AGENDA

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

Monday, August 1st, 2016, 5:30 p.m.
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, California

Purpose: The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee") is to advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, 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		
1.	**CALL TO ORDER**	David Reeder, Chair Quality Committee		5:30 – 5:31 p.m.
2.	**ROLL CALL**	David Reeder, Chair Quality Committee		5:31 – 5:32
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		5:32 – 5:33
4.	**QUALITY PROGRAM UPDATE – STEMI**	Dr. Chad Rammohan, Special Guest		**Discussion** 5:33 – 5:53
5.	**CONSENT CALENDAR ITEMS:** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee	*public comment*	**Motion Required** 5:53 – 5:58
	Approval: a. Minutes of Quality Committee Meeting - June 1, 2016 **Information:** b. Pacing Plan c. Patient Story d. Research Article **ATTACHMENT 5**			
6.	**REPORT ON BOARD ACTIONS**	David Reeder, Chair Quality Committee		**Discussion** 5:58 – 6:03
7.	**BOARD DISCUSSION – TIME SPENT ON QUALITY**	David Reeder, Chair Quality Committee	*public comment*	**Possible Motion** 6:03 – 6:13
8.	**COMMITTEE RECRUITMENT**	David Reeder, Chair Quality Committee	*public comment*	**Possible Motion** 6:13 – 6:23

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

Agenda: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
August 1, 2016

	AGENDA ITEM	PRESENTED BY		
9.	**FY17 COMMITTEE GOALS** **ATTACHMENT 9**	David Reeder, Chair Quality Committee	*public comment*	**Possible Motion** 6:23 – 6:33
10.	**FY17 EXCEPTION REPORT** **ATTACHMENT 10**	Shreyas Mallur, MD Associate Chief Medical Officer		**Discussion** 6:33 – 6:48
11.	**PUBLIC COMMUNICATION**	David Reeder, Chair Quality Committee		**Information** 6:48 – 6:51
12.	**ADJOURN TO CLOSED SESSION**			6:51 – 6:52
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		6:52 – 6:53
14.	**CONSENT CALENDAR** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee		**Motion Required** 6:53 – 6:56
	Approval: Meeting Minutes of the Closed Session *Gov't Code Section 54957.2.* - June 1, 2016 **Information:** Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* - Meeting Minutes of Quality Council May 4, 2016 -			
15.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Red Alert and Orange Alert Update	Shreyas Mallur, MD Associate Chief Medical Officer		**Discussion** 6:56 – 7:16
16.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Chair Quality Committee		7:16 – 7:19
	To report any required disclosures regarding permissible actions taken during Closed Session.			
17.	**ADJOURNMENT**	David Reeder, Chair Quality Committee		7:20p.m.

Upcoming FY 17 Quality Committee Meetings

- **August 29, 2016**
- **October 3, 2016**
- **November 2, 2016**
- **December 5, 2016**

a. Minutes of Quality Committee Meeting - June 1, 2016

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Wednesday, June 1st, 2016
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder; Jeffrey Davis, MD; Diana Russell, RN; Mikele Bunce, Nancy Carragee, Melora Simon, and Alex Tsao.	Peter Fung, MD; Katie Anderson, Lisa Freeman, and Wendy Ron.	Robert Pinsker, MD

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 1st day of June, 2016 meeting.

Agenda Item	Comments/Discussion	Approvals/Action
1. CALL TO ORDER	The meeting of the Quality, Patient Care, and Patient Experience Committee of El Camino Hospital (the "Committee") was called to order by Committee Chair Dave Reeder at 5:39 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted. **Motion:** To approve the consent calendar (Open Minutes of the May 2, 2016 meeting were approved). **Movant:** Simon **Second:** Davis **Ayes:** Davis, Russell, Bunce, Reeder, Carragee, and Simon. **Noes:** None **Abstentions:** None **Absent:** Fung, Anderson, Freeman, and Ron. **Excused:** Pinsker **Recused:** None	***The Open Minutes of the May 2nd, 2016 were approved.***
5. REPORT ON BOARD ACTIONS	Chair Reeder reported that the Board is currently focused on the Fiscal Year End Budget. He reported that while finances and investment returns are	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	improving, we are still experiencing low volumes in Maternal Health. Other areas of focus are the New Construction Projects which include the Parking Structure, BHS, iMob, and Women's Hospital. He also announced that as of July 1, 2016, Dr. Rebecca Fazilat will become the Mountain View Chief of Staff and Dr. Augusto Bastidas will become the Mountain View Vice-Chief of Staff. He further reported that Lisa Freeman has accepted a new job and will no longer serve on the Quality Committee. Chair Reeder thanked her for her time and expertise while serving on the Committee.	
6. BOARD DISCUSSION OF QUALITY ITEMS	Chair Reeder reported that the Board had asked the Quality Committee to consider and recommend how much time the Board should spend on quality topics and what specific quality related topics the Board should focus on. Chair Reeder asked for feedback and discussion ensued. The committee discussed increasing the percentage of time that the Board spends on quality-related topics to 10%. A suggestion was made that a monthly guest be invited to the Board Meeting for 20 minutes (starting in August) to highlight achievements and gaps in care. The suggestions included service line leaders and committee champions in sepsis and transitions of care. *Further dialog requested at the August 1st, 2016 Meeting.	***None***
7. FY16 EXCEPTION REPORT	Dr. Shin presented the FY16 Exception Report to the Committee. He reported that seven metrics are stable, but highlighted that responsiveness of hospital staff remains below average. He noted that specimen labeling errors problem has been resolved and proposed replacing this metric with a new sepsis metric for the FY17 Exception Report. The Committee generally agreed with this recommendation.	***None***
8. DRAFT FY17 EXCEPTION REPORT	Joy Pao, MD, Senior Director of Clinical Quality and Patient Safety, presented a sample of major quality, safety, and risk measures across the hospital to the Committee for consideration for the FY17 Exception Report and asked for questions and feedback. The Committee briefly discussed ideas for metrics for the Exception Report.	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	*The Committee requested that a Draft FY17 Exception Report, prepared by Dr. Pao, and more detailed discussion be agendized for August 1st, 2016 meeting.	
9. FY17 ORGANIZATIONAL GOALS	Mick Zdeblick, Chief Operating Officer presented the FY17 Organizational Goals to the Committee further detailed in the packet. He reiterated the Committee's agreement from the May 13th meeting with the recommendation to the Board Option #2 - Pain Management Indicator as a Quality Component to the FY17 Organizational Goals. This would be in conjunction with maintaining current readmission rates and achieving length of stay reductions in Medicare patients. Chair Reeder asked the Committee for feedback and discussion ensued. The Committee discussed pain reassessment as a process measure and patient satisfaction scores of pain management as an outcome measure for a quality component of Patient Safety and iCare FY 17 Organizational Goals. They also proposed a countermeasure for pain to assure narcotic safety.	***None***
10. PATIENT AND FAMILY ADVISORY COUNCIL UPDATE	Cheryl Reinking, Chief Nursing Officer, introduced RJ Salas, Director of Patient Experience, to the Committee and asked that he further detail the update on the Patient and Family Advisory Council as submitted in the packet. Mr. Salas presented an update regarding the Patient and Family Advisory Council's (PFAC): • Current Timeline • Efforts in Recruitment • Vision and Charter • Current PFAC Snapshot • Efforts in Increasing Patient and Family Involvement • and Increasing the Patient Voice Mr. Salus asked the Committee for questions or feedback and discussion ensued.	***None***
11. PUBLIC COMMUNICATION	None	***None***
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:19 p.m. **Movant:** Carragee **Second:** Russell **Ayes:** Davis, Russell, Bunce, Reeder, Carragee, and	***A motion to adjourn to closed session at 7:19 p.m. was approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Simon. **Noes:** None **Abstentions:** None **Absent:** Fung, Anderson, Freeman, and Ron. **Excused:** Pinsker **Recused:** None	
13. AGENDA ITEM 16 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 13– 15 were reported in closed session.* Chair Reeder reported that Closed minutes of the May 2, 2016 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.	***None***
14. AGENDA ITEM 17 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:21p.m.	***None***

Attest as to the approval of the Foregoing minutes by the Quality Committee and by the Board of Directors of El Camino Hospital:

_____

Dave Reeder
Chair, ECH Quality, Patient Care and
Patient Experience Committee

Pacing Plan

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE
PROPOSED FY2017 PACING PLAN

FY2017: Q1		
JULY - No Meeting	**AUGUST 1, 2016**	**AUGUST 29, 2016 (*In place of Sept Meeting*)**
Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2017 Committee Goal Completion Status ▪ Pacing Plan ▪ Quality Council Minutes ▪ Patient Story ▪ Research Article	▪ Review and discuss quality summary with attention to risks and overall performance ▪ Committee Recruitment ▪ Review FY17 Committee Goals **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ APPROVE FY 2017 Organizational Goals (Metrics) ▪ Approve FY 16 Organizational Goal Achievements ▪ Update on PaCT Plan ▪ Year-end review of RCA **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**
FY2017: Q2		
OCTOBER 3, 2016	**NOVEMBER 2, 2016**	**DECEMBER 5, 2016**
▪ Safety Report for the Environment of Care (consent calendar) **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Committee Goals for FY17 Update ▪ ICare Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ iCare Update **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

PROPOSED FY2017 PACING PLAN

FY2017: Q3		
JANUARY 30, 2017	**FEBRUARY 27, 2017**	**MARCH – No Meeting**
▪ Patient and Family Centered Care ▪ Service Line Update ▪ Top Risk Case Review **Committee Members to complete on-line self-assessment tool.* **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Begin Development of FY 2018 Committee Goals (3-4 goals) ▪ Peer Review/Care Review Process ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	
FY2017: Q4		
APRIL 3, 2017	**MAY 1, 2017**	**JUNE 5, 2017**
▪ Finalize FY 2018 Committee Goals ▪ Proposed Committee meeting dates for FY2017 ▪ Review DRAFT FY2018 Organizational Goals ▪ Annual Review of Committee Charter ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ Review DRAFT FY18 Organizational Goals (as needed) ▪ Set proposed committee meeting calendar for FY 2018 ▪ Review Committee Assessment Results ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**	▪ PFAC Update (6 months since Jan) ▪ Review and Discuss Self-Assessment Results ▪ Develop Pacing Calendar for FY18 ▪ Top Risk Case Review **Standing Agenda Items:** ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed **Info: Research Article & Patient Story**

Patient Story

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

2500 Grant Road
Mountain View, CA 94040-4378
Phone: 650-940-7000
www.elcaminohospital.org

Patient Story

A nurse from our Cardiopulmonary Wellness Center (CPWC) was working with a 17 year old patient being treated for POTS Syndrome (postural orthostatic tachy syndrome). POTS is a form of dysautonomia that affects the body's ability to regular blood pressure and heart rate and disrupts a person's lifestyle. The patient developed the disorder following a blow to the head with a hockey puck at a San Jose Sharks game in 2013. The first manifestation of the syndrome was problematic headaches and later he developed anxiety and depression episodes. Following the accident, the patient was no longer the normal carefree high school teen marching in the band and hanging out with friends.

It was thought that the patient would outgrow the headaches since many teens experience hormonal changes and tend to outgrow them, but this didn't happen for him. His doctor recommended exercise as a way to improve the orthostatic symptoms and his parents agreed. He (patient) started working out at El Camino's CPWC in October of 2015 with bicycling and other monitored exercise. As part of patient intake at the start of the program, as is with all CPWC patients, an initial depression screen – PHQ9 – was completed. The care team was aware that the patient had a history of depression, was on medications and saw a therapist. After 6 months, the patient was ready to "graduate" from the exercise program. Following ECH process, a PHQ9 screening was conducted again prior to discharge from the program, and this time, the scoring demonstrated a significant depression.

With this result, the nurse alerted her manager and discussed the case. Together, they talked to the patient and discussed the issue of depression with the patient. As a result, the patient was found to be at risk for self-harm. Another nurse in the department was also called in to help discuss this patient's stress and risk reduction. Different team members interviewed the patient, and confirmed that the patient could not deny that felt suicidal. The team notified his doctor and parent and escorted him to the Emergency Department to be seen by the ED physician for further treatment plans. In the end, the patient was released to the care of his parents and his current mental health provider. This case demonstrated a focused team effort that addressed a real risk in this patient that could have resulted in serious untoward events.

A Good Catch was awarded to the nursing staff for taking the time to assess and reassess this patient's risk for depression and suicide using an evidence-based tool and for diligently implementing further medical-psychiatric evaluation before discharging the patient to home.

This commitment to the ongoing care of our patients (beyond discharge) is noteworthy and truly demonstrates the excellence of El Camino!

Research Article

CMS Proposes Hospital Outpatient Prospective Payment Changes for 2017

Date	2016-07-06
Title	CMS Proposes Hospital Outpatient Prospective Payment Changes for 2017

QUALITY AND PERFORMANCE PROGRAM CHANGES

Hospital Value-Based Purchasing (VBP) Program[1]

The Hospital VBP Program, funded by a 2 percent reduction from participating hospitals' base operating diagnosis-related group (DRG) payments each year, requires CMS to redistribute a portion of the Medicare payments to hospitals for inpatient services based on performance. In this CY 2017 OPPS/ASC proposed rule[2], CMS is proposing to remove the Pain Management dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey for purposes of the Hospital VBP Program, beginning with the FY 2018 program (payment) year, [based on patient discharges from calendar year 2016]. Other Hospital VBP Program requirements will be set forth in an upcoming FY 2017 IPPS/LTCH PPS final rule to be issued on or around August 1, 2016.

CMS has received feedback that some stakeholders are concerned about the pain management dimension questions being used in the Hospital VBP Program, believing that the linkage of these particular questions to the Hospital VBP Program payment incentives creates pressure on hospital staff to prescribe more opioids in order to achieve higher scores on this dimension. The pain management dimension questions do not specify any particular type of pain control method. In addition, appropriate pain management includes communication with patients about pain-related issues, setting expectations about pain, shared decision-making, and proper prescription practices. Although CMS is not aware of any scientific studies that support an association between scores on the pain management dimension questions and opioid prescribing practices, we are proposing to remove the pain management dimension of the HCAHPS survey for purposes of the Hospital VBP Program in an abundance of caution. We are also developing and field testing alternative questions related to provider communications and pain in order to remove any potential ambiguity in the HCAHPS survey.

Background: *[excerpt from CMS published Federal Register July 8th, 2016]*

"Although we [CMS] are not aware of any scientific studies that support an association between scores on the Pain Management dimension questions and opioid prescribing practices, we are developing alternative questions for the Pain Management dimension in order to remove any potential ambiguity in the HCAHPS Survey…… HHS is also conducting further research to help better understand these stakeholder concerns and determine if there are any unintended consequences that link the Pain Management dimension questions to opioid prescribing practices. In addition, we are in the early stages of developing an electronically specified process measure for the inpatient and outpatient hospital settings that would measure concurrent prescribing of an opioid and benzodiazepine. We also are in the early stages of developing a process measure that would assess whether inpatient psychiatric facilities are regularly monitoring for adverse drug events of opioid and psychotropic drugs. The measure specifications will be posted on the CMS Web page and the public will have an opportunity to provide feedback before we make any proposal to adopt it for quality reporting purposes.

Due to some potential confusion about the appropriate use of the Pain Management dimension questions in the Hospital VBP Program and the public health concern about the ongoing prescription opioid overdose epidemic, while we await the results of our ongoing research and the above-mentioned modifications to the Pain Management dimension questions, we are proposing to remove the Pain Management dimension of the HCAHPS Survey in the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain beginning with the

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html

[2] https://www.federalregister.gov/articles/2016/07/14/2016-16098/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment; or https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-16098.pdf

FY 2018 program year. The FY 2018 program year uses HCAHPS performance period data from January 1st, 2016 to December 31st, 2016 to calculate each hospital's TPS, which affects FY 2018 payments.

….. For the FY 2019 program year, we [CMS] proposed performance standards in the FY 2017 IPPS/LTCH PPS proposed rule (81 FR 25114). We are proposing to remove the Pain Management dimension of the HCAHPS Survey in the calculation of the Patient- and Caregiver-Centered Experience of Care/Care Coordination domain score beginning with the FY 2018 program year.

CMS proposes eliminating pain management from HCAHPS payment score

Written by Heather Punke | July 07, 2016

In an effort to combat the opioid addiction raging in the U.S., CMS has proposed removing pain management-related questions on the HCAHPS survey from the hospital payment scoring calculation.

HHS announced CMS's proposal on Wednesday along with other actions to combat the opioid addiction epidemic. "Many clinicians report feeling pressure to overprescribe opioids because scores on the HCAHPS survey pain management questions are tied to Medicare payments to hospitals[3]," an HHS statement reads, even though the questions and Medicare payment "have a very limited connection."
Under the proposal, the three pain management questions on the HCAHPS survey would no longer factor into the Hospital Value-Based Purchasing Program payments from Medicare, staring in fiscal year 2018. The questions would remain on the survey, however.

Every day in the U.S., more than 650,000 opioid prescriptions are dispensed, and 3,900 people start using prescription opioid for a nonmedical purpose. Seventy-eight people die from an opioid-related overdose daily.
With this and other new actions, HHS and CMS hope to stem those prescriptions and overdose deaths.

CMS proposes removal of HCAHPS pain management questions: 4 takeaways

Written by Mary Rechtoris | Monday, 11 July 2016

Social sharing
CMS released its 2017 Medicare Outpatient Prospective Payment System proposed rule, which aims to enhance Medicare patients' quality of care. In the rule, CMS is proposing to remove the Hospital Consumer Assessment of Healthcare Providers and Systems' Pain Management dimension, which often determines providers' reimbursement rates.

Here are four takeaways:

1. CMS' proposal is in response to many healthcare leaders concerns over the pain management assessment's correlation to opioid prescribing patterns. Often, providers are motivated to prescribe opioids to alleviate patients' pain, thereby increasing satisfaction scores.
2. The current pain management questions do not ask specially about a type of pain-control method.
3. While CMS does not cite any proven studies that pain management dimension questions are linked to opioid prescribing patterns, the agency is proposing the emission to be cautious about the potential link.
4. Hospitals will continue to publicly report pain management data under the Hospital Inpatient Quality Reporting Program while CMS devises alternative pain management questions.

[3] *http://www.hhnmag.com/articles/7164-doctors-urge-cms-joint-commission-to-rethink-pain-treatment-to-help-stem-opioid-epidemic*

The HCAHPS Survey, Pain Management, and Opioid Misuse.
The CMS Perspective:
Clarifying Facts, Myths, and Approaches

A. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Timeline

- HCAHPS Survey was launched in 2006
- IPPS hospitals required to participate in 2007
- Public reporting of HCAHPS scores began in 2008 on the Hospital Compare Web site
- HCAHPS has been included in Hospital Value-Based Purchasing since 2012
- HCAHPS Pain Management Questions:

12. During this hospital stay, did you need medicine for pain?

- ☐ Yes
- ☐ No (If No, Go to Question 15)

13. During this hospital stay, how often was your pain well controlled?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

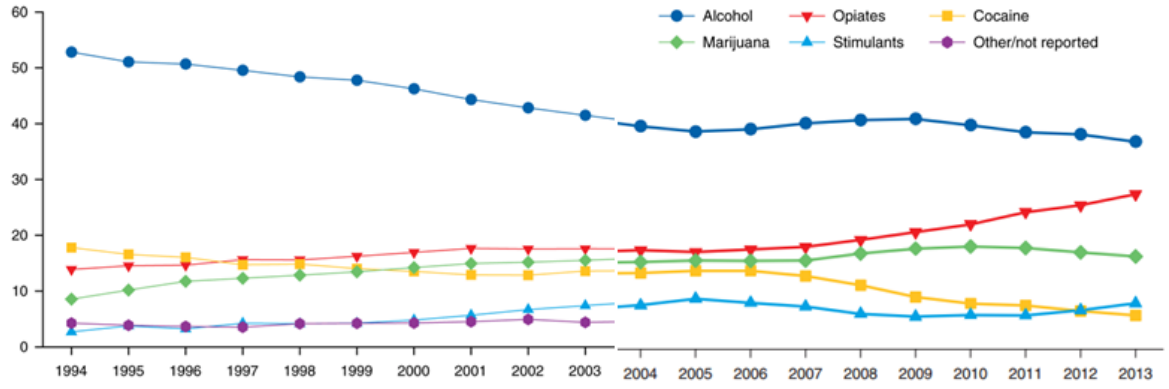
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

- Pain management is ⅛ th of the HCAHPS Domain in Hospital VBP; Hospital VBP affects 1.75% of hospital Base Operating DRG payment in FY 2016[4].

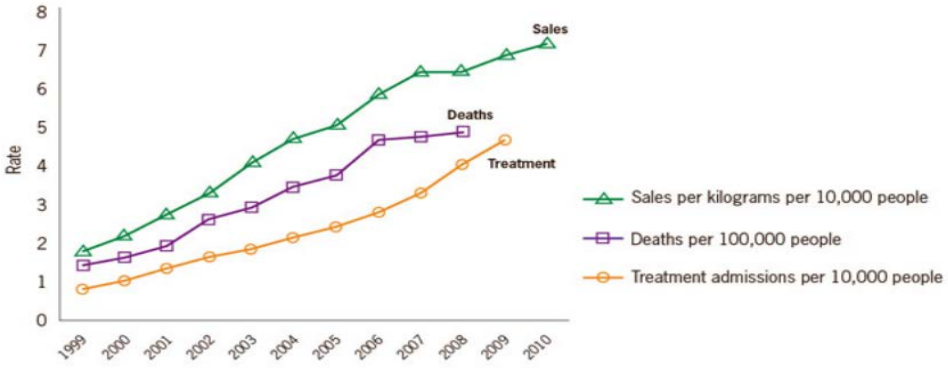
B. Primary Substance of Abuse at Admissions, 1994-2013[5]

TEDS treatment admissions were dominated by five substances: alcohol, opiates (primarily heroin), cocaine, marijuana, and stimulants (primarily methamphetamine). These substances together consistently accounted for between 95 and 96 percent of all TEDS admissions.

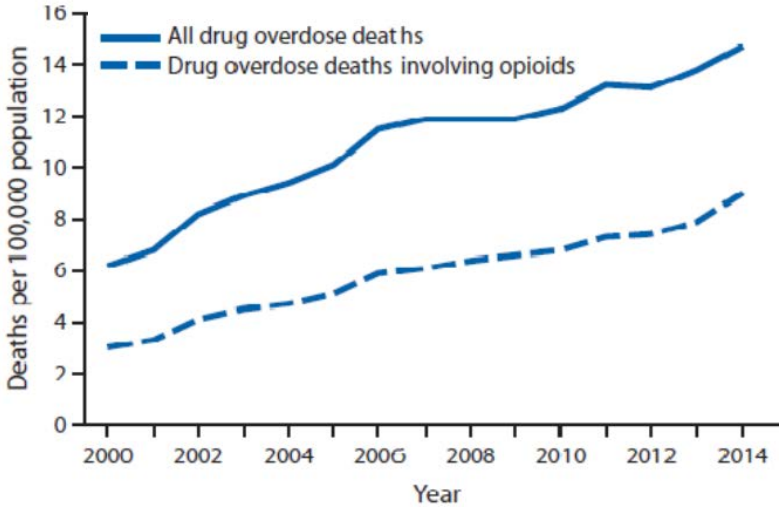


[4] *http://www.qualityreportingcenter.com/event/iqr-the-hcahps-survey-pain-management-and-opioid-misuse-the-cms-perspective/*
[5] *http://www.samhsa.gov/data/sites/default/files/2003_2013_TEDS_National/2003_2013_Treatment_Episode_Data_Set_National.pdf*

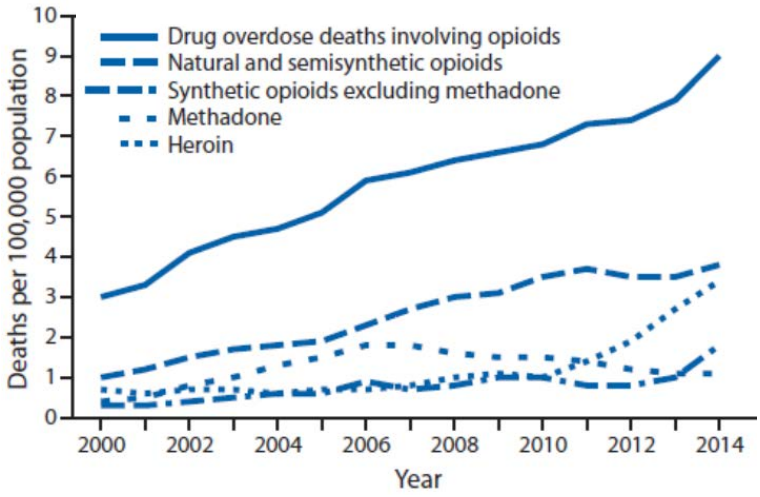
C. Rates of Prescription Opioid Sales, Death and Substance Abuse Treatment Admissions, 1999-2010[6]



D. Age-adjusted rate of drug overdose deaths and drug overdose deaths involving opioids: United States, 2000–2014[7]



E. Drug overdose deaths involving opioids by type of opioid: United States, 2000–2014



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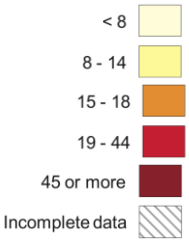
[6] *Lemeneh Tefera MD MSc Medical Officer William G. Lehrman, PhD Social Science Research Analyst January 26th, 2016; http://www.qualityreportingcenter.com/wp-content/uploads/2016/01/IQR-VBP_HCAHPS-and-Pain-Management_20160128_vFINAL508.pdf*
Sources: National Vital Statistics System, 1999-2008; Automatation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2999-2010; Treatment Episode Data Set, 1999-2009

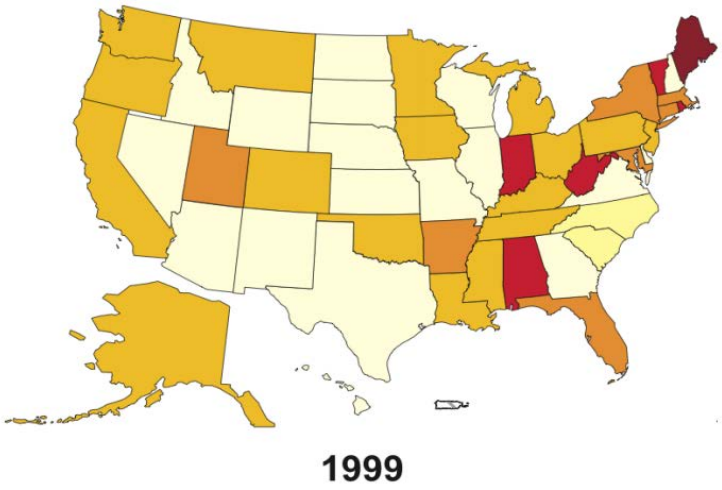
[7] *Source: National Vital Statistics System, Mortality File. CDC (2016). Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. Morbidity and Mortality Weekly Report (MMWR), Center for Disease Control and Prevention. 64:1378-1382*

F. Primary non-heroin opiates/synthetics admission rates, by state (per 100,000 population aged 12 and over)[8]



The proportion of *Treatment Episode Data Set* (TEDS) admissions for abuse of *opiates other than heroin increased from 1% in 1994 to 3% in 2004, and 5.9% in 2008*[9].

These drugs include methadone, codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects.



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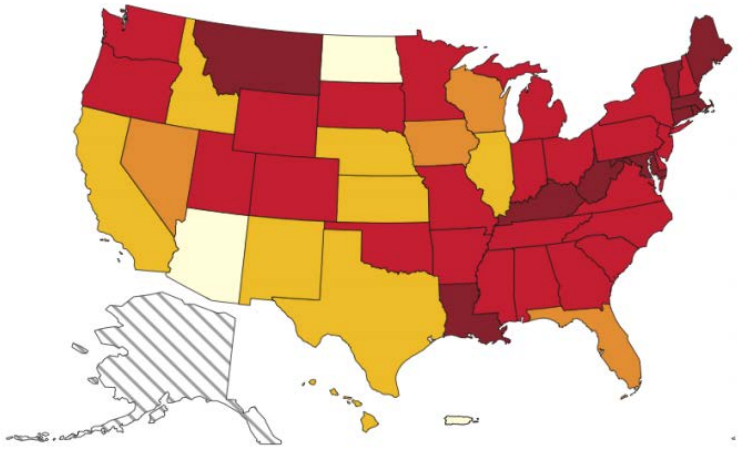

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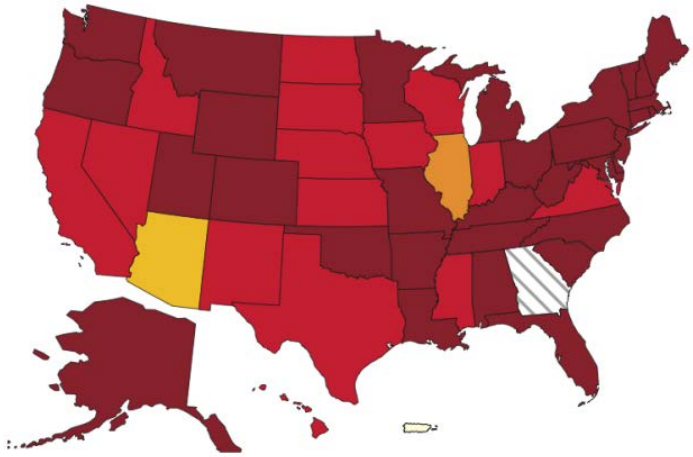


2009

[8] *Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through 11.03.10; and http://wwwdasis.samhsa.gov/teds04/TEDSAd2k4Chp2.htm*

[9] https://www.drugabuse.gov/publications/drugfacts/treatment-statistics; http://wwwdasis.samhsa.gov/teds07/TEDS2k7A508Web.pdf

ATTACHMENT 9

Quality, Patient Care and Patient Experience Committee Goals for FY 2017

Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee ("Quality 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 Quality Committee helps to assure that exceptional patient care and 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.

Staff: Chief Medical Officer

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff, VP of Patient Care Services, physicians, nurses, and members from the Community Advisory Councils or the community-at-large. The CEO is an ex-officio of this Committee.

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care, and Patient Experience Committee.	▪ Q1 – Goals ▪ Q3 - Metrics	▪ Review, complete, and provide feedback given to management, the governance committee, and the board.
2. Review peer review process and medical staff credentialing process. This should include the submission of a report demonstrating the implementation of changes to the Medical Staff peer review process.	▪ x times a year	Review the report and approve.

3. Develop a plan to review exceptions for goals that are being monitored by the management team and report those exceptions to the El Camino board of directors.	▪ Q3	
4. Review and oversee a plan to ensure the safety of the medication delivery process. The plan should include a global assessment of adverse events and it should include optimizations to the medication safety process using the new iCare tool.	▪ Q2	Review the plan and approve.
5. Further investigate Patient and Family Centered Care and develop an implementation plan.	▪ Q2	Review the plan and approve.

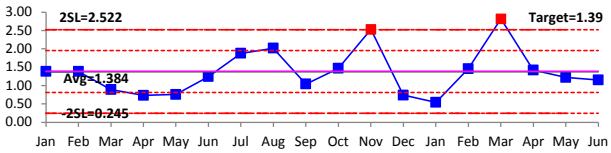
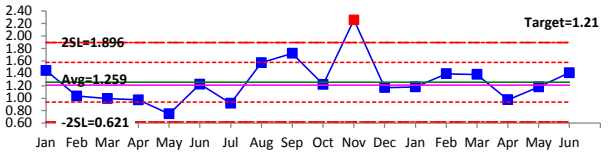
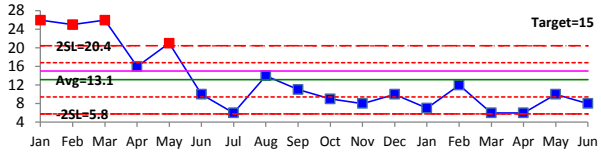
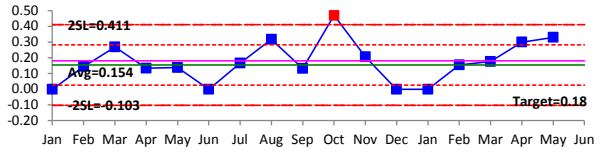
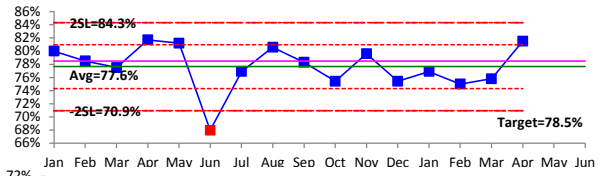
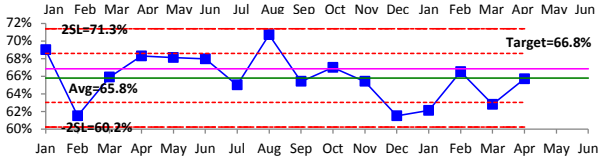
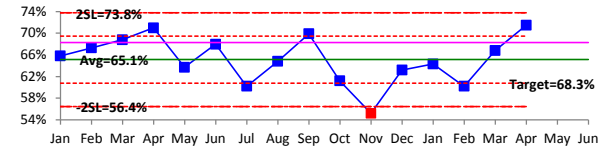
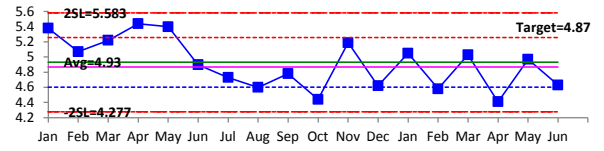
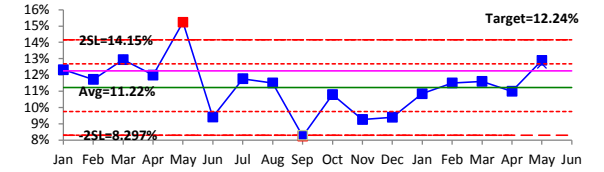
Submitted by:
Dave Reeder, Chair, Quality Committee
Daniel Shin, MD, Executive Sponsor, Quality Committee

ATTACHMENT 10

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

Date Reports Run: 4/18/2016

		Performance		Baseline	FY16 Goal	Trend
SAFETY EVENTS				FY2015	FY2016	
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: May 2016*	7/5726	1.15	1.39	1.39	
2	**Medication Errors** *Errors / 1000 Adj Total Patient Days* *Date Period: June 2016*	20/14149	1.41	1.21	1.21	
3	**Specimen Labeling Errors** *# Specimen Labeling Errors / Month* *Date Period: June 2016*	8	0	23	15	
COMPLICATIONS				FY2015	FY2016	
4	**Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: May 2016*	1	0.18	0.19	0.18	
SERVICE				FY2015	FY2016	
5	**Communication with Nurses** *(HCAHPS Score)* *Date Period: April 2016*	255/309	81.5%	78.5%	78.5%	
6	**Responsiveness of Hospital Staff** *(HCAHPS Score)* *Date Period: April 2016*	183/279	65.7%	66.8%	66.8%	
7	**Communication About Medicines** *(HCAHPS Score)* *Date Period: April 2016*	136/190	71.5%	68.3%	68.3%	
EFFICIENCY		Performance		Jan-Jun 2015 (6-month ave)	Jan-Jun 2016	
8	★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Report Run Date: July 24th, 2016*	FYTD 4829 01-06/16 2509	FYTD 4.76 01-06/16 4.78	4.63	5.07 (Min) 4.97 (Target) 4.87 (Max)	
9	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: July 25th, 2016*	FYTD 481/4408 01-06/16 247/2118	FYTD 10.91 01-06/16 11.66	11.48%	At or below 12.24	

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2015 Definition	FY 2016 Definition	Source
Patient Falls	Jane Truscott/Mae Dizon Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when staff attempts to minimize the impact of the fall, it is still a fall). *Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.*		**QRR Reporting and Staff Validation**
Medication Errors	Chris Tarver; Poopak Barirani; Joy Pao; Cheryl Reinking	Medication Safety Committee; P&T Committee	5 Rights MEdication Errors: [# of Med Errors (includes: Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Route.) divided by Adjusted Total Patient Days (includes L&D & Nursery)]* 1,000 *Excludes: Wrong Time, ADR, Contrast Reaction, Incorrect Dose, "Not Yet Rated" Med errors, No risk identified and near miss*		**QRR Reporting and Staff Validation**
Mislabeled Specimens	Edwina Sequeira; Cheryl Reinking	QIPSC	Number of blood and nonblood Laboratory specimens collected by non-Lab staff that are unlabeled or contain incomplete or incorrect information for patient ID, specimen source/site, date/time, collector initials. Soft ID GoLive in May 2015 for select units, MCH full GoLive date after iCare implementation in Nov 2015.		**Staff Manual Tracking (Thara Trieu, Laboratory)**
Surgical Site Infection	Catherine Nalesnik; Joy Pao; Carol Kemper, MD	Infection Control Committee	(Number of Deep Organ Space infections divided by the # of all sugery cases)*100 counted by the month procedure under which infection was attributed to and not by the month it was discovered. All Surgery Cases in the 29 Surgical Procedural Categories required by the California Department of Public Health.		**IC Surveillance and NHSN Data Reporting**
Communication with Nurses	RJ Salus; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	Percent of inpatients responding "Always" to the following 3 questions [% Top Box]: 1. *During hospital stay, how often did the nurses treat you with courtesy and respect?* 2. *During hospital stay, how often did nurses listen carefully to you?* 3. *During hospital stay, how often did nurses explain things in a way you can understand?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Responsiveness of Hospital Staff	RJ Salus; Eric Pifer	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 1. *During hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?* 2. *How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted (for patients who needed a bedpan)?* CMS Qualified values are pulled from the Avatar website.Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Communication About Medicines	RJ Salus; Cheryl Reinking; Bob Blair	Patient Experience Committee	Percent of inpatients (who received meds) responding "Always" to the following 2 questions [% Top Box]: 1. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? 2. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? CMS Qualified values are pulled from the Avatar website. Note: A complete month's data is available on the first Monday following 45 days after the end of the month.		**Press Ganey Tool**
Average Length of Stay	Eric Pifer, MD; Mick Zdeblick; Joy Pao; Petrina Griesbach	LOS Steering Committee	Average LOS of Medicare FFS, Paitents discharged from an Acute Care or Intensive Care unit. Excludes expired patients. Includes final coded patients aged 65 an older at the time of the encounter. The baseline period is from Jan-June 2015 and the performance period is from Jan-June 2016.		**EDW Data Pull, Department of Clinical Effectiveness**
30-Day Readmission (LOS-Focused)	Eric Pifer, MD; Margaret Wilmer; Joy Pao; Petrina Griesbach	Readmission Committee	Percent of Medicare inpatient discharges return for an unplanned IP stay for any reason within 30 days, aged ≥65. Excludes patients who die, leave AMA or are transferred to another acute care facility; excludes admits to ECH Rehab and Psych admissions and for medical treatment of cancer.		**EDW Data Pull, Department of Clinical Effectiveness**