygen Use
3) Reducing Terminal Falls (G+ severity) **
4) Reducing Falls with Injury **
5) Increased reporting of Patient Care Concerns
6) # of calls from community members that we were able to connect to a Gilchrist service New In FY19
7) Census of Elder Medical Care home based program New In FY19

II. Better Health:

1) % of GBMC Med-Surg Admissions receiving an advanced care management consult New In FY19
2) % of Howard County General Med-Surg Admissions receiving an advanced care management consult New In FY19
3) Monitoring the presence of Interdisciplinary Team Notes every 14 days
4) Referral Source Satisfaction (every other year)
5) Medication Errors **

III. Least Waste:

1) Reducing RN and AIDE Agency Use in our Centers

IV. More Joy:

1) Decrease Job Vacancy Time-to Fill (in days)
2) Reducing Employee Injuries
3) Engaging Staff in Stay Interviews
4) Employee Engagement Scores

** historically these have been occurrence measures, we will convert these to rate measures

New for 2019:

In FY19 all divisions, (Counseling and Support, Elder Medical Care and Hospice) will be represented on the Executive Dashboard. Each division will contribute at least one metric for on-going evaluation. Counseling and Support will be tracking metrics 1 and 2 under Better Health listed above and 6 under Better Care. Elder Medical Care's home-based census, 7 under Better Care will also be tracked.

[1] Few benchmarks exist for the quadruple aim measures. Many of the goals used for this work reflect improvements in our own work. Wherever possible, national and/or local benchmarks are used.

The Patient Family Advisory Council (PFAC) will include members from all of our divisions. PFAC members will collaborate with Gilchrist staff with the goal of providing the highest level of care and service to our patients and families. Through this partnership, we will seek to better understand the needs and desires of our patients and families to yield the most patient- and family- centered care experience possible. The goals of PFAC include: the creation of a recurring forum that fosters frank and meaningful discussion among both community and Gilchrist members, the documentation, testing, and appropriate implementation of new or improved elements of care based on PFAC feedback and recommendations, and the advancement of the patient and family experience of care. Patient Family Advisors (PFAs) will be selected following a nomination and application/interview process. All PFAs will be asked to share personal experiences, opinions and ideas in a constructive way to effectively improve the Gilchrist patient experience.

Areas of Focus for Standing Committees:

Education Committee:

Gilchrist will expand its educational and professional development offerings to include content about all Gilchrist programs and services, Elder Medical Care, Counseling and Support in addition to hospice. The Education Committee will provide learning forums delivering content to support resiliency, customer service, intergenerational work forces, diversity and the Language of Caring. We also expect to see an increase in the use of technology for delivering educational content.

Infection Control and Prevention:

The focus of this group will be to conduct observational visits to evaluate proper hand hygiene, wound care dressing procedures, proper use of Personal Protective Equipment, surveillance of flu vaccine and infection spread in residential community care facilities, and others as needed.

Pharmacy and Therapeutics:

This team will monitor costs and utilization of all medications, monitor the opioid shortage and make recommendations for alternative solutions, lead implementation of the new state law requiring clinicians to destroy home based opioids, use of medical marijuana and others as needed.

Safety Committee:

Review and monitor person and employee injuries, (e.g. falls, motor vehicle accidents) and make recommendations for reducing same. Conducts annual safety fair and evaluates areas of rising risk for review and policy development.

In summary, Gilchrist will be monitoring 50 discreet measures of quality. All members of the leadership team have an active role in meeting or exceeding these goals.

Utilization Review Committee:

Reviews all person files on service for more than 180 days, reviews files for on-going eligibility, reviews files of all persons being suggested for discharge, reviews documentation and makes recommendations for improvement.

FY19 Gilchrist Measures and Goals

Gilchrist FY19 Improvement Dashboard (Privileged and Confidential)	FY15 Actual	FY16 Actual	FY17 Actual	FY18 Goal	FY19 Goal
Annual CAHPS Goals at the Domain Level - Goals set at the CMS dB 75th pecentile.					
Overall Rating of Hospice (Q39)	--	81.8%	81.7%	88.2%	90.3%
Likelihood to Recommend (Q40)	--	82.4%	86.5%	90.5%	91.3%
Hospice Team Communications (Qs 6, 8, 9, 10, 14, 35)	--	78.0%	81.2%	85.0%	86.7%
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Treating Family Member with Respect (Qs 11, 12)	--	88.7%	91.8%	95.5%	95.0%
Getting Emotional and Religious Support (Qs 36, 37, 38)	--	88.7%	89.9%	95.8%	95.8%
Getting Help with Symptoms (Qs 16, 22, 25, 27)	--	88.7%	70.0%	78.1%	81.9%
Teaching How to Care for Patient at Home (Qs 18, 19, 20, 23, 29)	--	88.7%	67.5%	75.5%	86.1%
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Getting Emotional and Religious Support (Qs 36, 37, 38)	--	88.7%	89.9%	95.8%	95.8%
Getting Help with Symptoms (Qs 16, 22, 25, 27)	--	88.7%	70.0%	78.1%	81.9%
Teaching How to Care for Patient at Home (Qs 18, 19, 20, 23, 29)	--	88.7%	67.5%	75.5%	86.1%
Hospice Item Set (HIS)					
HIS Acceptance Rate	--	99.9%	95.6%	99.5%	99.5%
Treatment Preferences	--	--	99.8%	99.9%	100.0%
Beliefs/Values	--	--	98.2%	99.5%	99.0%
Pain Screening	--	--	99.2%	99.9%	99.5%
Pain Assessment (w/I 1 day of positive screen)	--	--	65.1%	85.0%	99.0%
Dypsnea Screening	--	--	99.0%	99.5%	99.5%
Dypsnea Treatment	--	--	98.5%	99.5%	99.3%
Bowel Regiment	--	--	99.2%	99.5%	99.8%
Discharge HIS:At least 1 visit in Final 3 Days of Life (O5010) **[RN, NP, PA, MD]**	--	--	--	--	90.0%
Discharge HIS: At least 2 visits in Final 7 Days of Life (O5030) **[HA, LPN, CHP, SW]**	--	--	--	--	85.0%

Gilchrist FY19 Improvement Dashboard (Privileged and Confidential)	FY15 Actual	FY16 Actual	FY17 Actual	FY18 Goal	FY19 Goal
Pain Management w/i 18 hours (IPU)	N/A	98%	99%	99%	99%
NEW IN FY19 Pain Management w/I 24 hours - Macy Catheter (IPU)	N/A	N/A	N/A	N/A	93%
Pain Management w/i 24 hours (RC+HC)	97%	96%	95%	98%	98%
Hospice Revocation w/I 15 Days of Admission	--	--	--	--	--
# of Hospitalizations in the last 7 days of life	--	--	--	--	--
# of Live Discharges	--	--	--	--	--
CMS Model/Gilchrist Care Choices (GCC)					
# African American population admitted to Care Choices Program	0	2	26	--	--
# African American population admitted to Gilchrist Hospice	1012	986	883	--	--
# African American population admitted to Care Choices and then Gilchrist Hospice	--	--	--	--	--

Gilchrist FY19 Improvement Dashboard (Privileged and Confidential)	FY15 Actual	FY16 Actual	FY17 Actual	FY18 Goal	FY19 Goal
Adverse Events	0	0	0	2 or less	2 or less
O2 Safety Compliance (HC only)	79%	92%	90%	95%	98%
Falls (G+) - IPU	0	5	0	1	1
Falls (G+) RC	12	18	11	8	8
FY19 RATE: Falls with Injury	434	501	553	498	1.86
IPU	26	30	28	25	1.45
RC	218	271	284	256	2.40
HC - includes kids	190	200	221	199	1.58
MOVED FROM BETTER HEALTH IN FY19 Medication Errors	0.61	0.39	0.28	74	0.35
Patient Care Concerns	3864	4276	2914	5120	3350
ETA Calls (Triage Only)	--	--	--	--	--
Medication Refills (Triage Only)	--	--	--	--	--
Constipation (Triage Only)	--	--	--	--	--
			FY18 Goal was not calculated using rate		

FYTD 18 Fall Rates by Division
Overall Fall with Injury Rate: 1.77
IPU Fall with Injury Rate: 0.81
RCC Fall with Injury Rate 1.62
HC Fall with Injury Rate 2.20

FY17 Fall Rates by Division
Overall Fall with Injury Rate: 1.86
IPU Fall with Injury Rate: 1.45
RCC Fall with Injury Rate: 1.58

Gilchrist FY19 Improvement Dashboard (Privileged and Confidential)	FY15 Actual	FY16 Actual	FY17 Actual	FY18 Goal	FY19 Goal
NEW IN FY19 % of GBMC Med Surg Admissions receiving an advanced care management consult	--	--	6.70%	7.50%	TBD
NEW IN FY19 % of Howard County General Med Surg Admissions receiving an advanced care management consult	--	--	5.31%	6.00%	TBD
Referral Source Engagement: Likelihood to Recommend this Hospice [Next research period FY21]	4.61 (FY14)	--	4.53	--	4.58
IDT Note Compliance	--	78%	87.7%	90%	96.5%
Inpatient Unit Agency Use (in dollars). **Leadership GEMBA Board**	--	--	--	--	--
			(Goal updated monthly at 7.3% rate)		
Observation Visit Compliance (monthly goal calculation)	--	--	--	**58.4%**	**98.0%**
Job Vacancy Time-to-Fill (in days)	--	--	--	--	--
Employee Injuries: Motor vehicle related	14	25	1	22	6
Employee Injuries: Non - motor vehicle related	8	6	6	4	5
Overall employee engagement	--	4.15	4.25	4.28	4.31

Glossary

Adverse Event: An Adverse Event is defined by Gilchrist as an unintended patient safety event that reaches a patient, and results in; severe, permanent harm, intervention required to sustain life, or unexpected death. An event will not be considered for adverse categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).

APU: Annual Payment Update

CHAP: Community Health Accreditation Partner. Gilchrist's accrediting body.

Employee injury: An injury as defined by the GBMC Employee Health/HR/System.

Falls with Injury: When a patient moves downward without control from a higher to a lower level and incurs an injury in the following categories:

E: A fall event that increased the need for intervention, and caused temporary harm

F: A fall event that contributed to or resulted in temporary harm and the patient is temporarily hospitalized

(G+) Fall: **G:** A fall event that contributed to or resulted in permanent harm. Gilchrist defines "permanent" as any event that will prevent the patient from returning to his/her prior level of function.

H: A fall event that required intervention to sustain life.

I: A fall event that directly contributed to or resulted in death not due to disease progression.

When a patient being cared for moves downward without control from a higher to a lower level and incurs an injury defined by the following severity categories:

G) A fall event that contributed to or resulted in permanent harm. Gilchrist defines "permanent" as any event that will prevent the patient from returning to his/her prior level of function. H) A fall event that required intervention to sustain life. I) A fall event that directly contributed to or resulted in death not due to disease progression. An event will not be considered for G+ categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).

HEART: **The Hospice Evaluation & Assessment Reporting Tool (HEART)** is a pilot expansion of the existing patient assessment item set (HIS), and consists of two phases. The project goals include; the provision of an expanded view of the quality of care that hospice delivers, and to more fully understand patient needs, preferences and values. The outcomes of this pilot will be used to further develop hospice quality measurement instruments.

The two pilot flights will occur January 2018 – February 2018, and July 2018 – September 2018. RTI International will warehouse and assess the data. No date for pilot data dissemination has been provided.

HIS Measures: **Acceptance Rate:** CMS portal report yields the # Populated (all measures)/Total number of admissions

Quality Measure #1: **Discharge HIS # of visits in final 3 days of life:** The percentage of patients who were visited at least once by either an MD, NP, RN, or PA in the last 3 days of life.

Quality Measure #2: **Discharge HIS # of visits in final 7 days of life:** The percentage of patients who were visited at least twice by a Medical Social Worker, Chaplain or Spiritual Counselor, LPN or Hospice Aide in the last 7 days of life.

Hospice CAHPS: The CMS developed post-death family caregiver survey intended to systematically assess patient and family experiences with hospice care. The survey is part of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) family of surveys and is officially designated by CMS as the CAHPS® Hospice survey.

The survey is 47 questions long, and includes 6 composite members, 3 single item measures, and 2 global measures.

Hospice Revocation w/i 15 Days of Admission: The number of patients and families who leave hospice within 15 days of admission to pursue another provider option.

Hospitalizations in the last 7 days of life: The number of hospice patients who choose to be hospitalized within the last 7 days of life.

IDT Note Compliance: Based on a census review of IDT notes, the percentage calculation is scored by the following two elements; 1. How many of the 4 disciplines (Nurse, Hospice Aide, SW, Chaplain) documented, or X/120 per month, and 2. % plans with descriptive plan, or X/24 per month. Note must contain more than "continue plan of care". Goal: 92% or for 1. 110/month and for 2. 22/month

Inpatient Unit Agency Use:	The total number of hours worked by non-Gilchrist nurses due to position vacancies.
# of Live Discharges:	The number of patients who are alive at discharge.
Medicare Care Choices Model:	Medicare insurance coverage for patients who want to receive concurrent care; both curative and hospice.
Medication Error:	As identified in Quantros, this is an instance during the reporting month where the patient/family/caregiver does not follow physician orders, or nurse instructions in administering medications; e.g. titration of IV opiates outside of physician ordered titration parameters. PRN medications being administered consistently at regularly scheduled intervals. Wrong medication, wrong time, wrong dose, wrong route of administration, or extra dose, omission of ordered drug as the result of nursing intervention. Missing a scheduled administration of subcutaneous, intramuscular, or intravenous medication, or any form of medication for any reason; e.g. staffing difficulties, equipment or supply failure. Prescription dispensed incorrectly/incorrectly labeled. (any pharmacy order).
Oxygen Safety:	**Requires an oxygen order be present in the care plan as well as an oxygen contract.**
Pain Management:	Percentage based on a comparison of EPIC note documented time of pain management compared to the documented start of pain protocol.
Patient Care Concerns:	The total number of Quantros events entered during the reporting month. This number includes Triage and Tell Line calls.
Pay-for-Reporting:	CMS releases or withholds Medicare dollars based on reporting on a quality item without regard for scoring.
Pay-for-Performance:	CMS releases or withholds Medicare dollars based on nationally compared scoring on the quality item.
Position Vacancy Time-to-Fill:	The average number of days between the publication of a job and getting an offer accepted.
Public Reporting:	CMS posts organization-specific HQRP data on an open website Most probably to be called “Hospice Compare”.

Supervisory/Stay Visit Compliance: Based on a census review of IDT notes, the percentage calculation is scored by the following two elements; 1. How many of the 4 disciplines (Nurse, Hospice Aide, SW, Chaplain) documented, or X/120 per month, and 2. % plans with descriptive plan, or X/24 per month. Note must contain more than "continue plan of care". Goal: 92% or for 1. 110/month and for 2. 22/month

Stakeholder Satisfaction: Self-reported approval of partnership with Gilchrist. Research conducted by Press Ganey which calculates average mean score on a 5-point scale with "5" being the best possible response.

Star Rating: Medicare uses a Star Rating System to measure how well hospices perform, and to translate the actual scoring into a rating system easily understood by consumers and referrers. Ratings range from 1 to 5 stars, with five being the highest and one being the lowest score.

Gilchrist FY18 Improvement Dashboard				FY15 Actual	FY16 Actual	FY17 Actual	FY18 Goal	Nat'l. Ave.	Desired Change	Desired Outcome	Source and Definition
Executive Sponsor	**Process Owner**		**Hospice CAHPS** Domains & Global Questions **Domain Measurement New in FY18**								
Jill Campbell	Sarah McCampbell	CMS - Dollars at Risk - Some National Benchmarks Available	Team Communications (Qs 6, 8, 9, 14, 35)	--	78.0%	81.2%	85.0%	81.1%	3.8%	**Higher**	**Source/Definition:** Deyta web platform. Domain top box scoring to be pulled using the following parameters: survey return date, CMS completes only, time frame to be rolling 4 quarter by calendar date.
			Getting Timely Care (Qs 5, 7)	--	73.0%	76.3%	79.2%	77.0%	2.9%		
			Treating Family Member with Respect (Qs 11, 12)	--	88.7%	91.8%	95.5%	91.0%	3.7%		
			Providing Emotional Support (Qs 37, 38)	--	88.2%	89.9%	95.8%	92.4%	5.9%		
			Support for Religious and Spiritual Beliefs (Q36)	--	92.2%	91.1%	100.0%	94.0%	8.9%		
			Getting Help for Symptoms (Qs 16, 22, 25, 27)	--	68.8%	70.0%	78.1%	75.8%	8.1%		
			Information Continuity (Q10)	--	83.0%	88.4%	92.6%	87.6%	4.2%		
			Understanding Side Effects of Pain Medication (Q18)	--	75.5%	71.6%	76.0%	74.4%	4.4%		
			Teaching How to Care for Patient at Home (Qs 19, 20, 23, 29)	--	68.0%	67.5%	75.5%	71.7%	8.0%		
			Overall Rating of Hospice (Q39)	--	81.8%	81.7%	88.2%	84.7%	6.5%		
			Likelihood to Recommend (Q40)	--	82.4%	86.5%	90.5%	86.5%	4.0%		91.9 = Stretch
Executive Sponsor	**Process Owner**		**Hopsice Item Set (HIS)**								
Nicole Strauss	Tina Maggio		HIS Acceptance Rate	--	99.9%	95.6%	99.5%	--	3.9%	**Higher**	
	Michelle Anderson		Treatment Preferences	--	--	99.8%	99.9%	98.5%	0.1%		
			Beliefs/Values	--	--	98.2%	99.5%	94.1%	1.3%		
			Pain Screening	--	--	99.2%	99.9%	94.4%	0.7%		
			Pain Assessment (w/I 1 day of positive screen)	--	--	65.1%	85.0%	79.3%	19.9%		**Source/Definition:** EPIC report indicates the completion rate of NQF# 1637 (Pain Assessment),
			Dypsnea Screening	--	--	99.0%	99.5%	97.5%	0.5%		
			Dypsnea Treatment	--	--	98.5%	99.5%	95.1%	1.0%		
			Bowel Regiment	--	--	99.2%	99.5%	93.5%	0.3%		
	Wendy Eppers (Sarah McCampbell)		Discharge HIS: # of Visits in Final 3 Days of Life (O5010) **New in FY18**	--	--	--	--	--	--	**Monitor (Higher)**	
			Discharge HIS: # of Visits in Final 7 Days of Life (O5020) **New in FY18**	--	--	--	--	--	--		
Gail Blackburn	Gina Ranieri-Bender		Pain Management w/i 18 hours (IPU)	N/A	98%	99%	99%	--	+	**Higher**	**Source/Definition:** Percentage based on a comparison of EPIC note documented time of pain management compared to the documented start of pain protocol. Source - I: drive pain protocol excel spreadsheet populated by team managers with start and stop dates documented in EPIC; reviewed by Christie Petti (HC and FBC) and Gina Ranieri Bender (IPUs); results compiled by Quality department
	Christy Petti		Pain Management w/i 24 hours (FBC+HC)	97%	96%	95%	98%	--	+		
Monitor			Hospice Revocation w/I 15 Days of Admission **New in FY18**	--	--	--	TBD	--	--	**Monitor (Lower)**	**Source/Definition:** Finance Analytics to provide the number of paitients and families within the reporting month who leave hospice within 15 days of admission in order to pursue another provider option.
			# of Hospitalizations in the last 7 days of life **New in FY18**	--	--	--	TBD	--	--		**Source/Definition:** Finance Analytics to provide the number of patients who choose to leqave hospice and be hospitalized within the last 7 days of life.
			# of Live Discharges **New in FY18**	--	--	--	TBD	--	--		**Source/Definition:** Finance Analytics to provide the rate of patients within a reporting month who are alive at discharge.
			CMS Care Choices (GCC)								
GCC PM	Alyssa Manuel		# African American population admitted to Care Choices Program **New in FY18**	0	2	26	--	--	+	**Monitor (Higher)**	
			# African American population admitted to Gilchrist Hospice **New in FY18**	1012	986	883	--	--	+		
			# African American population admitted to Care Choices and then Gilchrist Hospice **New in FY18**	TBD	TBD	TBD	--	--	+		**Source/Definition:** Finance Analytics to provide the counts in each category based on admission date of the currrent month.
Jen Avery	Michelle Teel	AIM - Better Care	**Adverse Events** (self-determination)	0	0	0	2 or less	--	--	**Lower**	**Definition:** An Adverse Event is defined by Gilchrist as a patient safety event that reaches a patient, and results in; severe, permanent harm, intervention required to sustain life, or unexpected death. An event will not be considered for adverse categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).
Dr. Riley	Bonnie Speicher		**O2 Safety Compliance** (HC only)	79%	92%	90%	95%	--	+ 5%	**Higher**	**Source:** Patient profile, scanned documents.. Universe: HC Only. **Definition:** PE requires that an O2 order be present in the care plan for them to deliver O2. Audit: SQL report of entire universe of active admissions. Manually validate the SQL report by comparing image title to actual document in 20 patient records.
Cathy Hamel	Dionne Savage		**Terminal Falls (G+)** - IPU **New in FY18**	0	5	0	1	--	1	**Lower**	**Source**: Quantros. **Definition:** When a patient being cared or in either a facility in inpatient setting moves downward without control from a higher to a lower level and incurs an injury defined by the following severity categories G: A fall event that contributed to or resulted in permanent harm. Gilchrist defines "permanent" as any event that will prevent the patient from returning to his/her prior level of function. H: A fall event that required intervention to sustain life. I: A fall event that directly contributed to or resulted in death not due to disease progression. An event will not be considered for G+ categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).
			Terminal Falls (G+) FBC **New in FY18**	12	18	11	8	--	3	**Lower**	
			Falls with Injury	434	501	553	498	--			**Source/Definition:** As identified in Quantros, when a patient moves downward without control from a higher to a lower level and incurs an injury defined by the following severity categories E-F. An event will not be considered for Fall with injury categorization if the patient and Health Care Agent have been educated on
			IPU	26	30	28	25	--	0	**Lower**	

			FBC	218	271	284	256	--	0	**Lower**	be considered for Fall-with-Injury categorization if the patient and Health Care Agent have been educated on the risks inherent in the execution of the patient's right to self-determination, (e.g. disregard for safety suggestions in return for independent self-will) and documentation of such conversation is present and available in the patient's electronic health record (EHR).
			HC - includes kids	190	200	221	199	--			
Catherine Frome	Deb Peterson		**Patient Care Concerns**	3864	4276	2914	5120	--	+2206	**Higher**	**Source/Definition:** The total number of Quantros events entered during the reporting month. This number includes unduplicated Triage and Tell Line calls.
Cathy Hamel	Trisha Kendall	**AIM - Better Health**	**Medication Errors**	135	104	79	74	--	-5	**Lower**	**Source:/Definition:** As identified in Quantros, this is an instance during the reporting month where the: Patient/family/caregiver does not follow physician orders, or nurse instructions in administering medications; e.g. titration of IV opiates outside of physician ordered titration parameters. PRN medications being administered consistently at regularly scheduled intervals. Wrong medication, wrong, time, wrong dose, wrong route of administration, or extra dose, omission of ordered drug as the result of nursing intervention. Missing a scheduled administration of sub-cutaneous, intra-muscular, or intravenous medication, or nay form of medication for any reason; e.g. staffing difficulties, equipment or supply failure. Prescription dispensed incorrectly/incorrectly labeled. (any pharmacy order) Notes: Reviewed at P&T, and last Wednesday of the month with Trisha and Misty.
Anne Evans	Deb Brown		**Referral Source Engagement: Likelihood to Recommend this Hospice**	4.61 (FY14)	--	TBD	N/A	N/A	FY19	**Higher**	**Source/Definition:** Research conducted by Deyta who calculates average mean score on a 5-point scale with "5" being the best possible response. Access and Innovations Dept. survey to hospice referrers. Frequency: Every other year.
Gail Blackburn	Gina Norton		**IDT Note Compliance**	**--**	78%	87.7%	90%	--	+2.3%	**Higher**	**Source/Definition:** Based a census review of IDT notes, the percentage calculation is scored by the following two elements; 1. How many of the 4 disciplines (Nurse, Hospice Aide, SW, Chaplain) documented, or X/120 per month, and 2. % plans with descriptive plan, or X/24 per month. Note must contain more than "continue plan of care". Goal: 92% or for 1. 110/month and for 2. 22/month
Catherine Frome	Katie Packett	**AIM - Least Waste**	**Inpatient Unit Agency Use (in dollars)**. **New in FY18** **Leadership GEMBA Board**	--	--	--	TBD	--	-	**Lower**	Pending
Michele Sullivan	Kerry Avant	**AIM - More Joy**	**Stay Interview Compliance**	54%	29%	76%	88%	--	+12%	**Higher**	**Source/Definition:** Based a census review of IDT notes, the percentage calculation is scored by the following two elements; 1. How many of the 4 disciplines (Nurse, Hospice Aide, SW, Chaplain) documented, or X/120 per month, and 2. % plans with descriptive plan, or X/24 per month. Note must contain more than "continue plan of care". Goal: 92% or for 1. 110/month and for 2. 22/month
Cathy Hamel	Joy Curbean - Johnson		**Job Vacancy Time-to-Fill (in days)** **New in FY18**	--	--	--	TBD	--	+	**Lower**	**Source/Definition:** Using the universe of all job offers accepted in the reporting month, Human Resources calculates the average number of days between the publication of a job (externally) and offer acceptance.
Joy Curbean - Johnson	Rukayat Tijani		**Employee Injuries:** Motor vehicle related	14	25	1	22	--	-3	**Lower**	
			Employee Injuries: Non - motor vehicle related	8	6	6	4	--	-2		**Source/Definition:** As provided and defined by the GBMC Employee Health/HR/System.
Cathy Hamel	Joy Curbean - Johnson		**Overall employee engagement**	--	4.15	4.25	4.28	--	+0.03	**Higher**	**Source/Definition:** Research conducted by Press Ganey who calculates average mean score on a 5-point scale with "5" being the best possible response. Frequency: 1 X/ year

CMS - Dollars at Risk - Some National Benchmarks Available

Executive Sponsor	Process Owner	Gilchrist FY19 Improvement Dashboard (Privledged and Confidential)	FY15 Actual
		Annual CAHPS Goals at the Domain Level - Goals set at the CMS dB 75th pecentile.	
--	--	Overall Rating of Hospice (Q39)	--
--	--	Likelihood to Recommend (Q40)	--
Catherine Frome	**Michelle Teel**	Hospice Team Communications (Qs 6, 8, 9, 10, 14, 35)	--
Jill Campbell	**Venus Corpuz**	Getting Timely Care (Qs 5, 7)	--
Catherine Frome	**Gina Ranieri-Bender**	Treating Family Member with Respect (Qs 11, 12)	--
Gail Blackburn	**Robin Contino**	Getting Emotional and Religious Support (Qs 36, 37, 38)	--
Gail Blackburn	**Bonnie Speicher**	Getting Help with Symptoms (Qs 16, 22, 25, 27)	--
Jill Campbell	**Gina Norton**	Teaching How to Care for Patient at Home (Qs 18, 19, 20, 23, 29)	--
		Hospice Item Set (HIS)	
Nicole Strauss	**Tina Maggio**	HIS Acceptance Rate	--
	Sarah McCampbell	Treatment Preferences	--
		Beliefs/Values	--
		Pain Screening	--
		Pain Assessment (w/I 1 day of positive screen)	--
		Dypsnea Screening	--
		Dypsnea Treatment	--
		Bowel Regiment	--
	Wendy Eppers	Discharge HIS:At least 1 visit in Final 3 Days of Life (O5010) **[RN, NP, PA, MD]**	--
		Discharge HIS: At least 2 visits in Final 7 Days of Life (O5030) **[HA, LPN, CHP, SW]**	--

Internal Care & Ability to Serve	Gail Blackburn	Gina Ranieri-Bender	Pain Management w/i 18 hours (IPU)	N/A
			NEW IN FY19 Pain Management w/l 24 hours - Macy Catheter (IPU)	N/A
		Christy Petti	Pain Management w/i 24 hours (RC+HC)	97%
	Dr. Riley		Hospice Revocation w/l 15 Days of Admission	--
			# of Hospitalizations in the last 7 days of life	--
			# of Live Discharges	--
	Anne Evans	Rene Mayo	**CMS Model/Gilchrist Care Choices (GCC)**	
			# African American population admitted to Care Choices Program	0
			# African American population admitted to Gilchrist Hospice	1012
			# African American population admitted to Care Choices and then Gilchrist Hospice	--
AIM - Better Care	Cathy Hamel	Jen Avery/ Michelle Teel	**FYTD 18 Fall Rates by Division** Overall Fall with Injury Rate: 1.77 IPU Fall with Injury Rate: 0.81 RCC Fall with Injury Rate 1.62 HC Fall with Injury Rate 2.20	Adverse Events 0
	Dr. Riley	Bonnie Speicher		O2 Safety Compliance (HC only) 79%
	Cathy Hamel	Dionne Savage	**FY17 Fall Rates by Division** Overall Fall with Injury Rate: 1.86 IPU Fall with Injury Rate: 1.45 RCC Fall with Injury Rate: 1.58 HC Fall with Injury Rate 2.40	Falls (G+) - IPU 0
				Falls (G+) RC 12
				FY19 RATE: Falls with Injury 434
				IPU 26
				RC 218
				HC - includes kids 190
	Cathy Hamel	Trisha Kendall		**MOVED FROM BETTER HEALTH IN FY19** Medication Errors 0.61
	Catherine Frome	Jen Avery		**Patient Care Concerns** 3864
				ETA Calls (Triage Only) --
				Medication Refills (Triage Only) --
				Constipation (Triage Only) --

				FY
AIM - Better Health	Leana Hoover/Diane Sancillio	Tracie Shwoyer-Morgan	**NEW IN FY19** % of GBMC Med Surg Admissions receiving an advanced care management consult	--
	Leana Hoover/Diane Sancillio	Tracie Shwoyer-Morgan	**NEW IN FY19** % of Howard County General Med Surg Admissions receiving an advanced care management consult	--
	Anne Evans	Beth Brown	Referral Source Engagement: Likelihood to Recommend this Hospice [Next research period FY21]	4.61 (FY14)
	Dr. Riley	Shawn Brast	IDT Note Compliance	--
AIM - Least Waste	Wayne Barth	Katie Packett	**Inpatient Unit Agency Use (in dollars)**. **Leadership GEMBA Board**	--
AIM - More Joy	Michele Sullivan	Kerry Avant	**Observation Visit Compliance (monthly goal calculation)**	--
	Lyn San Juan	Kristen Collins	**Job Vacancy Time-to-Fill (in days)**	--
	Dionne Savage	Maria Lawson	**Employee Injuries: Motor vehicle related**	14
			Employee Injuries: Non - motor vehicle related	8
	Cathy Hamel	Lyn San Juan	**Overall employee engagement**	--

CMS - Dollars at Risk - Some National Benchmarks Available

Executive Sponsor	Process Owner	FY16 Actual	FY17 Actual	FY18 Goal	FY19 Goal	Nat'l. Ave.	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
--	--	81.8%	81.7%	88.2%	90.3%	84.6%	81.6%	81.0%	79.9%	82.1%	82.1%
--	--	82.4%	86.5%	90.5%	91.3%	86.1%	86.7%	88.2%	86.8%	88.0%	87.9%
Catherine Frome	Michelle Teel	78.0%	81.2%	85.0%	86.7%	81.1%	81.6%	81.2%	80.1%	79.3%	79.3%
Jill Campbell	Venus Corpuz	73.0%	76.3%	79.2%	83.3%	76.7%	77.0%	72.4%	74.5%	73.3%	72.7%
Catherine Frome	Gina Ranieri-Bender	88.7%	91.8%	95.5%	95.0%	95.0%	92.1%	90.4%	90.6%	89.7%	89.6%
Gail Blackburn	Robin Contino	88.7%	89.9%	95.8%	95.8%	92.4%	90.2%	89.3%	89.8%	91.0%	91.0%
Gail Blackburn	Bonnie Speicher	88.7%	70.0%	78.1%	81.9%	75.5%	71.1%	76.0%	72.7%	72.5%	72.0%
Jill Campbell	Gina Norton	88.7%	67.5%	75.5%	86.1%	76.6%	70.0%	72.7%	71.6%	71.2%	69.4%
									Hospice Item Set (HIS)		
Nicole Strauss	Tina Maggio	99.9%	95.6%	99.5%	99.5%	--	99.7%	99.6%	99.5%	99.2%	93.5%
	Sarah McCampbell	--	99.8%	99.9%	100.0%	99.1%	99.7%	100.0%	100.0%	100.0%	100.0%
		--	98.2%	99.5%	99.0%	96.2%	99.7%	98.9%	96.6%	100.0%	100.0%
		--	99.2%	99.9%	99.5%	96.7%	98.8%	98.0%	100.0%	99.5%	100.0%
		--	65.1%	85.0%	99.0%	88.8%	88.0%	89.0%	96.7%	99.3%	99.4%
		--	99.0%	99.5%	99.5%	98.3%	97.3%	99.4%	98.8%	99.2%	99.7%
		--	98.5%	99.5%	99.3%	96.1%	98.8%	98.8%	100.0%	99.5%	98.9%
		--	99.2%	99.5%	99.8%	95.6%	100.0%	100.0%	98.5%	100.0%	100.0%
	Wendy Eppers	--	--	--	90.0%	--	65.0%	80.0%	90.0%	100.0%	90.0%
		--	--	--	85.0%	--	35.0%	25.0%	55.0%	30.0%	40.0%

Internal Care & Ability to Serve	Gail Blackburn	Gina Ranieri-Bender	98%	99%	99%	99%	--	100%	98.0%	100%	100%	100%
			N/A	N/A	N/A	93%	--					
		Christy Petti	96%	95%	98%	98%	--	100%	100%	100%	100%	83%
	Dr. Riley		--	--	--	--	--	1	0	3	3	4
			--	--	--	--	--	2	1	1	1	0
			--	--	--	--	--	24	31	26	36	46
	Anne Evans	Rene Mayo										
			2	26	--	--	--	0	1	2	6	1
			986	883	--	--	--	80	102	89	107	81
			--	--	--	--	--	1	1	1	3	1
AIM - Better Care	Cathy Hamel	Jen Avery/ Michelle Teel	0	0	2 or less	2 or less	--	0	0	0	0	0
	Dr. Riley	Bonnie Speicher	92%	90%	95%	98%	--	98.7%	98.6%	97.8%	96.0%	96.8%
	Cathy Hamel	Dionne Savage	5	0	1	1	--	0	0	0	0	0
			18	11	8	8	--	0	1	0	0	2
			501	553	498	1.86	--	42	64	31	46	45
			30	28	25	1.45	--	1	0	0	0	2
			271	284	256	2.40	--	27	36	14	28	24
			200	221	199	1.58	--	14	28	17	18	19
	Cathy Hamel	Trisha Kendall	0.39	0.28	74	0.35	--	3	9	7	10	9
												Falls YTD green or red ca
	Catherine Frome	Jen Avery	4276	2914	5120	3350	--	256	281	238	271	276
			--	--	--	--	--	70	74	74	82	57
			--	--	--	--	--	29	30	31	36	7
			--	--	--	--	--	19	12	16	16	19

AIM - Better Health	'18 Goal was not calculated using rate											
	Leana Hoover/Diane Sancillio	**Tracie Shwoyer-Morgan**	--	6.70%	7.50%	TBD	--	6.40%	6.80%	8.70%	10.40%	10.60%
	Leana Hoover/Diane Sancillio	**Tracie Shwoyer-Morgan**	--	5.31%	6.00%	TBD	--	6.50%	5.70%	5.40%	7.20%	5.80%
	Anne Evans	**Beth Brown**	--	4.53	--	4.58	--	4.53	--	--	--	-
	Dr. Riley	**Shawn Brast**	78%	87.7%	90%	96.5%	--	95.0%	96.0%	97.6%	96.7%	95.9%
AIM - Least Waste	**Wayne Barth**	**Katie Packett**	--	--	--	--	--	$ 16,008.80	$ 22,848.00	$ 16,177.92	$ 14,511.36	$9,792.00
	(Goal updated monthly at 7.3% rate)											
AIM - More Joy	**Michele Sullivan**	**Kerry Avant**	--	--	**58.4%**	**98.0%**	--	--	--	--	**25.0%**	**32.0%**
	Lyn San Juan	**Kristen Collins**	--	--	--	--	--	35.9	87	36.28	--	--
	Dionne Savage	**Maria Lawson**	25	1	22	6	--	0	0	0	0	0
			6	6	4	5	--	0	1	1	1	2
	Cathy Hamel	**Lyn San Juan**	4.15	4.25	4.28	4.31	--	--	--	--	--	--

CMS - Dollars at Risk - Some National Benchmarks Available

Executive Sponsor	Process Owner	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	FY18 YTD	Desired Outcome	Monthly actual needed to make goal
--	--	83.0%	82.1%	81.7%					81.7%	Higher	N/A
--	--	87.9%	86.1%	86.6%					86.6%		
Catherine Frome	Michelle Teel	80.1%	80.0%	80.5%					80.5%		
Jill Campbell	Venus Corpuz	72.6%	72.6%	72.2%					72.2%		
Catherine Frome	Gina Ranieri-Bender	89.4%	89.7%	89.8%					89.8%		
Gail Blackburn	Robin Contino	90.5%	91.4%	91.9%					91.9%		
Gail Blackburn	Bonnie Speicher	73.3%	72.2%	72.3%					72.3%		
Jill Campbell	Gina Norton	71.3%	71.5%	72.0%					72.0%		
Nicole Strauss	Tina Maggio	99.7%	99.9%	TBD					98.7%	Higher	
	Sarah McCampbell	100.0%	*	*					100.0%		
		100.0%	*	*					99.2%		
		100.0%	*	*					99.4%		
		98.1%	*	*					95.1%		
		99.4%	*	*					99.0%		
		98.0%	*	*					99.0%		
		100.0%	*	*					99.8%		
	Wendy Eppers	80.0%	90.0%	100.0%					86.9%	Monitor (Higher)	N/A
		20.0%	30.0%	30.0%					33.1%		N/A

Internal Care & Ability to Serve	Gail Blackburn	Gina Ranieri-Bender	100%	100%	100%					99%	Higher	N/A
		Christy Petti	100%	91%	100%					97%		N/A
	Dr. Riley		4	9	4					28	Monitor (Lower)	N/A
			3	1	1					10		N/A
			27	16	28					234		N/A
	Anne Evans	Rene Mayo	1	5	4					20	Monitor (Higher)	N/A
			97	104	85					745		
			0	1	1					9		
AIM - Better Care	Cathy Hamel	Jen Avery/ Michelle Teel	0	0	0					0	Lower	0
	Dr. Riley	Bonnie Speicher	98.1%	97.7%	97.9%					98%	Higher	N/A
	Cathy Hamel	Dionne Savage	0	0	0					0	Lower	N/A
			1	1	3					8	Lower	N/A
			44	49	47					368	Lower	41.5
			1	5	2					11		2.1
			20	23	28					200		21.3
			23	21	17					157		16.6
	Cathy Hamel	Trisha Kendall	10	16	7					71	Lower	6 or less
	Iculated based on likelihood of achieving adjusted monthly goal for the period March 1 - June 30, 2018											
	Catherine Frome	Jen Avery	249	322	309					2202	Higher	427
			62	67	90					576		--
			36	24	41					234		
			12	24	14					132		

AIM - Better Health	Leana Hoover/Diane Sancillio	Tracie Shwoyer-Morgan	10.20%	8.90%	11.60%							
	Leana Hoover/Diane Sancillio	Tracie Shwoyer-Morgan	5.30%	7.50%	6.00%							
	Anne Evans	Beth Brown	--	--	--					4.53	Higher	--
	Dr. Riley	Shawn Brast	96.0%	97.6%	95.0%					96.2%	Higher	--
AIM - Least Waste	Wayne Barth	Katie Packett	$4,899.84	$6,288.88	$599.04					$ 91,125.84	Lower	--
									FYTD = Current Month			
AIM - More Joy	Michele Sullivan	Kerry Avant	38.0%	46.0%	56.0%					56.0%	Higher	+7.3%
	Lyn San Juan	Kristen Collins	--	--	--					--	Lower	--
	Dionne Savage	Maria Lawson	0 1	0 1	0 0					0 7	Lower	1.8 --
	Cathy Hamel	Lyn San Juan	--	--	--					--	Higher	--