

AGENDA

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

Monday, December 5th, 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. CONSENT CALENDAR ITEMS: Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee	<i>public comment</i>	Motion Required 5:33 – 5:36
<u>Approval:</u> a. Minutes of Quality Committee Meeting - November 2, 2016 <u>Information:</u> b. Pacing Plan c. Patient Story d. Research Article			
5. REPORT ON BOARD ACTIONS ATTACHMENT 5	David Reeder, Chair Quality Committee		Discussion 5:36 – 5:39
6. QUALITY PROGRAM UPDATE: EMERGENCY DEPARTMENT ATTACHMENT 6	Laura Cook, MD Medical Director of Emergency Medicine- MV		Discussion 5:39 – 5:59
7. ICARE UPDATE ATTACHMENT 7	Deb Muro, Interim Chief Information Officer		Discussion 5:59 – 6:14
8. FY17 QUALITY DASHBOARD ATTACHMENT 8	Dan Shin, MD, Medical Director of Quality and Patient Safety		Discussion 6:14 – 6:24

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
December 5, 2016

AGENDA ITEM	PRESENTED BY		
9. PAIN GOALS DISCUSSION	William Faber, MD Chief Medical Officer		Discussion 6:24 – 6:34
10. PATIENT AND FAMILY CENTERED CARE	Mick Zdeblick, Chief Operating Officer		Discussion 6:34 – 6:39
11. PUBLIC COMMUNICATION	David Reeder, Chair Quality Committee		Information 6:39– 6:42
12. ADJOURN TO CLOSED SESSION			6:42– 6:43
13. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	David Reeder, Chair Quality Committee		6:43 – 6:44
14. CONSENT CALENDAR Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee		Motion Required 6:44 – 6:47
Approval: Meeting Minutes of the Closed Session <i>Gov't Code Section 54957.2.</i> - November 2, 2016 Information: Report related to the Medical Staff quality assurance matters, <i>Health and Safety Code Section 32155.</i> Meeting Minutes of Quality Council - October 5, 2016			
15. Report related to the Medical Staff quality assurance matters, <i>Health and Safety Code Section 32155.</i> CMO Report	William Faber, MD Chief Medical Officer		Discussion 6:47 – 6:57
16. Report related to the Medical Staff quality assurance matters, <i>Health and Safety Code Section 32155.</i> Red and Orange Alert	Shreyas Mallur, MD Associate Chief Medical Officer		Discussion 6:57 – 7:17
17. RECONVENE OPEN SESSION/REPORT OUT To report any required disclosures regarding permissible actions taken during Closed Session.	David Reeder, Chair Quality Committee		7:17 – 7:20
18. ADJOURNMENT	David Reeder, Chair Quality Committee		7:20 p.m.

Upcoming FY 17 Quality Committee Meetings

- **December 5, 2016**
- **January 30, 2017**
- **February 27, 2017**
- **April 3, 2017**

a. Minutes of Quality Committee Meeting - November 2, 2016

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Wednesday, November 2nd, 2016
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present

Dave Reeder; Robert Pinsker, MD;
 Diana Russell, RN; Mikele Bunce,
 Melora Simon, Alex Tsao,
 and Wendy Ron.

Members Absent

Peter Fung, MD;
 Nancy Carragee,
 and Katie Anderson.

Members Excused

None

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 2nd day of November, 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 5:40p.m.	<i>None</i>
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	<i>None</i>
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.	<i>None</i>
4. CONSENT CALENDAR ITEMS	<p>Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted.</p> <p><u>Motion:</u> To approve the consent calendar (Open Minutes of the October 3, 2016 meeting were approved).</p> <p><u>Movant:</u> Russell</p> <p><u>Second:</u> Tsao</p> <p><u>Ayes:</u> Reeder, Pinsker, Russell, Bunce, Ron, Simon, and Tsao.</p> <p><u>Noes:</u> None</p> <p><u>Abstentions:</u> None</p> <p><u>Absent:</u> Fung, Anderson, and Carragee.</p> <p><u>Excused:</u> None</p> <p><u>Recused:</u> None</p>	<i>The Open Minutes of the October 3, 2016 meeting were approved.</i>
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and introduced the new interim CEO, Mr. Don Sibery. Mr. Sibery briefly introduced himself, reviewed his prior	<i>None</i>

Agenda Item	Comments/Discussion	Approvals/Action
	background, and regarded Ms. Ryba in her very detailed and thorough handoff.	
6. QUALITY PROGRAM UPDATE: CANCER CENTER	<p>Dr. Shyamali Singhal, MD from the Cancer Center reviewed the Cancer Center Program with the Committee. Dr. Singhal reviewed the growth of the program over the past 9 years, demonstrated our program's favorable comparison to other community hospital cancer centers in terms of five-year survival for the most frequent cancers, and highlighted some of our state-of-the-art treatment modalities and unique cancer navigation, early detection and prevention offerings.</p> <p>Dr. Singhal asked for feedback and questions from the Committee and a brief discussion ensued.</p>	<i>None</i>
7. FY17 EXCEPTION REPORT	<p>Dr. Dan Shin, MD, Medical Director of Patient Safety and Quality Assurance presented the FY17 Exception Report to the Committee. He reported that seven metrics remain stable; the only exception being an upward trend in patient falls. Though our overall performance in falls exceeds national benchmarks, nursing administration is currently exploring additional modalities to mitigate this trend, including visual monitoring. Dr. Shin noted that there has been an improvement in Communications with Nurses.</p> <p>Dr. Shin asked for feedback from the Committee and discussion ensued.</p>	<i>None</i>
8. PATIENT AND FAMILY CENTERED CARE	Cheryl Reinking, Chief Nursing Officer introduced RJ Salas, Director of Patient Experience and announced that Mr. Salas would be leaving the Organization to pursue another opportunity. Mr. Salas reported that the Patient and Family Centered Care project is on track and will be maintained despite his departure, and that we are following up on the PlaneTree recommendations by conducting site visits to several health systems with outstanding patient experience. Mr. Salas detailed the handoff of responsibilities and roles to others going forward, and future Organizational needs.	
9. PUBLIC COMMUNICATION	None	<i>None</i>

Agenda Item	Comments/Discussion	Approvals/Action
10. ADJOURN TO CLOSED SESSION	<p><u>Motion:</u> To adjourn to closed session at 6:55 p.m. <u>Movant:</u> Russell <u>Second:</u> Simon <u>Ayes:</u> Reeder, Pinsker, Russell, Bunce, Ron, Simon, and Tsao. <u>Noes:</u> None <u>Abstentions:</u> None <u>Absent:</u> Fung, Anderson, and Carragee. <u>Excused:</u> None <u>Recused:</u> None</p>	<i>A motion to adjourn to closed session at 6:55 p.m. was approved.</i>
11. AGENDA ITEM 15 RECONVENE OPEN SESSION/ REPORT OUT	<p><i>Agenda Items 11 – 14 were reported in closed session.</i> Chair Reeder reported that Closed minutes of the October 3, 2016 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.</p>	<i>None</i>
12. AGENDA ITEM 26 ADJOURNMENT	<p>There being no further business to come before the Committee, the meeting was adjourned at 7:30p.m.</p>	<i>None</i>

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: <ul style="list-style-type: none"> Approval of Minutes FY 2017 Committee Goal Completion Status Pacing Plan Quality Council Minutes Patient Story Research Article 	<ul style="list-style-type: none"> Review and discuss quality summary with attention to risks and overall performance Committee Recruitment Review FY17 Committee Goals Standing Agenda Items: <ul style="list-style-type: none"> Consent Calendar Exception Report Patient Centered Care Plan Drilldown on Quality Program Red and Orange Alert as Needed Info: Research Article & Patient Story	<ul style="list-style-type: none"> APPROVE FY 2017 Organizational Goals (Metrics) Update on PFCC Standing Agenda Items: <ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Approve FY 16 Organizational Goal Achievements Year-end review of RCA Standing Agenda Items: <ul style="list-style-type: none"> Consent Calendar Exception Report Patient Centered Care Plan Drilldown on Quality Program Red and Orange Alert as Needed Info: Research Article & Patient Story	<ul style="list-style-type: none"> iCare Update Safety Report for the Environment of Care (consent calendar) Standing Agenda Items: <ul style="list-style-type: none"> Consent Calendar Exception Report Patient Centered Care Plan Drilldown on Quality Program Red and Orange Alert as Needed Info: Research Article & Patient Story	<ul style="list-style-type: none"> iCare Update Committee Goals for FY17 Update Standing Agenda Items: <ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> ▪ Patient and Family Centered Care ▪ Service Line Update ▪ Top Risk Case Review <p><i>*Committee Members to complete on-line self-assessment tool.</i></p> <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed <p>Info: Research Article & Patient Story</p>	<ul style="list-style-type: none"> ▪ Begin Development of FY 2018 Committee Goals (3-4 goals) ▪ Peer Review/Care Review Process ▪ Top Risk Case Review <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed <p>Info: Research Article & Patient Story</p>	
FY2017: Q4		
APRIL 3, 2017	MAY 1, 2017	JUNE 5, 2017
<ul style="list-style-type: none"> ▪ 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 <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed <p>Info: Research Article & Patient Story</p>	<ul style="list-style-type: none"> ▪ Review DRAFT FY18 Organizational Goals (as needed) ▪ Set proposed committee meeting calendar for FY 2018 ▪ Top Risk Case Review <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed <p>Info: Research Article & Patient Story</p>	<ul style="list-style-type: none"> ▪ PFAC Update (6 months since Jan) ▪ Review and Discuss Self-Assessment Results ▪ Develop Pacing Calendar for FY18 ▪ Top Risk Case Review <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Exception Report ▪ Patient Centered Care Plan ▪ Drilldown on Quality Program ▪ Red and Orange Alert as Needed <p>Info: Research Article & Patient Story</p>

Patient Story

Patient/Staff Story

Ivy Whitford, RN began working at ECH in the ED just under 6 months ago. She is an experienced emergency nurse from Regional Medical Center. When a patient with peripheral neuropathy arrived in the ED for treatment of the pain with a lidocaine infusion, Ivy conducted the pre-infusion assessment. She noted on the cardiac monitor that the patient had a conduction abnormality of his heart evident on the monitor. The patient was unaware of the change in his EKG. The neurologist was notified and ordered the consultation of a cardiologist.

Upon discussion of the condition with the cardiologist, the infusion was not given. The conduction delay noted by Ivy could have worsened into a complete degradation of the heart's conduction system leading to a complete heart block. The patient was sent home without the therapy for her peripheral neuropathy, but avoided being given a contraindicated medication.

Ivy's assessment skills and inquiry prevented patient harm and was thus awarded a "Good Catch" from the Quality Improvement / Patient Safety Committee.

Research Article

Older Patients in the Emergency Department: A Review

Nikolaos Samaras, MD, Thierry Chevalley, MD, Dimitrios Samaras, MD, Gabriel Gold, MD

From the Department of Community Medicine and Primary Care (N. Samaras), the Division of Bone Diseases (Chevalley, D. Samaras) and Department of Rehabilitation and Geriatrics (Chevalley, D. Samaras, Gold), Geneva University Hospitals, Geneva, Switzerland.

Older patients account for up to a quarter of all emergency department (ED) visits. Atypical clinical presentation of illness, a high prevalence of cognitive disorders, and the presence of multiple comorbidities complicate their evaluation and management. Increased frailty, delayed diagnosis, and greater illness severity contribute to a higher risk of adverse outcomes. This article will review the most common conditions encountered in older patients, including delirium, dementia, falls, and polypharmacy, and suggest simple and efficient strategies for their evaluation and management. It will discuss age-related changes in the signs and symptoms of acute coronary events, abdominal pain, and infection, examine the yield of different diagnostic approaches in this population, and list the underlying medical problems present in half of all "social" admission cases. Complete geriatric assessments are time consuming and beyond the scope of most EDs. We propose a strategy based on the targeting of high-risk patients and provide examples of simple and efficient tools that are appropriate for ED use. [Ann Emerg Med. 2010;56:261-269.]

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INTRODUCTION

Older patients represent an ever-increasing population in emergency medicine.¹ Such patients often present with atypical signs and symptoms and multiple comorbidities that complicate diagnosis and treatment.² They are at increased risk of emergency department (ED) return visits, hospitalization, and death.² Furthermore, outcomes may be related in part to issues such as functional status,²⁻⁴ comorbidity score,^{2,5} age,² social supports,^{2,3} polypharmacy,² cognitive impairment,² and depression.^{2,3}

Most emergency physicians have not been trained in specific geriatric approaches, and many report being less comfortable when dealing with older patients.⁶

This article reviews the most common conditions affecting older patients in the ED, points out the main pitfalls and difficulties that may be encountered, and provides a brief description of appropriate instruments that can be easily used in the ED setting to assess older individuals and target high-risk patients for referral to a specialized physician or ward.

EPIDEMIOLOGY

Overall, older people account for 12% to 24% of all ED visits⁷⁻¹¹ (Table 1). They visit the ED more frequently than younger adults (during 2006, the annual ED visit rate was of 49/100 persons older than 65 years and 60/100 persons older than 75 compared with an overall rate of 41/100 persons in the United States¹²). ED visits of patients aged 65 to 74 years increased by 34% between 1993 and 2003.¹³

Older patients present with a higher level of emergency^{12,14} and more serious medical illness.^{15,16} They arrive more often by ambulance^{12,14-16} and have higher rates of test use and longer

ED stays.¹⁵ They have a 2.5 to 4.6 times higher risk for hospitalization² and a 5-fold higher admission rate to an ICU.¹⁷ They are also more likely to be misdiagnosed and, consequently, are more frequently discharged with unrecognized and untreated health problems.²

CONDITIONS FREQUENTLY ENCOUNTERED Neuropsychiatric Disorders

Impaired mental status occurs in approximately one quarter of all older patients presenting to the ED as a result of delirium, dementia, or both.^{18,19} The Geriatric Emergency Medicine Task Force recommends a mental status assessment for all older patients in the ED.²⁰

Delirium is by definition a result of an underlying condition, potentially severe and important to recognize quickly.^{18,21} It occurs in 7% to 10% of this population^{18,19,21,22} and is associated with increased mortality^{18,23} and higher risk of admission to the hospital.²² Fifty percent of patients with delirium in the ED also have an underlying dementia;²³ thus, distinguishing the 2 pathologies may be complicated. Table 2 summarizes the principal characteristics and differences between the 2 entities. Studies show that delirium in the ED is recognized with a high specificity (98% to 100%) but a fairly low sensitivity (16% to 35%).^{19,22} The Confusion Assessment Method²⁴ (Figure 1) is quick and easy to use and has a high specificity (100%) and sensitivity (86%) for the diagnosis of delirium.²⁵ This simple tool has been validated in acute settings and could greatly improve the detection of delirium in the ED.

Once delirium has been excluded, patients can be screened for the presence of the chronic cognitive deficits observed in dementia, a condition that affects medication compliance and adherence to

Table 1. Percentage of ED visits concerning older patients (on the total number of ED visits).

Study	Age Limits, Years	Year of Publication	Percentage	Country
Roussel-Laudrin et al ⁷	>75	2002	12-14	France
Hu et al ⁸	>65	1999	24	Taiwan
Lim and Yap ¹¹	>60	1999	12.4	Singapore
Wofford et al ⁹	>65	1996	19.6	United States
Strange et al ¹⁰	>65	1992	15	United States

Table 2. Differential diagnosis between dementia and delirium.

	Dementia	Delirium
Onset	Progressive	Acute (associated with acute disease, drug modifications, changes in the patient's environment, etc)
Moment of onset	Uncertain, hard to identify	Usually precise, easy to identify
Progression	Slow chronic decline (years)	Condition fluctuates and is reversible
Duration	Long (years)	Short (hours to weeks)
Vigilance	Normal	Altered, varies between states of hyper- and hypovigilance
Orientation	Space and time orientation disorders present in late stages of the disease	Disorders present early and may fluctuate

1. Is there evidence of an acute change in mental status from the patient's baseline?
- 2a. Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?
- 2b. Did the behavior fluctuate during the interview, that is, tend to come and go, or increase and decrease in severity?
3. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
4. Overall, how would you rate this patient's level of consciousness?
 - alert (normal)
 - vigilant (hyperalert)
 - lethargic (drowsy, easily aroused)
 - stupor (difficult to arouse)
 - coma (unarousable)
 (feature shown by any answer other than "alert")

Figure 1. Confusion Assessment Method: The diagnosis of delirium by the Confusion Assessment Method requires the presence of features 1 and 2 and either 3 or 4; adapted from Inouye et al.²⁴ Reproduced from *Ann Intern Med.*, Inouye et al, Clarifying confusion: the confusion assessment method: a new method for detection of delirium, 1990, with permission from the American College of Physicians.

discharge instructions¹⁸ and increases the risk of repeated ED visits.⁴ Complete diagnosis of such disorders relies on long and time-consuming neuropsychological evaluations, which are beyond

Table 3. Six-Item Screener.

Reproduced from *Med Care*, Callahan et al, Six-item screener to identify cognitive impairment among potential subjects for clinical research, 2002, with permission from Wolters Kluwer Health. The interviewer says the following: I would like to ask you some questions that ask you to use your memory. I am going to name 3 objects. Please wait until I say all 3 words and then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat these words for me: apple, table, penny. (Interviewer may repeat names 3 times if necessary, but repetition is not scored.)

Did patient correctly repeat all 3 words?	Yes	No
Item	Incorrect	Correct
What year is this?		
What month is this?		
What is the day of the week?		
What are the 3 objects I asked you to remember?		
Apple		
Table		
Penny		

A score less than or equal to 4 (each correct answer counts as 1 point) corresponds to a positive screen for cognitive impairment²⁰; adapted from Callahan et al.²⁶

the scope of any ED. The Six Item Screener²⁶ (Table 3) is short and easy to use and detects cognitive impairment with a sensitivity of 94% and a specificity of 86% in the ED context.²⁰

Depression may be present in up to one third of older ED patients.²⁷⁻²⁹ It may interfere with the clinical presentation of acute medical disorders^{27,29} and results in a greater number of ED visits.²⁹ The ED-DSI (Table 4) is appropriate for the detection of depression in the ED because it is brief (3

Table 4. ED depression screening instrument.

Question	Response	
1. Do you often feel sad or depressed?	Yes	No
2. Do you often feel helpless?	Yes	No
3. Do you often feel downhearted and blue?	Yes	No

At least one positive response corresponds to a positive screening result for depression; adapted from Fabacher et al.³⁰ Reproduced from *The American Journal of Emergency Medicine*, Fabacher et al, Validation of a brief screening tool to detect depression in elderly ED patients, 2001, with permission from Elsevier.

- | | |
|---|---|
| C | Caregiver and housing (information on the circumstances of present fall and falls history) |
| A | Alcohol (including withdrawal) |
| T | Treatment (medications, recently added or stopped, compliance) |
| A | Affect (depression or lack of initiative) |
| S | Syncope (any episodes of fainting) |
| T | Teetering (dizziness) |
| R | Recent illness |
| O | Ocular problems |
| P | Pain with mobility (as the reason for falls in chronic joint pain or as the result and proof of repeated falls) |
| H | Hearing (necessary to avoid hazards) |
| E | Environmental hazards (rags, steps, etc) |

Figure 2. A mnemonic for important elements to consider when retracing the history and analyzing the differential diagnosis of an older patient's fall; adapted from Sloan.³² Reproduced from *Protocols in Primary Care Geriatrics*, Sloan JP, 1997, with permission from Springer.

questions) and has a sensitivity of 79% and a specificity of 66% compared with the longer Geriatric Depression Scale.³⁰

Falls

Falls are the main cause of ED admissions for elderly patients (15% to 30%).^{7,31} A targeted interview of the patient and the caregiver on previous falls, as well as location, activity, and symptoms preceding the actual fall, assisted by the mnemonic "CATASTROPHE"³² (Figure 2), may help to distinguish between an isolated episode and a fall as a result of an underlying pathology or general frailty. Twenty percent of elderly patients with cardiovascular syncope present with a complaint of unexplained falls, whereas older patients with carotid sinus syndrome or documented orthostatic hypotension and documented falls may not recall loss of consciousness before falling.³³ Falls may also be the chief symptom of other pathologies such as acute myocardial infarction, sepsis, medication toxicity, acute abdominal pathology, and elder abuse.³⁴ Inability to recollect the falls' circumstances, fall recurrence, impossibility to get up after a fall (also a risk factor for health decline, hospitalization, and death³⁵) and inability to

arise from the hospital bed and walk should incite emergency physicians to admit the older patient for further assessment.

Four percent to 6% of falls result to fractures,^{34,35} hip fractures accounting for 1% to 2% of them.³⁴ Two percent to 10% of falls produce other major injuries requiring hospitalization or immobilization.³⁴ Hip fractures are more frequently missed on radiographs in this population, and admission for further investigations should be considered when hip pain is present.³⁶ Vertebral fractures are also common, and elderly patients with back pain should undergo radiographic control.³⁷ The presence of coexisting medical illness makes this group vulnerable to complications, and the premature mortality after hip (25% at 1 year³⁸) and vertebral fractures is now well recognized.³⁸⁻⁴¹ Finally, pelvic fractures in elderly patients carry a higher risk of bleeding and need for angiography,⁴² as well as high in-hospital mortality (12% versus 2% for younger patients⁴³).

Age-related physiologic changes such as lower elasticity and higher fragility of vessels, modified mechanical properties of bridging veins, and stress placed on venous structures as a result of cerebral atrophy increase the brain's vulnerability to injury. The increase in space between the brain and skull permits the expansion of intracranial content, with fewer symptoms.⁴⁴ Even trivial injury mechanisms such as falls from standing could result in serious intracranial injury with an atypical presentation.⁴⁵ Thus, chronic subdural hematoma may be present for weeks or months before symptoms appear and motivate an ED visit, whereas the initial head trauma may be so trivial that it is not recalled in 30% to 50% of cases. Various degrees of altered mental state, focal neurologic deficits, headache, and falls are some of its possible presentations.⁴⁶ Acute subdural hematoma, on the other hand, is mostly encountered in younger patients after severe trauma and presents with initial coma in 40% to 80% of cases.⁴⁷ No validated guidelines exist for older patients with blunt brain trauma. High suspicion index, prolonged observation, and a more frequent use of brain imaging is a reasonable approach for these patients.⁴⁵

Coronary Disease

Age is a well-known risk factor for coronary artery disease, with 30% of acute myocardial infarction occurring in patients older than 75 years⁴⁸ and more than 60% of patients hospitalized for unstable angina being older than 65 years.⁴⁹ In the ED, approximately 20% of older patients have dyspnea or chest pain as principal complaints.^{7,31} Coronary disease mortality is also high,^{50,51} with 80% of deaths caused by ischemic heart disease occurring in patients older than 60 years.⁵²

According to the American Heart Association, "because of the high prevalence of atypical features and associated worse outcomes in the elderly, a high index of suspicion for acute coronary disease is advisable."⁵⁰ Acute myocardial infarction presentation in older patients is frequently atypical, presenting as shortness of breath, syncope, nausea and vomiting,^{50,52} and

falls.³⁴ Only 40% of patients older than 85 years and with non-ST-elevation myocardial infarction (STEMI)⁵⁰ and 57% with STEMI⁵¹ have chest pain as their main complaint compared with 77% non-STEMI⁵⁰ and 90% STEMI⁵¹ patients younger than 65 years. Moreover, ECG is nondiagnostic in 43% of patients older than 85 years and with non-STEMI compared with only 23% of patients younger than 65 years.⁵⁰ Additionally, left bundle branch block on ECG is present in 34% of patients older than 85 years and with STEMI compared with only 5% of those younger than 65 years,⁵¹ making diagnosis harder. Because ECG abnormalities are relatively common at an advanced age, it is particularly important to obtain old ECG results whenever possible so that findings in the ED can be compared with previous changes and interpreted accordingly.

The likelihood for treatment with aspirin and β -blockers decreases by 15% and 21%, respectively, for every 10 years of increasing age after aged 65 years. Patients older than 80 years are also less likely to receive thrombolytics than younger patients.⁵³ Atypical presentation, diagnostic difficulties, and a less clear benefit/risk ratio^{50,51} certainly have a role. Nevertheless, a recent study showed that the main factor related to a lower use of recommended medical and interventional therapies in older patients is age itself.⁵⁴ Treatment decisions should rely more on a thorough evaluation of comorbidities, functional status, and quality of life.⁵⁰ Unfortunately, there is a lack of data on outcomes of acute coronary events treatment according to the older patient's functional status.

Polypharmacy and Adverse Drug Effects

Adverse drug effects lead to 11% of ED visits in patients older than 65 years versus 1% to 4% in the general population.⁵⁵ Higher numbers of medications and age-related modifications in pharmacokinetics and pharmacodynamics participate in the higher rates of adverse drug effects.⁵⁵ Older patients admitted to the ED receive an average of 4.2 medications per day (ranging from 0 to 17 medications), with 91% receiving at least 1 and 13 % receiving 8 or more.⁵⁵ On presentation, 11% of these patients receive at least 1 inappropriate medication,⁵⁶ according to the Beers criteria.⁵⁷

Emergency physicians must be acutely aware of the particularities of drugs prescription in older individuals. Unfortunately, no validated screening method exists, and obtaining an accurate list of drugs is frequently difficult. A recent study based on the National Electronic Injury Surveillance System–Cooperative Adverse Drug Event Surveillance system showed that 3 medication classes caused 48% of all ED visits for adverse drug effects in patients older than 65 years: oral anticoagulant or antiplatelet agents (warfarin, aspirin, and clopidogrel), antidiabetic agents (insulin, metformin, glyburide, and glipizide), and agents with a narrow therapeutic index (digoxin and phenytoin). Most frequently implicated medications from these classes, accounting for one third of adverse-effect-induced ED visits, were warfarin, insulin, and digoxin.⁵⁸

A heightened awareness of this issue and systematic screening for use of the above medications should lead to better detection of adverse drug events in the ED. Communicating with the patient's primary physician is also crucial.

Alcohol and Substance Abuse

Alcohol disorders are present in 5% to 14% of older patients in the ED,^{59,60} depending on the criteria used. In a French study, the most frequent alcohol-induced disorders were alcohol intoxication (36%), alcohol withdrawal or intoxication-related delirium (21%), and alcohol-induced mood disorders (15%).⁶¹ Compared with that for alcohol abuse, few data exist on substance abuse. Illicit drugs use is rare in this population but widely recognized as a growing problem.^{62,63} Substance abuse by older patients is more often related to prescription drugs such as benzodiazepines, sedative-hypnotics, and opioid analgesics.⁶² A study that used saliva tests for alcohol and urine test to detect drug consumption found that undeclared substance abuse was strongly related to an age older than 65 years and mainly involved opioids, benzodiazepines, and stimulants.⁶⁴

Only 21% of elderly current alcohol abusers are detected in the ED.⁶⁰ Some screening questionnaires specific for older patients have been developed such as the Michigan Alcoholism Screening Test Geriatric Version.⁶⁵ Many physicians use existing screening tools such as the CAGE.⁶⁶ Nevertheless, some authors have questioned their usefulness in older age groups.⁶⁷⁻⁷⁰ To our knowledge, no validated screening instruments for substance abuse in geriatric patients are available.^{62,71}

Despite the abovementioned screening difficulties, alcohol and substance abuse are involved in various geriatric conditions such as falls, delirium, and agitation^{61,62,70,72} and should be considered in older patients in the ED.

Abdominal Pain

Abdominal pain is the main complaint in 3% to 13% of ED visits in older patients.^{7,31,73} Compared with that of younger patients, mortality rates are 6 to 8 times higher and surgery rates are increased 2-fold.⁷³ The rates of correct diagnoses for abdominal pain in the ED differ greatly throughout the literature and range from 40% to 82%.^{73,74} Seventy-eight percent of emergency physicians report greater difficulty with abdominal pain management in older patients.⁷⁵ Discrepancies between ED and final diagnosis concern more often gallbladder disease, nonspecific abdominal pain, cancer, and diverticulitis⁷³ (Figure 3).

Abdominal computed tomography (CT) is well studied and has proved its efficacy in this context. It is performed for 37% to 59% of older patients^{73,76,77} and leads to a diagnosis in 57% to 67% of cases.^{73,76} In one study, it modified the admission decision for 26% of cases, the need for surgery for 12%, antibiotics prescription for 21%, and the suspected diagnosis in almost half.⁷⁵

Abdominal ultrasonography is a less common modality for the diagnosis of abdominal pain in elderly ED patients (used in only 9% to 11% of cases^{73,76}). The American College of

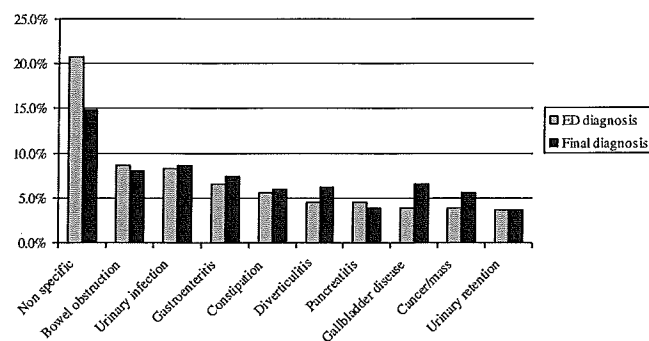


Figure 3. Diagnosis for abdominal pain at the ED and 2 weeks after ED or hospital discharge, adapted from Lewis et al.⁷³

Table 5. Best imaging examination, depending on pain location according to the American College of Radiology Appropriateness Criteria;⁷⁸⁻⁸⁰ adapted by Cartwright and Knudson.⁸¹ Reproduced from *American Family Physician*, Cartwright and Knudsen, Evaluation of acute abdominal pain in adults, 2008, with permission from the American Academy of Family Physicians.

Pain Location	Radiologic Examination
Right upper quadrant	Ultrasonography
Right lower quadrant	CT with intravenous contrast media
Left lower quadrant	CT with oral and intravenous contrast media
Left upper quadrant	CT
Suprapubic	Ultrasonography

Radiology suggests ultrasonography as a first-choice examination for certain cases of right upper quadrant pain and jaundice in general population⁷⁸⁻⁸¹ (Table 5). However, because age is a main risk factor for contrast-induced nephropathy,⁸² ultrasonography and abdominal CT without contrast may be most appropriate for patients at high risk for renal complications such as chronic kidney disease, diabetes, chronic heart failure, or significant volume depletion.

High morbidity and mortality in older patients with abdominal pain manifest the necessity of heightened awareness concerning its clinical, radiologic, and prognostic characteristics. Emergency physicians should more readily perform abdominal CT and admit older patients for further observation, diagnostic tests, and treatment.

Infections

Infection is the main complaint of 4%^{7,31} of elderly ED patients. The most frequent conditions are pneumonia (25%), urinary tract infection (22%), and sepsis and bacteremia (18%).⁸³ Infection presentation is frequently atypical in this population.^{83,84} Falls³⁴ or delirium⁸⁴ may be the only clinical manifestations of otherwise serious infections, whereas more classic symptoms such as tachycardia and fever may be absent.⁸⁴ Thus, acute cholecystitis may present without pain (5%), fever (56%), or complete blood count modifications (41%).⁸⁵

Appendicitis presents with classic symptoms in only 20% of geriatric cases, and fever occurs in less than half the cases.⁸⁶

There are no well-established guidelines for identification of infection in older ED populations. A 2-step protocol used an electronic notification system for the presence of 2 or more criteria for systemic inflammatory response syndrome during the first 6 hours of ED stay and then confirmation by the physician in charge of the absence of a noninfectious explanation. It led to improved identification of serious infection, with a specificity of 98% but fairly low sensitivity (11%), because nonserious infections were less well identified by the systemic inflammatory response syndrome criteria.⁸⁷ Unfortunately, the authors did not comment on the role of atypical presentation of infection in this age group.

Infections are related to higher morbidity and mortality in elderly patients. Old (aged between 65 and 84 years) and oldest old (older than 85 years) patients with community-acquired bacteremia have a higher risk of developing organ failure and higher 90-day mortality rates (15% for young patients versus 20% and 26%, respectively, for old and oldest old).⁸⁴ To our knowledge, risk-stratification scores such as the Mortality in Emergency Department Sepsis score⁸⁸ lack specific validation in this population.

Social Cases, the Search for Hidden Illness

A number of geriatric ED admissions appear to have no medical basis and seem motivated by the impossibility of the family, including the nurses and neighbors, to maintain the patient at home. Although purely "social" ED admissions certainly occur (eg, hospitalization or death of primary caregiver, formal home care services withdrawal), emergency physicians must always consider that subacute or acute illness can present as functional decline, motivating the social ED visit. In fact, 74% of older patients report that functional decline resulting from initial symptoms determined their ED consultation.⁸⁹ Thus, delirium, infections, acute pain, recently prescribed medications, cardiovascular disease, and chronic disease exacerbation may result in acute modifications of the patient's functional status and an ED visit. Chronic orthopedic, cardiovascular, and neurologic conditions may also lead to altered functional status, primary caregiver exhaustion, and social ED admission. A recent study reported that although 9% of older patients were admitted to the ED ostensibly for social reasons (inability to take care of self), 51% of these patients had an underlying acute medical problem such as infectious (24%), cardiovascular (14%), neurologic (9%), digestive (7%), pulmonary (5%), or other disorders (delirium, fractures, anemia, acute renal failure, uncontrolled pain, etc).⁹⁰ In another study, the 1-year mortality of such patients was as high as 34%.⁹¹

Elder Abuse and Neglect

Elder abuse or neglect is defined by the American Medical Association as "actions or the omission of actions that result in harm or threatened harm to the health or welfare of the

elderly.”⁹² It includes battery, psychological abuse, abandonment, exploitation, and neglect and may be intentional or unintentional.⁹³ Among a multitude of risk factors, the most important are a relationship of dependency, social isolation, and psychopathology of the abuser.⁹⁴ Elder abuse prevalence in the United States is approximately 10%.⁹³ In a state elderly protective program, 66% of older patients who visited the ED in a 5-year period had an injury-related discharge diagnosis.⁹⁵ Only 9% of these ED visits resulted in referral to appropriate services.⁹⁵ Lack of specific protocols and time constraints make elder abuse recognition difficult and result in less referral to the appropriate authorities.⁹³

The majority of caregivers and families demonstrate a high level of selflessness and devotion in taking care of their spouses and relatives. Nevertheless, emergency physicians should have high levels of awareness for such incidents and include elder abuse more frequently in their differential diagnosis.

TARGETING “HIGH-RISK” ELDERLY

Given the lack of time and important workload in the ED, considering every patient older than 65 years for a thorough geriatric evaluation is not realistic. Moreover, the needs of older patients in the ED concerning such evaluations vary. Appropriate screening and elaboration of specific intervention protocols may help emergency physicians target patients prone to benefit from a more detailed evaluation in the ED on one hand and better orient such patients toward the correct ward or community service provider on the other.

Several scales have been used to screen high-risk older patients in the ED. Most studied, the Identification of Seniors at Risk tool⁹⁶ (Figure 4) is a 6-item self-report screening tool with simple yes/no questions that can be administered to the patient or the primary caregiver. It performs as well as other screening tools developed for hospitalized and community-based elderly populations and was developed for the ED.⁹⁷ Well-known risk factors for adverse health outcomes in older patients are included among the questions (activities of daily living, visual and cognitive impairment, hospitalization history, and polypharmacy).⁹⁶ The Identification of Seniors at Risk tool is known to have an excellent concurrent validity for detecting impaired functional status and depression at the evaluation.^{96,98} It also predicts ED revisits^{3,98} and hospitalization after the index ED visit,⁹⁶⁻⁹⁸ mortality,⁹⁶ admission to a nursing home,⁹⁶ use of community services,⁹⁸ and decrease in functional status⁹⁶ in a 4-month⁹⁸ or 6-month^{3,96} follow-up. Consequently, it has both immediate clinical relevance and good predictive validity.⁹⁶ Other screening tools have been developed such as the Triage Risk Screening Tool, the Runciman Questionnaire, and the Rowland Questionnaire but are less studied and seem less efficient.^{99,100}

High-risk older patients may benefit from a more thorough geriatric evaluation in the ED, including mood, cognition, and functional status evaluation, as well as referral to an onsite geriatrician. Several EDs have developed protocols to target high-risk elderly patients and provide a comprehensive geriatric

1. Before the illness or injury that brought you to the emergency department, did you need someone to help you on a regular basis? (yes)
2. Since the illness or injury that brought you to the emergency department have you needed more help than usual to take care of yourself? (yes)
3. Have you been hospitalized for one or more nights during the past 6 months (excluding a stay in the emergency department)? (yes)
4. In general, do you see well? (no)
5. In general, do you have serious problems with your memory? (yes)
6. Do you take more than 3 different medications every day? (yes)

Figure 4. Identification of Seniors at Risk tool. Each high-risk response indicated on this table counts as 1 point for a total score ranging from 0 to 6. A patient is considered at high risk when the score is 2 or more; adapted from McCusker et al.⁹⁶ Reproduced from *Journal of the American Geriatrics Society*, McCusker et al, Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool, 1999, with permission from Blackwell Publishing.

assessment to detect geriatric syndromes, increase referrals to community service providers, and avoid hospital admissions and ED revisits.² No widely accepted protocol is actually available; some use a 2-step evaluation pattern (screening and then assessing “high-risk” patients)^{101,102} and others, a 1-step pattern with¹⁰³ or without¹⁰⁴ follow-up by a hospital-based multidisciplinary team. Such interventions demonstrated moderate but encouraging results, with a reduction in post-ED discharge hospital admissions,¹⁰³ ED revisits,¹⁰⁴ and functional decline¹⁰¹⁻¹⁰³ and an increase in home care services referrals.¹⁰² We believe that a “target and refer” model using the Identification of Seniors at Risk tool is realistic in the ED context and may help physicians provide high-quality care to older patients.

CONCLUSION

Older people visit the ED ever more frequently and can benefit from a targeted approach. A greater knowledge of the atypical presentation of disease, the complex interrelated acute medical and psychosocial issues of such patients, and the appropriate use of available screening and assessment tools can help emergency physicians provide high-quality care to this increasing population.

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ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Report on Board Actions Quality Committee Meeting Date: December 5, 2016
Responsible party:	Cindy Murphy, Board Liaison
Action requested:	For Information
Background: IN FY16 we added this item to each Board Committee agenda to keep Committee members informed about Board actions via a verbal report by the Committee Chair. This written report is intended to supplement the Chair's verbal report.	
Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
Summary and session objectives : To inform the Committee about recent Board actions	
Suggested discussion questions: None.	
Proposed Committee motion, if any: None. This is an informational item	
LIST OF ATTACHMENTS: Report on November 2016 Board Actions	

November 2016 Board Actions*

1. November 9, 2016

- a. Approved Collective Bargaining Agreements with PRN and Local 39
- b. Approved FY17 Executive Salary Ranges and Base Salaries
- c. Approved FY16 Executive Incentive Goal Scores and Incentive Payments
- d. Approved Appointment of Lanhee Chen, Dave Reeder, John Zoglin, Lane Melchor, Ramtin Agah, MD; Karen Pike, MD; Teri Eyre and Gary Kalbach to the CEO Search Committee

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

ATTACHMENT 6



Emergency Department MV Quality and Safety

December 5th, 2016

Noble Cause in the ED

- **Our goal is to provide the best medical care possible in a compassionate, patient-centered way**
- How do we achieve this?
 - Collaborate with other hospital services
 - Build an ED team that shares this vision
 - Use cultural values to drive quality, safety, and performance



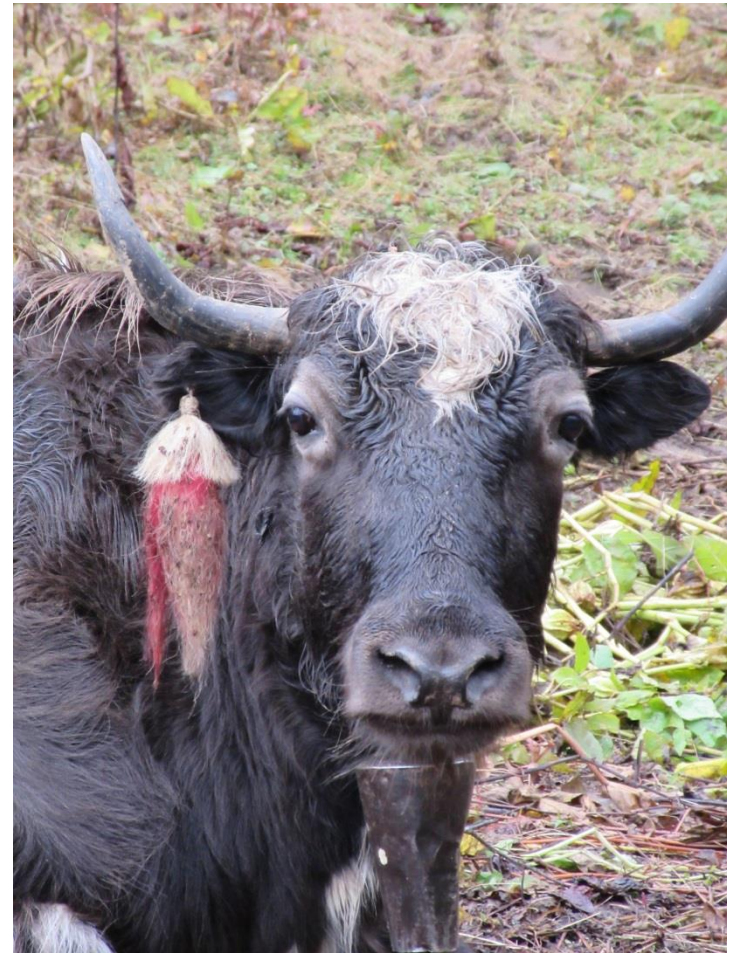
Quality Program – Multifaceted Approach

- Identification
 - Risk within the department
 - Provider quality of care
- Investigation
 - All patient complaints
 - Monthly indicators
 - Vigorous, comprehensive peer review
- Improvement/Education
 - Individual/Departmental education
 - CMS core measures/hospital initiatives
 - ED-specific department initiatives
 - Continual re-evaluation and process improvement



Risk within the ED

- 2014: CEP provided a full Risk Assessment in which they outlined specific areas of concern
- Examples:
 - Pediatric patients – met with LPEC and Lucille Packard leaders to streamline the process
 - Behavioral Health patients – PES RN 24/7
 - PA supervision – stricter guidelines on which cases require direct MD supervision



Patient Complaints

- Opportunity to get direct patient feedback
- Source of complaints: ad hoc, patient complaint phone line or emails, satisfaction surveys (CEP), QRR's, billing complaints
- Log all complaints
- Patient Grievance Committee (ED specific)



Peer Review – Proactive Approach

- Try to identify educational opportunities for individual providers
- Monthly indicators
 - Return visit admits within 72 hours
 - Transfers (peds)
 - Mortalities
 - Case referrals
 - QRR's
 - Patient complaints
- Subcommittee review and “score” the cases and the provider
- Log all cases so as to identify trends



Peer Review Scoring System

- Care appropriate – no educational opportunity
- Educational opportunity identified
- Standard of care not met – mandates provider feedback and entire group educational session
- Operational opportunity identified
- Behavioral opportunity identified

Monthly Education – Mimic M&M

- Educational sessions that are evidence based: specific case is presented Educational sessions are held jointly with Los Gatos via teleconferencing
- MD's, PA's, Lead Scribes are required to attend



CMS Core Measures/Hospital Initiatives

- Outlier cases are reviewed and presented to entire group (e.g. Sepsis case where inadequate fluids were used for volume resuscitation)
- Hospital initiatives are presented and reviewed monthly



ED Department Specific Initiatives

- Through the QA process, we may identify opportunities for process change, education beyond just a single case presentation, or group behavioral changes, etc.
- Examples
 - Patient callbacks
 - Trauma pts that are transferred vs. admitted
 - Point of care ultrasound
 - Hip fracture management
 - Opiate Rx's
 - Process for identifying patients that were just d/c'd from hospital so we can involve social services earlier
 - Triage redesign
 - MD in triage during busy times
 - Surge plan, etc.

Continual Re-evaluation and Improvement – required for sustainability

- Once we do an intervention with either a provider or with a process change, we continue to monitor the situation
- Provider: we do not see any change, then we try a different approach. We initially see a change, then slippage: the provider gets a reminder
- Process: We continually monitor for safety issues, patient complaints, measurable parameters (such as time to provider)



**Our goal is to provide the best medical care possible in a
compassionate, patient-centered way**



ATTACHMENT 7



El Camino Hospital[®]
THE HOSPITAL OF SILICON VALLEY

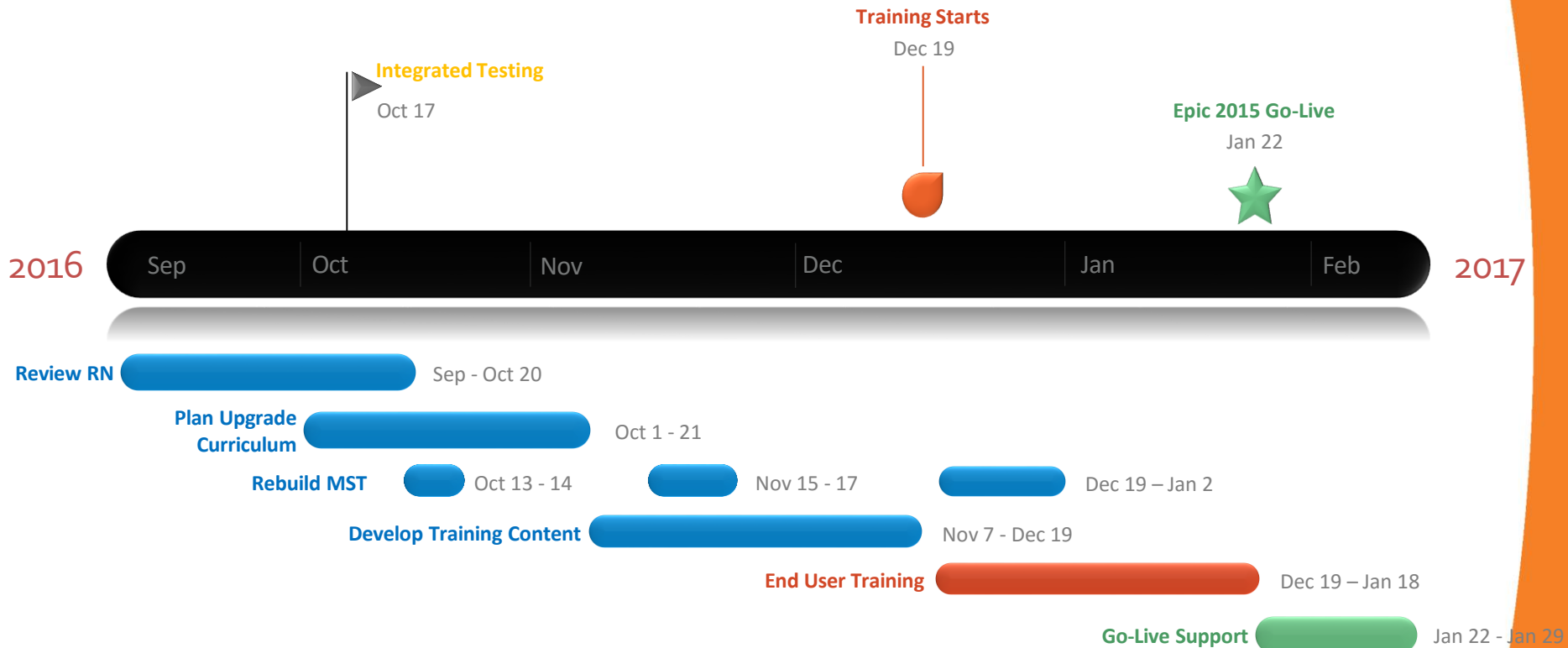
iCare Update

Quality Committee
December 5, 2016

iCare Update

- ✓ Alcohol Withdrawal Protocol activation on 10/31/16
- ✓ Pathways Home Care and Hospice Go-live on 11/1/16
- ✓ Epic Integration with NICU Bedside Monitors completed
- ✓ Focus on Data Governance and Reporting Strategy
 - Development of Pain Reassessment reports
 - OR Reports configuration in process
 - Truven eCQM reports live in December
 - Initiation of Data Warehouse Project
 - Meaningful Use Structure/Reporting in place
- ✓ Planning has begun for implementation of Healthy Planet population health management functionality
- ✓ Epic Version 2015 Upgrade scheduled for 1/22/17

Upgrade Timeline



Upgrade Overview and Impact

- Upgrade Training will be conducted using on-line courses lasting approximately one hour starting December 19th
- On-line training will be supplemented by user specific tip sheets
- Epic 2015 Sandbox will be available to users in early January for practice and exposure to changes
- Upgrade training content has been reviewed/approved by departmental and nursing leadership
- A Command Center structure will be implemented at go-live with floor support available to assist employees during the immediate activation period

Physician Impact

- The Interim CMIO, Dr. Craig Joseph, is guiding physician preparation and planning with expectation that physician workflow changes will be minor and intuitive
 - Think smartphone app upgrades
 - “Where’s that button? Oh, there it is.”
- Similar to nursing, Training will involve 1-2 page handouts called Tip Sheets for small topics with short e-learning modules available as needed
- Summary: if you could do your work on Friday, you will be able to do your work on Monday

ATTACHMENT 8

Quality and Safety Dashboard (Monthly)

Date Reports Run: 4/18/2016

		Baseline		FY17 Goal	Trend
SAFETY EVENTS		Performance		FY2016	FY2017
1	Patient Falls Med / Surg / CC Falls / 1,000 CALNOC Pt Days Date Period: October 2016	8/4975	1.61	1.51	1.39 (goal for FY 16)
2	Pain reassessment within 60 mins after pain med administration Errors / 1000 Adj Total Patient Days Date Period: October 2016	7369/10889	67.7%	56.3% (Jan-Jun 2016)	75% to 80%, stretch goal=90%
3	Medication Errors (Overall, Reached to patients, and Near miss) Errors / 1000 Adj Total Patient Days Date Period: September 2016	31/13445	2.31	2.68	0.00
COMPLICATIONS		Performance		FY 2016	FY 2017
4	Surgical Site Infection (SSI) SSI per 100 Surgical Procedures Date Period: September 2016	0	0.00	0.20	0.18 (goal for FY 16)
SERVICE		Performance		FY 2016	FY 2017
5	Communication with Nurses (HCAHPS composite score, top box) Date Period: Aug 2016	220/281	78.3%	78.0%	78.5%
6	Responsiveness of Hospital Staff (HCAHPS composite score, top box) Date Period: Aug 2016	197/266	74.0%	64.9%	66.8%
7	Pain management (HCAHPS composite score, top box) Date Period: Aug 2016	171/221	77.4%	72.5%	
8	Communication About Medicines (HCAHPS composite score, top box) Date Period: Aug 2016	125/185	67.7%	64.7%	68.3%
EFFICIENCY		Performance		Jan-Jun 2016 (6-month ave)	FY 2017
9	★Organizational Goal Average Length of Stay (days) (Medicare definition, MS-CC, ≥ 65, inpatient) Date Period: October 2016	FYTD 1566 01-06/16 2509	FYTD 4.56 01-06/16 4.78	4.78	4.87
10	★Organizational Goal 30-Day Readmission (Rate, LOS-Focused) (ALOS-Linked, All-Cause, Unplanned) Date Period: September 2016	FYTD 82/803 01-06/16 288/2497	FYTD 10.22 01-06/16 11.53	11.53	At or below 12.24

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
Patient Falls	Sheetal Shah; Cheryl Reinking	Falls Committee	<p>All med/surg/CC falls reported to CALNOC per 1,000 CALNOC (med/surg/CC) patient days</p> <p>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).</p> <p><i>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</i></p>		QRR Reporting and Staff Validation
Pain Reassessment within 60 minutes after pain med administration	Chris Tarver; Cheryl Reinking			Pain Reassessment is measured as documentation on the iCare EHR Flowsheet in at least one of the 9 designated flowsheet rows, for designated medications marked as "given" on the MAR. The designated medications cover 95% of the PRN pain medications administered as "PRN" (pharmacy class/medication IDs). Exclusion criteria is as follows: Epidural route, Endoscopy Unit, Interventional Services, and the "PRN reasons" of "shivering, none (NULL) and other".	EPIC report
Medication Errors	Sheetal Shah; Cheryl Reinking	Medication Safety Committee; P&T Committee	<p>5 Rights Medication Errors: [# of Med Errors (includes: Duplicate Dose, Omitted Dose, Incorrect Patient, Incorrect Medication, and Incorrect Route, Incorrect Dose, Incorrect Time, Incorrect Medication order, Medication Reconciliation) divided by Adjusted Total Patient Days (includes L&D & Nursery)]* 1,000</p> <p><i>Near miss and reached patients.</i></p>		QRR Reporting and Staff Validation
Surgical Site Infection	Catherine Nalesnik; Carol Kemper, MD	Infection Control Committee	<p>(Number of Deep Organ Space Infections divided by the # of all surgery cases)*100 counted by the month procedure under which infection was attributed to and not by the month it was discovered.</p> <p>All Surgery Cases in the 29 Surgical Procedural Categories required by the California Department of Public Health.</p>		IC Surveillance and NHSN Data Reporting
Communication with Nurses	RJ Salus; Meena Ramchandani; Cheryl Reinking	Patient Experience Committee	<p>Percent of inpatients responding "Always" to the following 3 questions [% Top Box]:</p> <ol style="list-style-type: none"> 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? <p>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.</p>		Press Ganey Tool
Responsiveness of Hospital Staff	RJ Salus	Patient Experience Committee	<p>Percent of inpatients responding "Always" to the following 2 questions [% Top Box]:</p> <ol style="list-style-type: none"> 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)? <p>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.</p>		Press Ganey Tool
Pain management	Chris Tarver, Meena Ramchandani	Patient Experience Committee	<p>Percent of inpatients responding "Always" to the following 2 questions [% Top Box]:</p> <ol style="list-style-type: none"> 1. Pain well controlled, 2. Staff do everything help with pain 		Press Ganey Tool
Communication About Medicines	RJ Salus; Cheryl Reinking; Bob Blair	Patient Experience Committee	<p>Percent of inpatients (who received meds) responding "Always" to the following 2 questions [% Top Box]:</p> <ol style="list-style-type: none"> 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? <p>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.</p>		Press Ganey Tool
Average Length of Stay	Cheryle Reinking; Mick Zdeblick	LOS Steering Committee	<p>Average LOS of Medicare FFS, Patients discharged from an Acute Care or Intensive Care unit. Excludes expired patients. Includes final coded patients aged 65 and older at the time of the encounter. The baseline period is from Jan-June 2015 and the performance period is from Jan-June 2016.</p>		EDW Data Pull, Department of Clinical Effectiveness
30-Day Readmission (LOS-Focused)	Margaret Wilmer; Cheryl Reinking	Readmission Committee	<p>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.</p>		EDW Data Pull, Department of Clinical Effectiveness