

AGENDA

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

Monday, January 30th, 2017, **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 - December 5, 2016 b. Environment of Care Policies <u>Information:</u> c. Pacing Plan d. Patient Story e. Research Article			
5. REPORT ON BOARD ACTIONS ATTACHMENT 5	David Reeder, Chair Quality Committee		Discussion 5:36 – 5:39
6. QUALITY PROGRAM UPDATE: BEHAVIORAL HEALTH SERVICES ATTACHMENT 6	Michael Fitzgerald, Executive Director of Behavioral Health Services		Discussion 5:39 – 5:59
7. FY17 QUALITY DASHBOARD ATTACHMENT 7	Dan Shin, MD, Medical Director of Quality and Patient Safety		Discussion 5:59 – 6:09

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Agenda: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
January 30, 2017

AGENDA ITEM	PRESENTED BY		
8. QUARTERLY QUALITY REPORT <u>ATTACHMENT 8</u>	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		Discussion 6:09 – 6:19
9. PUBLIC COMMUNICATION	David Reeder, Chair Quality Committee		Information 6:19– 6:22
10. ADJOURN TO CLOSED SESSION			6:22– 6:23
11. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	David Reeder, Chair Quality Committee		6:23 – 6:24
12. CONSENT CALENDAR Any Committee Member may pull an item for discussion before a motion is made. Approval: Meeting Minutes of the Closed Session <i>Gov't Code Section 54957.2.</i> - December 5, 2016 Information: Report related to the Medical Staff quality assurance matters, <i>Health and Safety Code</i> <i>Section 32155.</i> Meeting Minutes of Quality Council - November 2, 2016	David Reeder, Chair Quality Committee		Motion Required 6:24 – 6:27
13. Report related to the Medical Staff quality assurance matters, <i>Health and Safety Code</i> <i>Section 32155.</i> CMO Report	William Faber, MD Chief Medical Officer		Discussion 6:27 – 6:37
14. Report related to the Medical Staff quality assurance matters, <i>Health and Safety Code</i> <i>Section 32155.</i> Red and Orange Alert	Shreyas Mallur, MD Associate Chief Medical Officer		Discussion 6:37 – 6:57
15. RECONVENE OPEN SESSION/REPORT OUT	David Reeder, Chair Quality Committee		6:57 – 6:58
To report any required disclosures regarding permissible actions taken during Closed Session.			
16. ADJOURNMENT	David Reeder, Chair Quality Committee		7:00 p.m.

Upcoming FY 17 Quality Committee Meetings

- **February 27, 2017**
- **April 3, 2017**
- **May 1, 2017**
- **June 5, 2017**

a. Minutes of Quality Committee Meeting - December 5, 2016

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, December 5th, 2016
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present

Dave Reeder; Robert Pinsker, MD;
 Diana Russell, RN; Nancy Carragee,
 Katie Anderson, Alex Tsao, and
 Wendy Ron.
 Melora Simon joined the meeting @
 5:45pm.

Members Absent

Peter Fung, MD;
 and Mikele Bunce.

Members Excused

None

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 5th day of December, 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 5:38p.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 November 2, 2016 meeting were approved).</p> <p><u>Movant:</u> Russell</p> <p><u>Second:</u> Tsao</p> <p><u>Ayes:</u> Anderson, Carragee, Pinsker, Reeder, Ron, Russell, and Tsao.</p> <p><u>Noes:</u> None</p> <p><u>Abstentions:</u> None</p> <p><u>Absent:</u> Bunce, Fung, and Simon.</p> <p><u>Excused:</u> None</p> <p><u>Recused:</u> None</p>	<i>The Open Minutes of the November 2, 2016 meeting were approved.</i>

Agenda Item	Comments/Discussion	Approvals/Action
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and reported that the Board had approved appointment of a CEO Search Committee to include: Lanhee Chen, Dave Reeder, John Zoglin, Lane Melchor, Ramtin Agah, MD; Karen Pike, MD; Teri Eyre and Gary Kalbach.	<i>None</i>
6. QUALITY PROGRAM UPDATE: EMERGENCY DEPARTMENT	<p>Dr. Laura Cook, MD, Medical Director of Emergency Medicine – Mountain View, highlighted the Emergency Department with the Committee. Dr. Cooks reviewed the ED’s current goals and collaborative efforts for achievement to include a multifaceted approach toward identification, investigation, and improvement/education. She further detailed current risk within the ED and sources of Patient Complaints. Dr. Cook explained the proactive approach to Peer and scoring system, Monthly Education and Initiatives, as well as the need for Continual Re-evaluation and Improvement required for sustainability.</p> <p>Dr. Cook asked for feedback and questions from the Committee and a brief discussion ensued. Items of discussion included staffing strategy around peek time, and the ED department’s Peer Review process.</p> <p>Dr. Faber asked for the Committee’s feedback on Program Update preference for future Committee meetings. The general consensus of the Committee was to invite Service Lines with high volumes or Service Lines that would like to receive feedback on specific challenges or needs from the Committee members.</p> <p><i>*Melora Simon joined the meeting @ 5:45pm.</i></p>	<i>None</i>
7. ICARE UPDATE	<p>Deb Muro, Interim Chief Information Officer, updated the Committee on the upcoming iCare upgrade and anticipated impact on the Staff, Physicians, and Patients. Ms. Muro further reported the scope and timeline of the project, and overview of the upgrade features as detailed in the packet.</p> <p>Ms. Muro asked for feedback and questions from the Committee and a brief discussion ensued. Items of discussion included further detail of the upgrade features and the current challenge of infrequent users training and support.</p>	<i>None</i>

Agenda Item	Comments/Discussion	Approvals/Action
8. FY17 QUALITY DASHBOARD	<p>Dr. Dan Shin, MD, Medical Director of Patient Safety and Quality Assurance presented the FY17 Quality Dashboard to the Committee. He reported that nine metrics remain stable; the only exception being a slight decline in communications about medicines. Dr. Shin further noted the improvement in patient falls.</p> <p>Dr. Shin directed the Committee's attention to the new metrics and definitions added to the dashboard to include Pain reassessment within 60 minutes after pain medicine administration, and pain management. He noted that item 7 Goal had been off the report and clarified the goal as Minimum of 73%, Target of 74%, Stretch Goal of 76%.</p> <p>Dr. Shin asked for feedback and questions from the Committee and a brief discussion ensued.</p> <p><i>*The Committee requested the addition of annotations of initiatives to be reflected on the Dashboard in correlation with improvements. A Committee member noted the correlation between the pain reassessment /management goal and responsiveness of staff.</i></p>	<i>None</i>
9. PAIN GOALS DISCUSSION	<p>Will Faber, MD, Chief Medical Officer, further explained the addition of the Pains Goals and Definitions to the Quality Dashboard. Dr. Faber reminded the Committee that we are measuring our baseline of responsiveness as we develop the program, but performance will be measured in the fourth quarter.</p>	<i>None</i>
10. PATIENT AND FAMILY CENTERED CARE	<p>Mick Zdeblick, Chief Operating Officer, briefly updated the Committee on the current status of Patient and Family Centered Care Focus. Mr. Zdeblick reported on a recent successful site visit and feedback received from the participants to include the recommendation of the Lean principle of introducing the care partner. A brief discussion ensued.</p> <p><i>*Committee members asked for the opportunity for patient rounding with the executives during the holiday season, specifically the end of the week of Dec 19th. Stephanie to work with Cindy on scheduling and campus preference.</i></p>	<i>None</i>
11. PUBLIC COMMUNICATION	None	<i>None</i>

Agenda Item	Comments/Discussion	Approvals/Action
12. ADJOURN TO CLOSED SESSION	<p><u>Motion:</u> To adjourn to closed session at 6:38 p.m. <u>Movant:</u> Simon <u>Second:</u> Anderson <u>Ayes:</u> Anderson, Carragee, Fung, Pinsker, Reeder, Ron, Russell, Simon, and Tsao. <u>Noes:</u> None <u>Abstentions:</u> None <u>Absent:</u> Bunce <u>Excused:</u> None <u>Recused:</u> None</p>	<i>A motion to adjourn to closed session at 6:38 p.m. was approved.</i>
13. AGENDA ITEM 17 RECONVENE OPEN SESSION/ REPORT OUT	<p><i>Agenda Items 13 – 16 were reported in closed session.</i> Chair Reeder reported that Closed minutes of the November 2, 2016 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.</p>	<i>None</i>
14. AGENDA ITEM 18 ADJOURNMENT	<p>There being no further business to come before the Committee, the meeting was adjourned at 6:57p.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

Environment of Care Policies

SUMMARY OF POLICIES/PROTOCOLS FOR REVIEW AND APPROVAL-QUALITY

NEW POLICIES				
Policy Number	Policy Name	Department	Date	Summary of Policy Changes
POLICIES WITH MAJOR REVISIONS				
Policy Number	Policy Name	Department	Review or Revised Date	Summary of Policy Changes
POLICIES WITH MINOR REVISIONS				
Policy Number	Policy Name	Department	Review or Revised Date	Summary of Policy Changes
POLICIES WITH NO REVISIONS - REVIEWED				
Policy Number	Policy Name	Department	Review or Revised Date	
	Anesthesia Equipment, Care, Handling, Decontamination, Sterilization of	Sterile Processing	12/16	
	Automated Mechanical Cart Washer, Operation of	Sterile Processing	12/16	
	Bronchoscope Care, Handling, Disinfection and Sterilization of	Sterile Processing	12/16	
	Cleaning and Maintenance of Steam Sterilizers	Sterile Processing	12/16	
	Consignment Loaned Equipment and Instrumentation, Acquisition and Documentation of	Sterile Processing	12/16	
	Decontamination of Instrumentation, Rigid Containers and Mobile Patient Care Equipment	Sterile Processing	12/16	
	Departmental Cleaning	Sterile Processing	12/16	
	Environmental Design and Safety Control	Sterile Processing	12/16	

	Flashpak Sterilizatoin Container System	Sterile Processing	12/16	
	High Risk Trays, Decontamination and Assembly	Sterile Processing	12/16	
	Olympic Sterile Drier, Operation of	Sterile Processing	12/16	
	Rigid and Flexible Endoscopes, Care, Handling, Disinfection and Sterilization of	Sterile Processing	12/16	
	Steam Sterilizers, Operation of	Sterile Processing	12/16	
	Sterrad Sterilization, Operating Instructions for	Sterile Processing	12/16	
	Supply Storage, Maintenance of	Sterile Processing	12/16	
	Surgical Instrumentation Handling and Transport Post Procedure	Sterile Processing	12/16	
	Surgical Instruments, Removing Stains from	Sterile Processing	12/16	
	Surgical Power Equipment, Care, Handling, Disinfection and Sterilization of	Sterile Processing	12/16	
	Traffic Control and Work Flow Practices	Sterile Processing	12/16	
	Ultrasonic Cleaner Monitoring efficacy of the unit with SonoCheck	Sterile Processing	12/16	
	Ultrasonic Cleaner Monitoring efficacy of the unit with Wash Check	Sterile Processing	12/16	
	Ultrasonic Cleaner, Operation of	Sterile Processing	12/16	
	Washer Disinfectors, Routine Cleaning of	Sterile Processing	12/16	
	Dress Code and Use of PPE	Sterile Processing	12/16	
	Requested Time Off	Sterile Processing	12/16	
	Staff Competency, Training and Education	Sterile Processing	12/16	

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 ▪ Quarterly Quality Report 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 ▪ Quarterly Quality Report 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 ▪ Quarterly Quality Report <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Clinical Program Update ▪ 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 <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Clinical Program Update ▪ 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 ▪ Quarterly Quality Report <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Clinical Program Update ▪ 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 <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Clinical Program Update ▪ 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 <p>Standing Agenda Items:</p> <ul style="list-style-type: none"> ▪ Consent Calendar ▪ Clinical Program Update ▪ 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

January 2017

El Camino Hospital – Quality Committee of the Board

Patient Story:

Mr. W, 92 years old, was already a patient in ECH Mountain View Critical Care Unit with Flu when his wife came into the Emergency Department in early January also with the Flu. Mrs. W, also 92 years old, had decided against any lifesaving measures and was placed on Comfort Care for end of life treatment.

The ED nurse called the CCU nurse to find out if Mr. W could come to the ED to see his wife. The CCU staff covered this nurse's other patient so she could take Mr. W to the ED.

That evening Mrs. W. was admitted to the PCU unit and the ED nurse who has cared for her all day contacted the CCU again to ask if Mr. W. was well enough to be moved to the PCU. Mr. W's physician was contracted and orders were provided to move Mr. W to the PCU and arrangements were made to place both Mr. and Mrs. W in the same double bed room. Cohorting patients can be done when both patients have the same infection.

Both patients are still hospitalized as of January 13, 2017, and getting better. The collaboration between ED nurses, CCU nurses, and hospitalists enabled this long married couple be together away from home. The focus of these healthcare providers was 100% on these patients and what was best for them, and was not about how we usually do things at the hospital.

Research Article

Transcranial Magnetic Stimulation (TMS) as a Treatment for Refractory Depression

 womensmentalhealth.org/posts/transcranial-magnetic-stimulationtms-treatment-refractory-depression/

MGH Center for Women's Mental Health

2/27/2014

As many as 30% of people suffering from depression do not respond to antidepressant treatment¹. When treatment options are exhausted psychiatrists often turn to electroconvulsive therapy (ECT). An electric current is used to cause a brief seizure in the brain. Although this is a relatively safe method of treatment, impairments of both cognition and memory are potential side effects².

Transcranial magnetic stimulation or TMS is similar to ECT but uses electromagnetic pulses to generate electrical current in specific regions of the brain that are known to modulate mood. TMS is less likely to cause side effects and has thus been proposed as a possible alternative therapy for those suffering from treatment-resistant depression.

With TMS, an electromagnetic coil, called an “8-coil”, is placed on the scalp and generates a brief but powerful magnetic pulse. This induces a small electrical current which depolarizes neurons in the cortex³. The 8-coil works to a maximum depth of 1.5-2.5 cm. In contrast, deep TMS is applied using an H-coil, which modulates excitability up to a maximum depth of 6cm⁴. Consequently, deep TMS influences not only cortical activity, but also the activity of deeper neuronal circuits.

TMS for Depression

Early TMS studies used single pulse stimulations. A variant of TMS, repetitive transcranial magnetic stimulation (rTMS), utilizes repetitive stimulations at different frequencies to modulate cortical activity². rTMS has been tested as a treatment for various neurological and psychiatric disorders.

Brain circuits thought to be involved in Major Depressive Disorder (MDD) include the prefrontal cortex, cingulate gyrus, amygdala, ventral striatum and medial thalamus⁵. These networks govern executive functioning and mood regulation. According to the imbalance hypothesis of Major Depressive Disorder (MDD), major depression is associated with prefrontal cortex asymmetry with relative hypoactivity in the left dorsolateral prefrontal cortex (DLPFC), along with relative hyperactivity in the right DLPFC⁶. High frequency rTMS stimulation increases cortical excitability, while low frequency stimulation is inhibitory. Thus, rTMS efficacy is linked to either high frequency stimulation of the left DLPFC or low frequency inhibition of the right DLPFC².

Safety of TMS

Unlike ECT, which may impact cognition and memory, there have been reports of *improved* cerebral functioning after high-frequency stimulation with rTMS in normal participants². Furthermore, rTMS, unlike ECT, does not require general anesthesia⁷. The greatest risk associated with rTMS is the risk of seizure. However, this appears to occur infrequently. More common side effects include headache, lightheadedness, tingling or twitching of facial muscles, and scalp irritation at the site of the coil.

Efficacy of TMS as a Treatment for Depression

There has been some debate over the efficacy of rTMS for the treatment of depression. Although there have been numerous studies of rTMS, the lack of procedural standardization makes interpretation of these studies difficult. Furthermore, most of these individual studies are underpowered, thus meta-analytic studies seem to be most informative with regard to assessing the efficacy of rTMS.

A meta-analysis from Couturier and colleagues concluded that rTMS was not an effective treatment⁸. The analysis included only randomized controlled trials, with rTMS application over the left DLPFC. Unfortunately, six studies included in this analysis did not have enough power to detect a difference between sham control and treatment⁹.

Aurre and colleagues¹⁰ reviewed 12 studies for an evaluation of rTMS efficacy in depression. The studies varied in the way rTMS was administered, treatment duration, control condition and patient characteristics and were too diverse for formal meta-analysis. Consequently, results were inconsistent, with an overall clinically insufficient antidepressant effect.

Burt and colleagues analyzed nine open trials and 16 controlled studies¹¹. Their mean effect sizes were 1.37 and .67 respectively. Meta-analysis showed that rTMS has superior outcomes when compared to sham treatment, but the two week course has only a modest clinical effect, indicating that a longer course of rTMS may be necessary for optimal treatment response⁹.

Recent large randomized placebo controlled studies¹²⁻¹⁴ have found that rTMS is more effective than sham stimulation at decreasing MADRS scores.

Limitations of Interpreting rTMS Studies

Most studies seem to suggest that rTMS is a legitimate treatment for depression. However, many have reported initial success at reducing depressive symptoms, but have failed to show the same success two weeks post-treatment². Besides the differences in methodologies and small sample sizes of most rTMS studies, interpretation of the larger placebo controlled trials is complicated by the questionable suitability of the sham coil as the placebo control, since the sensation of the two treatments is significantly different². Furthermore, variability of effect sizes in the studies can reflect the variability of study parameters. So far no study presents clear variables that predict efficacy⁷.

Potential Areas of Future Study

Most studies have focused on left DLPFC stimulation. According to the imbalance hypothesis of MDD, inhibiting the right side by low frequency stimulation can be just as effective⁹. Some open trial studies have shown positive results using this approach (low frequency inhibition of the right DLPFC)¹⁵, in contrast to the mixed results in controlled trials. Bilateral DLPFC stimulation studies have had negative outcomes⁹. Stimulating other brain regions can also be effective. Low frequency stimulation of the right parietal cortex or high frequency stimulation of the cerebellar cortex could be beneficial⁹.

The best way to deliver rTMS is still controversial. Some studies show that treatments of higher intensities are more likely to have positive results¹⁶, but many do not demonstrate this effect⁹. A recent study suggests that stimulation of deep brain structures may be necessary for the maximal efficacy of the rTMS. Levkovitz and colleagues developed an H coil that is able to deliver higher intensity stimulation to deeper brain regions. High intensity H coil stimulation of left DLPFC was more effective than bilateral rTMS stimulation of the DLPFC with lower intensity stimulation⁶. It is possible, however, that the positive effect seen may have been due to the greater brain volume being stimulated rather than deeper brain stimulation.

TMS and Pregnancy

TMS, if effective, would be an ideal treatment for women who develop depressive symptoms during pregnancy in that there would be no exposure to medications. To our knowledge, there has been only one study assessing the [safety and effectiveness of rTMS in pregnant patients with depression](#).

In this study, 30 depressed pregnant patients received rTMS over the left prefrontal cortex for 6 days per week for

3 weeks.¹⁷ All of these women were considered to be “treatment-refractory”, meaning that they had failed to respond to treatment with at least two pharmacologically distinct antidepressants. After 18 sessions of rTMS, the mean HAMD score for the study group decreased from 26.77 \pm 5.58 at baseline to 13.03 \pm 6.93 ($p < 0.001$). After the treatment period, 41.4 % of the study group demonstrated significant mood improvements as indexed by a reduction of more than 50 % on the HAMD score. In addition, 20.7 % attained remission (HAMD score < 8). The treatment was well tolerated, and no significant adverse effects were reported.

This study indicates that rTMS may be a useful treatment option for women with depression during pregnancy. However, more study is required in order to determine which women are likely to benefit from this treatment. Most of the women included in this study had moderate depressive symptoms. Given the preliminary nature of this data, ECT may be a better option for women with more severe or treatment-refractory depressive symptoms and women with suicidality and/or psychotic symptoms.

Summary

Although there is some convincing evidence to indicate that excitation of the left DLPFC with TMS is effective for treating depression, there is not enough clinical and scientific evidence to validate an rTMS specific paradigm at this point². rTMS is potentially a safer alternative to ECT; however, ECT is more widely used because there is not yet consensus regarding the optimal delivery of rTMS. Nor do we know for which populations rTMS is most useful. Further study of rTMS is needed before we can recommend TMS for the treatment of patients with treatment-resistant depression.

Maria Barsky, BS

Snezana Milanovic, MD

References

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ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

Item:	Report on Board Actions Quality Committee January 30, 2017
Responsible party:	Cindy Murphy, Board Liaison
Action requested:	For Information
Background: In FY16, staff 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: 1. Report on November 2016 and January 2017 Board Actions	

November 2016 – January 2017 Board Actions*

1. November 9, 2016 – Hospital Board
 - 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
2. December 6, 2016 – District Board
 - a. Elected Dennis Chiu, Julia Miller and John Zoglin to new terms on the Hospital Board
 - b. Directed an Ad Hoc Committee of the District Board to begin work on recruitment of a Hospital Board member to replace Dr. Neal Cohen who is not seeking reappointment when his current term ends on June 30, 2017.
3. January 4, 2017 – Hospital Board
 - a. Held a closed session study session on strategic priorities
4. January 11, 2017 – Hospital Board
 - a. Approved FY17 Period 3 and 4 Financials
 - b. Reviewed and discussed CEO Position Specification
 - c. Approved Annual Board Self-Assessment Survey Tool
 - d. Appointed Nahid Aliniazei to the El Camino Hospital Foundation Board of Directors
 - e. Appointed Lica Hartman to the Corporate Compliance, Privacy and Internal Audit Committee
 - f. Approved Funding for MV Lab Upgrades, LG Medical Office Building Upgrades and an updated Stryker Laparoscopic Platform

*This list is not meant to be exhaustive, but includes agenda items the Board has 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



El Camino Hospital

THE HOSPITAL OF SILICON VALLEY

Behavioral Health Services
ECH Board Quality Committee
January 30, 2017

Michael Fitzgerald, Exec. Dir.

Evan Garner, MD

Reena Trivedi, MD

Proposed Strategic Focus Areas

FY 2018-2020

- Focus on readiness for occupation of the new Mental Health building: facility, IT, policies/procedures, community education/outreach, hiring, infrastructure
- Focus on optimizing current services to meet the Triple Aim: quality, service, affordability
- Focus on regional collaboration opportunities to improve our system of care and respond to changes in mental health and addiction in our market

Mental Health and Addiction Care: The Road Forward

- *Conceptual Change: Mental health conditions are endemic to the human condition.*
- Population Health Management strategy with linkage to primary care providers for screening and referral to treatment.
- Surveillance and maintenance following discharge
- Goal of gradual integration of payers and providers to reduce service redundancy

Quick Tour of Services:

- Inpatient: beds down to 18 (from 25) due to construction: expands to 36 in new building
- Outpatient:
 - Adult- 7 programs + 1 clinic, 3 sites (2 MV, 1 LG)
 - Adolescent- 5 programs, 2 sites (LG/MV)
 - ~100 pts. some days
- Psychiatric Emergency / Consultation Services (MV)
 - ~126/month in emergency department
 - ~20/month chemical dependency consults
 - ~20/month crisis intervention medical floors

Core Measure Set of Hospital Based Inpatient Psychiatric Services

1. Complete admission screening for violence risk, substance use, psychological trauma history, and patient strengths.
2. Hours of physical restraint use.
3. Hours of seclusion use.
4. Tracking patients discharged on multiple antipsychotic medications to see if there is appropriate justification.

Core Measure Set (Inpatient)

5. Post-discharge continuing care plan created.
E.g. outpatient psychiatrist appointment within seven days of discharge.
6. Post discharge continuing care plan transmitted to next level of care provider upon discharge
7. Tobacco use screen, with treatment offered or provided at discharge.
8. Alcohol use screen, brief intervention offered or provided during treatment and at discharge.

Psychiatric Outpatient Services

- Adult Mood Program Partial Hospitalization Program (PHP)
 - Intensive Outpatient Program (IOP)
- Maternal Outreach Mood Services (MOMS)
 - Intensive Outpatient Program (IOP)
- Electroconvulsive Therapy Service

Youth Outpatient Services

- Middle School (11-13) ASPIRE program
(Mountain View)
- High School (13-18) ASPIRE program
(Mountain View and Los Gatos)
- Transitional Age (18-25) ASPIRE program
(Los Gatos)

Adult Outpatient Services

- Continuing Care Program (CCP) (MV)
 - Focused on psychotic conditions
- Older Adults Transitions Program (OATS) (MV & LG)
 - Focused on depression, anxiety, mood
- Addiction Services Program (evening 6-9 pm)
 - Abstinence based (vs. harm reduction)
- Dual Diagnosis Program (both MH & CD)
 - Daytime intensive program

Adult Outpatient Services

- Adult Mood Program
 - Focus on depression, anxiety in adults
 - Most patients referred from inpatient settings
 - Both Partial Hospitalization and Intensive Outpatient (step-down)
- Maternal Outreach Mood Services (MOMS)
 - Post-Partum Depression/Perinatal Mood

Outcome Measures

ADULT MOOD, CONTINUING CARE, DUAL DIAGNOSIS, ADDICTIONS, INPATIENT ACUTE

MEASUREMENT TOOLS

Effective 2017, BASIS 24 outcome measure for adult programs.

The 24-item Behavior and Symptom Identification Scale, BASIS-24®, is a leading behavioral health assessment tool. The BASIS-24® identifies a wide range of symptoms and problems that occur across the diagnostic spectrum.

Maternal Outreach Mood Disorder Program (MOMS)

MEASUREMENT TOOLS for Outcomes and assessment

Edinburgh Postnatal Depression Scale (EDPS)

Self assessment Symptom Identification (Dhami)

After School Program for Resiliency Education (ASPIRE) MV and LG and Transitional Age Youth (TAY)

MEASUREMENT TOOLS for Outcomes and assessment

BASC 3 implemented FY 2017

PHQ-9A

Older Adult Transition Services (OATS) MV and LG

MEASUREMENT TOOLS

Patient Health Questionnaire (PHQ-9)

Montreal Cognitive Assessment (MOCA)

Inpatient Safety

Measures	FY13	FY14	FY15	FY16
Hours of physical restraint use	92.6 hrs	34.3 hrs	29.42 hrs	58.9 hrs
Hours of seclusion use	11.5 hrs	28.6 hrs	17.57 hrs	9.65 hrs

Electroconvulsive Therapy Service

	Q4 2016	Q3 2016	Q2 2016	Q1 2016	Q4 2015	Q3 2015
# Stimulations	324	365	330	301	219	270
Patient Census	34	34	28	25	30	33
% of patients treated with valid consents	100%	100%	99.7%	100%	100%	100%
# business days from referral to first-offered MD assessment GOAL = <5 days for any patients evaluated **ECT Coordinator on medical leave; no data	3.7	2.4	**	**		2.1
% patients with >50% reduction in MADRS at end of all acute series	70%	100%	67%	62%	60%	50%
% patients in remission on MADRS at end of acute series	40%	73%	-	31%	60%	29%

Behavioral Health Centers of Excellence

January 2016:

Department of Psychiatry appoints psychiatrists to develop Centers of Excellence for specific populations (shown on right)

- Multi-disciplinary team, community engagement with consumers, families, providers
- Determine standards that define a Center of Excellence for a Community Hospital
 - Adopt National Council of Behavioral Health elements for COE
 - Focus on Access, Community Need, Scalability, Best Practices, Innovation, Physician and Workforce Excellence, Value
 - Measurable determination of outcomes
- Reports due to Dept. of Psychiatry by the end of FY16 for approval of COE standards
- Budgetary approval as needed FY2017
- Initiate implementation of standards
- Seek program endowments for each center



Youth & Young Adult
Mental Health



Adult Mood



Perinatal Mental Health
(and other women's focus services)



Thought Disorder



Addiction



Senior Mental Health

Addictions Strategic Vision

Vision

ECH will provide high-quality, affordable and accessible addiction treatment for residents of the Silicon Valley. Services will provide evidence-based, innovative treatment approaches that engages individuals where they are in the recovery process. Families, employers and other health care providers will be included to ensure support structures are in place to reduce risk of relapse.

Goals

FY16

1. Continued to identify service gaps and best practice
2. Successful marketing strategy
3. Workforce development expansion

FY17

1. Begin Development of an Addictions Service COE
2. Expand ECH's outpatient addiction services
3. Continue volume expansion

FY18

1. Institute seamless referral processes between primary care and BHS
2. Continue development of service along continuum as gaps become apparent and best practice is translated into program components

Actions

FY16

- Identify Center of Excellence standards for Addictions programs, approved through Dept. of Psy.
- Develop coordinated alcohol detox service with ER
- Identify and implement best practices in access to addiction services (reduce delay in treatment initiation)
- Contract discussions with county for Medi-Cal patients
- Design and initiate marketing strategy
- Initiate discussions with Hazelden/Betty Ford

FY17

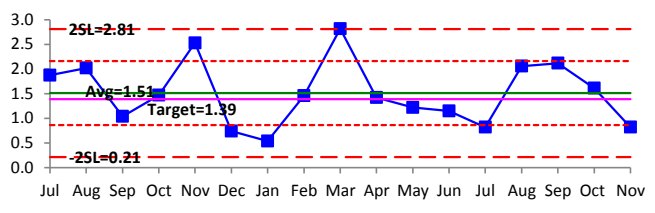
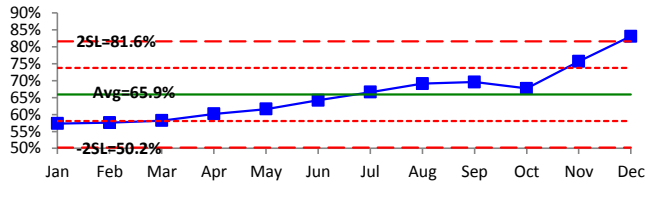
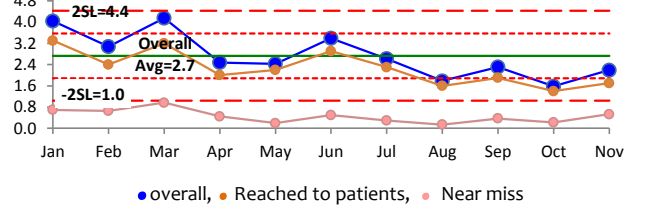
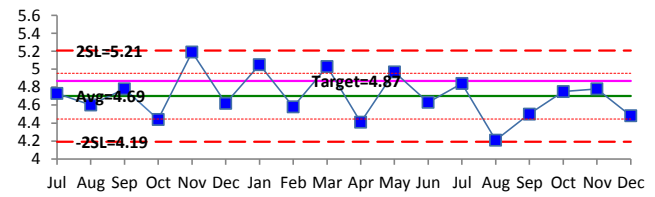
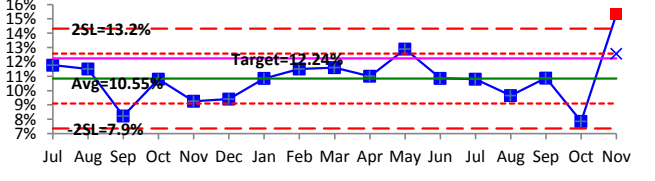
- Identify and implement effective physician services across the continuum at ECH.
- Initiate implementation of COE standards
- Engage in strategic discussions with residential care providers to expand continuum of services in addictions

FY18

- Direct referral process from primary care to ECH addiction services
- ECH will explore expansion of addiction services to day programs
- Explore day services program

ATTACHMENT 7

Quality and Safety Dashboard (Monthly)

Date Reports Run: 1/6/2017				Baseline	FY17 Goal	Trend	Comments
SAFETY EVENTS		Performance		FY2016	FY2017		
1	Patient Falls Med / Surg / CC Falls / 1,000 CALNOC Pt Days Date Period: November 2016	4/4882	0.82	1.51	1.39 (goal for FY 16)		Team focus on bed/chair alarms and accompanying pts. to & in BR. Decrease may be a function of increased census in November
	Pain reassessment within 60 mins after pain med administration Errors / 1000 Adj Total Patient Days Date Period: December 2016	7777/9359	83.1%	56.3% (Jan-Jun 2016)	75% (min) 80% (mid) stretch goal=90%		New report built in ICARE to capture reassessment data, with weekly team focus on results by department. Recognition for units achieving 99-100% compliance daily.
	Medication Errors (Overall: reached to patients and near miss) Errors / 1000 Adj Total Patient Days Date Period: November 2016	29/13269	2.19	2.68	0.00		Decreases in 2016 due to correction of ICARE issues, and a focus on med errors in 3 groups meeting each month.
EFFICIENCY		Performance		Jan-Jun 2016 (6-month avg)	FY 2017		
4	★Organizational Goal Average Length of Stay (days) (Medicare definition, MS-CC, ≥ 65, inpatient) Date Period: December 2016	FYTD 2446 01-06/16 2509	FYTD 4.58 01-06/16 4.78	4.78	4.87		
	★Organizational Goal 30-Day Readmission (Rate, LOS-Focused) (ALOS-Linked, All-Cause, Unplanned) Date Period: November 2016	FYTD 212/1934 01-06/16 288/2497	FYTD 10.96 01-06/16 11.53	11.53	At or below 12.24		60/384 – 15.32% Spike of readmissions in November due to increase in Pneumonia/Resp.failure to 41% of the readmits over Oct. @ 29%. Unavoidable readmits up to 64%, highest % in 2016. 12% of these readmits were due to medication management., which can be subjective physician practice. Use of ID MD & ID pharmacist consults encouraged.

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		<p>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”.</p>		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 Rout, 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
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; Cheryle 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

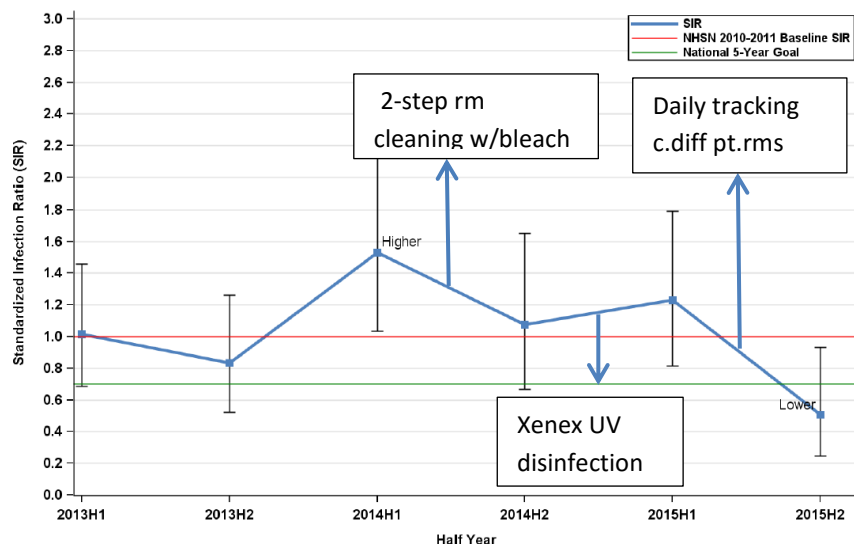
Date Reports Run: 1/6/2017				Baseline	FY17 Goal	Trend	Comments
COMPLICATIONS		Performance		FY 2016	FY 2017		
6	Surgical Site Infection (SSI) SSI per 100 Surgical Procedures Date Period: November 2016	2/639	0.31	0.20	0.18 (goal for FY 16)		Increase Oct & Nov: Oct 2 cases: 1 Colon due to abscess after expl. Lap for re-do of colon anastomosis, 1- Exp Lap with repair of hernia w/necrotic abd. Wound Nov 2 cases: 1 Colon w/ resection and tumor debulking, developed abscess & perforated bowel. SSI Task Force initiated at LG
SERVICE		Performance		FY 2016	FY 2017		
7	Communication with Nurses (HCAHPS composite score, top box) Date Period: Oct 2016	213/256	83.2%	78.0%	78.5%		HCAHPS is a lagging indicator, and increase due to improvement in pain reassessment noted in item #2. Improvement coincides with work of Medication error task force and reduction in med errors that began in July in item #3.
8	Responsiveness of Hospital Staff (HCAHPS composite score, top box) Date Period: Oct 2016	154/240	64.0%	64.9%	66.8%		
9	Pain management (HCAHPS composite score, top box) Date Period: Oct 2016		76.0%	72.5%			
10	Communication About Medicines (HCAHPS composite score, top box) Date Period: Oct 2016	115/165	69.6%	64.7%	68.3%		

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
Surgical Site Infection	Catherine Nalesnik; 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
Nov 2 cases: 1 Colon w/ resection and tumor debulking, developed abscess & perforated bowel.					
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	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
Pain management	Chris Tarver, Meena Ramchandani	Patient Experience Committee	Percent of inpatients responding "Always" to the following 2 questions [% Top Box]: 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	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

ATTACHMENT 8

The CDPH HAI Program offers assistance to hospitals with high HAI incidence

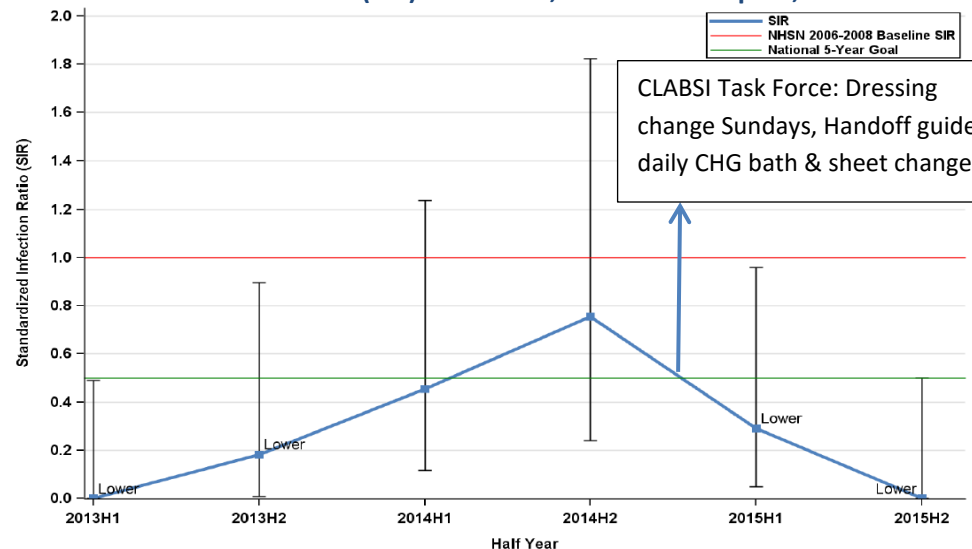
Standardized Infection Ratios (SIR) for CDI, El Camino Hospital, 2013-2015



CDI SIRs are risk-adjusted to account for CDI test type, medical school affiliation, facility bedsize, and admission CDI prevalence rate

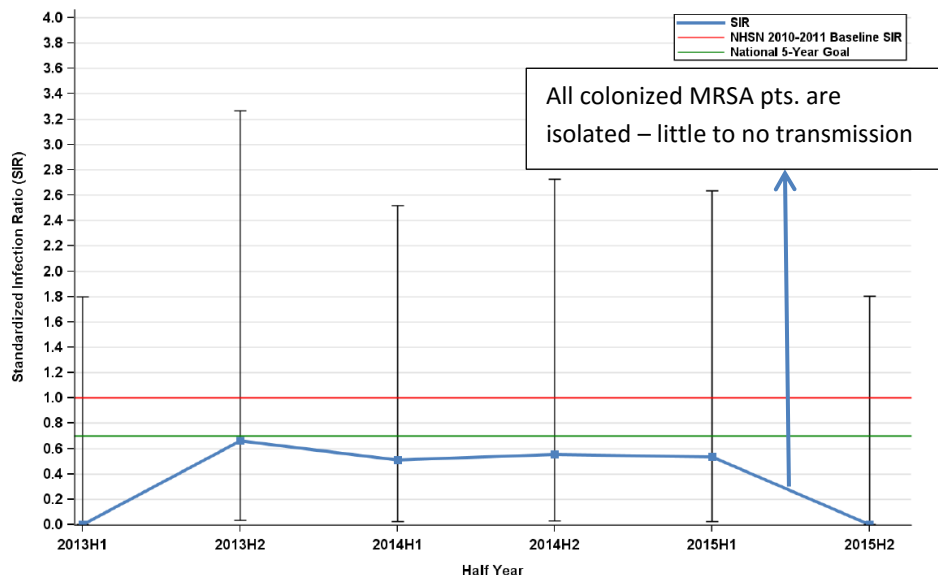
2015 Data Downloaded as March 1, 2016. 2013 and 2014 Data downloaded as of January 14, 2016

Standardized Infection Ratios (SIR) for CLABSI, El Camino Hospital, 2013-2015



CLABSI SIRs are risk-adjusted to account for patient care location type. 2015, 2014, and 2013 Data Downloaded as March 1, 2016.

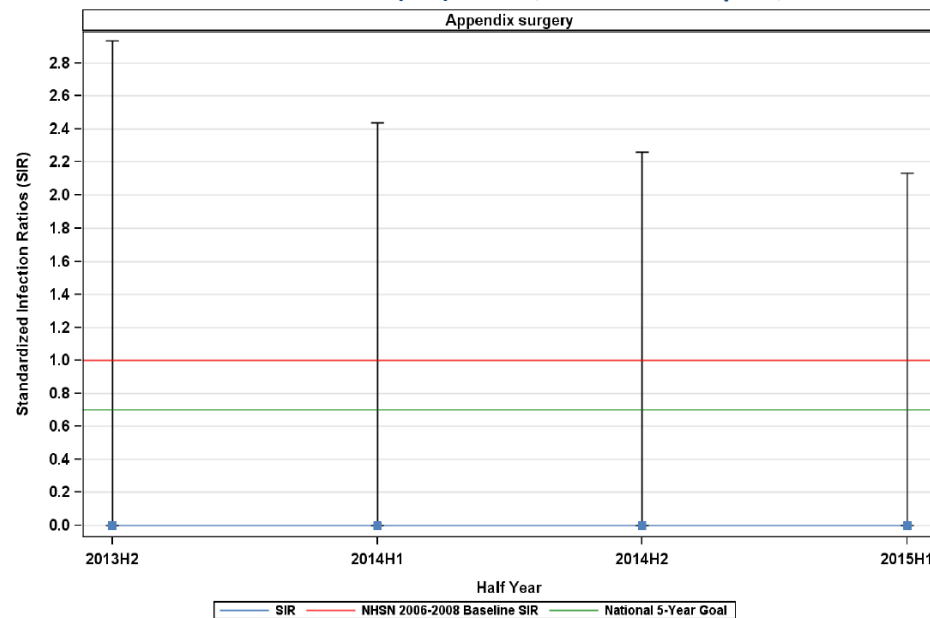
Standardized Infection Ratios (SIR) for MRSA BSI, El Camino Hospital, 2013-2015



MRSA SIRs are risk-adjusted to account for medical school affiliation, facility bedsize, and admission MRSA bacteremia prevalence rate.

2015, 2014, and 2013 Data 2015 Data Downloaded March 1, 2016; 2014 and 2013 Data Downloaded November 27, 2016

Standardized Infection Ratios (SIR) for SSI, El Camino Hospital, 2013-2015



Data Reported as of September 21, 2016.

Standardized Infection Ratios (SIR) for SSI, El Camino Hospital, 2013-2015

Data Reported as of September 21, 2016.

