El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Monday, February 27, 2017 **5:30 pm**
El Camino Hospital | Conference Rooms A&B
2500 Grant Road, Mountain View, CA 94040

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		ESTIMATED TIMES
1.	**CALL TO ORDER**	David Reeder, Chair, Quality Committee		**5:30 – 5:31 pm**
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. ***Approval*** a. Minutes of Quality Committee Meeting - January 30, 2017 ***Information*** b. Pacing Plan c. Patient Story d. Article of Interest	David Reeder, Chair, Quality Committee	*public comment*	**motion required 5:33 – 5:36**
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	David Reeder, Chair, Quality Committee		**discussion 5:36 – 5:39**
6.	**QUALITY PROGRAM UPDATE: INTERVENTIONAL PULMONOLOGY** **ATTACHMENT 6**	Ganesh Krishna, MD		**discussion 5:39 – 5:54**
7.	**PROPOSED FY18 QUALITY COMMITTEE GOAL** **ATTACHMENT 7**	William Faber, MD, Chief Medical Officer		**discussion 5:54 – 6:04**
8.	**FY17 QUALITY REPORT** a. Dashboard b. Sepsis Update c. CMS Hospital Compare Star Report	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**discussion 6:04 – 6:19**
9.	**GREELEY UPDATE** **ATTACHMENT 9**	Dave Francisco, MD, Chairman, Greeley Committee		**discussion 6:19 – 6:34**
10.	**PUBLIC COMMUNICATION**	David Reeder, Chair, Quality Committee		**information 6:34 – 6:37**

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	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
11.	**ADJOURN TO CLOSED SESSION**			**motion required 6:37– 6:38**
12.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair, Quality Committee		**6:38 – 6:39**
13.	**CONSENT CALENDAR** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair, Quality Committee		**motion required 6:39 – 6:42**
	Approval *Gov't Code Section 54957.2.* Meeting Minutes of the Closed Session - January 30, 2017 ***Information*** Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Meeting Minutes of Quality Council - January 4, 2017			
14.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155:* - CMO Report	William Faber, MD, Chief Medical Officer		**discussion 6:42 – 6:52**
15.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155:* - Red and Orange Alert	Shreyas Mallur, MD, Associate Chief Medical Officer		**discussion 6:52 – 7:12**
16.	**ADJOURN TO OPEN SESSION**	David Reeder, Chair, Quality Committee		**7:12 – 7:13**
17.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Chair, Quality Committee		**7:13 – 7:14**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
18.	**ADJOURNMENT**	David Reeder, Chair, Quality Committee		**7:14 – 7:15 pm**

Upcoming FY 17 Quality Committee Meetings

- April 3, 2017
- May 1, 2017
- June 5, 2017

a. Minutes of Quality Committee Meeting - January 30, 2017

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, January 30, 2017
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	**Members Absent**	**Members Excused**
Dave Reeder; Peter Fung, MD; Diana Russell, RN; Wendy Ron, Melora Simon, Mikele Bunce, *Katie Anderson, and *Jeffrey Davis, MD.	Jeffrey Davis, MD: Robert Pinsker, MD; Nancy Carragee, And Alex Tsao.	None

**Katie Anderson joined the meeting @ 5:45pm.*
**Jeffrey Davis, MD joined the meeting @ 6:52pm.*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 30th day of January, 2017 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 5:35p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted. **Motion:** To approve the consent calendar (Open Minutes of the December 5, 2016 meeting were approved). **Movant:** Fung **Second:** Simon **Ayes:** Reeder, Ron, Russell, Bunce, Fung, and Simon. **Noes:** None **Abstentions:** None **Absent:** Davis, Anderson, Carragee, Pinsker, and Tsao. **Excused:** None **Recused:** None	***The Open Minutes of the December 5, 2016 meeting were approved.***

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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 briefly highlighted the Board's current priorities to include: • CEO Search with the Russell Reynolds Firm • New Board Member Search with Witt Kieffer Firm • Construction Update	***None***
6. QUALITY PROGRAM UPDATE: BEHAVIORAL HEALTH SERVICES	Michael Fitzgerald, Executive Director of Behavioral Services, and Dr. Reena Trivedi highlighted the clinical and quality programs of Behavioral Health Services. Dr. Trivedi reviewed the FY18-20 Proposed Strategic Focus Areas, Current Services, as well as the Core and Outcome measures for these services, as further detailed in the packet. Mr. Fitzgerald highlighted that unlike other Behavioral Health programs, we have a Physician Expert that leads each service offering - e.g. Mood Disorder, Addictions, Adolescent Psych Services, Maternal Psych Services, etc. He further detailed BHS's current vision, goals, and action plans for FY16-18. Mr. Fitzgerald asked the Committee for questions or feedback and a brief discussion ensued. Item of discussion included Electroconvulsive Therapy Service. **Katie Anderson joined the meeting @ 5:45pm.*	***None***
7. FY17 QUALITY DASHBOARD	Catherine Carson, Senior Director of Patient Safety and Quality Assurance presented the FY17 Quality Dashboard to the Committee with the addition of annotations of initiatives in correlation with improvements. She reported that nine metrics remain stable; the only exception being a spike in Readmissions rate in November, possibly due to increase in respiratory illness. Ms. Carson asked for feedback and questions from the Committee and a brief discussion ensued. **The Committee requested the addition of the goal to item 9.*	***None***
8. QUARTERLY QUALITY REPORT	Catherine Carson, Senior Director of Patient Safety and Quality Assurance presented the California Department of Public Health's Hospital Infection Report comparing ECH to other hospitals in the area.	***None***

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Agenda Item	Comments/Discussion	Approvals/Action
	Ms. Carson reported data on our standardized infection ratios for CDI, CLABSI, MRSA BSI, and Surgical Site Infections as further detailed in the packet. She further noted the initiatives in correlation with improvements. Ms. Carson reported that future Quarterly Quality Dashboards will continue to capture ECH global quality status rather than focusing exclusively on exceptions.	
9. PUBLIC COMMUNICATION	None	***None***
10. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:44 p.m. **Movant:** Fung **Second:** Anderson **Ayes:** Anderson, Reeder, Ron, Russell, Bunce, Fung, and Simon. **Noes:** None **Abstentions:** None **Absent:** Davis, Carragee, Pinsker, and Tsao. **Excused:** None **Recused:** None	***A motion to adjourn to closed session at 6:44 p.m. was approved.***
11. AGENDA ITEM 15 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 11 – 14 were reported in closed session.* Chair Reeder reported that Closed minutes of the December 5th, 2016 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.	***None***
12. AGENDA ITEM 16 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:13p.m.	***None***

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

_____

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

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Pacing Plan

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

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

QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

PROPOSED FY2017 PACING PLAN

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

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Patient Story

Patient Story
Quality Committee Meeting
February 27, 2017

Dear Nurses of ICU,

My mother was a patient here at the end of September 2016, and had been a patient here several times this past year. I know that she was not the easiest of patients, and she was also not the easiest mother; and in turn, I was not the best daughter to her. She was not supposed to survive this last stay, but with the care you all gave her, she did survive. After this hospital stay, she agreed it was time to go home and begin hospice. I spent the next 2 weeks with her, and was able to repair much of our relationship. I also got to have some extra laughs with her.

She passed away Sunday morning on the 23rd of October. I would not have been able to have this time with her if it wasn't for the care, patience and laughter you all gave her. It was a true blessing. The value of your work is immeasurable, and I thank you from the bottom of my heart.

Sincerely,
The daughter of a patient

Article of Interest

Article Link: http://www.webmd.com/lung/interventional-pulmonology-uses-effects

Lung Disease & Respiratory Health Center

Interventional Pulmonology

In this article

Interventional pulmonology is a relatively new field in pulmonary medicine. Interventional pulmonology uses endoscopy and other tools to diagnose and treat conditions in the lungs and chest.

These procedures may be offered by pulmonologists (lung specialists) who have undergone extra training Cardiothoracic and other surgeons also routinely perform interventional pulmonology procedures.

Interventional Pulmonology Procedures

Procedures for interventional pulmonolgy include:

Flexible bronchoscopy. Bronchoscopy is the most common interventional pulmonology procedure. Durin bronchoscopy, a doctor advances a flexible endoscope (bronchoscope) through a person's mouth or nose into the windpipe. The doctor advances the bronchoscope through the airways in each lung, checking for problems. Images from inside the lung are displayed on a video screen.

The bronchoscope has a channel at its tip, through which a doctor can pass small tools. Using these tools, the doctor can perform several other interventional pulmonology procedures.

Bronchoalveolar lavage. Bronchoalveolar lavage is performed during bronchoscopy. Sterile water is injected through the bronchoscope into a segment of the lung. The fluid is then suctioned back and sent fc tests. Bronchoalveolar lavage can help diagnose infection, cancer, bleeding, and other conditions.

Biopsy of lung or lymph node. During bronchoscopy, a doctor may collect a small piece of tissue from eith the lung or a nearby lymph node. The interventional pulmonologist can use a needle or forceps advanced through the bronchoscope to get a sample of tissue. Biopsies can detect cancer, infection, sarcoidosis, and other conditions.

For people with lung cancer or other cancers, interventional pulmonology biopsies can often accurately identify spread of cancer into lymph nodes. This can prevent unnecessary surgery or help determine the best choice for treatment.

Airway stent (bronchial stent). Advanced cancer or certain other conditions can constrict or compress an airway tube (bronchus). If the bronchus becomes blocked, difficulty breathing, cough, and pneumonia can result.

Using a bronchoscope, a doctor can advance a wire mesh stent into a narrowed airway. Expanding the ste can open a bronchus and relieve symptoms caused by the constriction.

Balloon bronchoplasty. A doctor advances a deflated balloon into a section of abnormally narrowed airw By inflating the balloon with water, the airway is expanded, potentially relieving symptoms. Balloon bronchoplasty may be performed prior to airway stent placement to help expand a bronchus.

Interventional Pulmonology Procedures continued...

Rigid bronchoscopy. In rigid bronchoscopy, a long metal tube (rigid bronchoscope) is advanced into a person's windpipe and main airways. The rigid bronchoscope's large diameter allows the doctor to use mo sophisticated surgical tools and techniques. Rigid bronchoscopy requires general anesthesia (unconsciousness with assisted breathing), similar to a surgical procedure.

Foreign body removal. Bronchoscopy is the preferred interventional pulmonology procedure to remove inhaled foreign objects that are lodged in an airway. A doctor may be able to remove the object using flexible bronchoscopy, or rigid bronchoscopy may be required.

Pleuroscopy. A doctor cuts small incisions in the chest wall and advances a pleuroscope (a type of endoscope) into the chest cavity. The pleuroscope is advanced around the chest wall and lung on one side. Pleuroscopy can diagnose some conditions of the pleura (lining of the lung). Pleuroscopy also allows a viev of the outside edges of the lung, which bronchoscopy cannot provide.

Thoracentesis. To drain fluid from around the lungs (pleural effusion), a doctor inserts a needle into the chest wall. A plastic catheter is advanced over the needle, which is then removed. The excess pleural fluid suctioned out of the chest and the catheter is removed and discarded.

Pleurodesis. Pleurodesis is an interventional pulmonology procedure performed for people with recurrin pleural effusions (fluid around the lungs). In pleurodesis, a doctor makes an incision in the chest wall. A plastic tube is inserted into the chest cavity, and an irritating chemical is sprayed around the lung. Over time, the inflamed lung lining (pleura) adheres tightly to the chest wall. This prevents fluid from reaccumulating around the lung.

Indwelling pleural catheter. A pleural catheter is an alternative to pleurodesis for treatment of a recurrer pleural effusion. Through minor surgery, a plastic catheter is tunneled beneath the skin, with its tip placed inside the chest cavity. As pleural fluid accumulates around the lung, a person can drain the indwelling pleural catheter at home, using special sterile supplies.

Bronchoscopic thermoplasty. Thermoplasty is an interventional pulmonology procedure for certain peop with severe asthma that can't be controlled with medications. During bronchoscopy, a doctor applies a he

probe to the walls of the airways. The heat destroys the smooth muscle layers whose constriction contributes to asthma symptoms.

Interventional Pulmonary Diagnostics

Interventional pulmonology procedures offer the potential advantage of avoiding more invasive surgery. For example, before interventional pulmonology, biopsy of lymph nodes in the chest required chest wall surgery.

Two recent advances in technology are extending the reach of interventional pulmonology procedures:

- Endobronchial ultrasound system (EBUS): An ultrasound probe on the tip of a bronchoscope allows a doctor to biopsy lymph nodes with more precision. In experienced hands, EBUS increases the likelihoo of a correct diagnosis significantly.
- Electromagnetic navigation bronchoscopy (superDimension): An advanced system that guides the bronchoscope farther than traditional bronchoscopy allows. This system permits biopsy of hard-to-reach abnormal areas of the lung, which would otherwise require more invasive testing.

Interventional Pulmonology Risks and Limitations

Although interventional pulmonology procedures carry low risks, they are not risk-free. Uncommon complications of interventional pulmonology procedures include:

- Pneumothorax (collapsed lung)
- Bleeding
- Oversedation, leading to pneumonia or the need for temporary life support

Interventional pulmonology procedures are generally safer and have a shorter recovery time, compared t surgery. However, surgery remains the best option for diagnosis and treatment of many lung conditions.

WebMD Medical Reference
SOURCES:
Mason, R. *Murray and Nadel's Textbook of Respiratory Medicine*, 5th edition, Saunders, 2010.
Kennedy. M.P. *Seminars in Respiratory Critical Care Medicine*, 2008; vol 29: pp 453-464.
Yoneda, K.Y. *Clinical Lung Cancer*, 2007; vol 8: pp 535-547.
Haas, A.R. *Chest*, 2007; vol 132: pp 1036-1041.
Folch, E. *Seminars in Respiratory Critical Care Medicine*, 2008; vol 29: pp 441-452.

Reviewed by William Blahd, MD on November 22, 2015
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Top Picks

Green Mucus: Does That Mean You Need an Antibiotic?

5 Common Lung Cancer Tests

ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Quality, Patient Care and patient Experience Committee February 27, 2017
	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: 1. Report on February 2017 Board Actions	

February 2017 Board Actions*

1. February 8, 2017 – Hospital Board
    a. Approved Extension of MOU with SEIU/UHW – 3% across the board increases for two years and market adjustments for 12 difficult to recruit for positions.
    b. Approved FY17 Period 6 Financials.
    c. Approved funding of $400,000 from the Board-Designated Community Benefit Fund in FY18 and no changes to the endowment principal.
    d. Approved amendment to contract with Stanford to provide PT and OT services in the NICU.
    e. Approved 2 policies: Board of Director Approval of Policies and Policy and Procedure Formulation, Approval, and Distribution (Policy on Policies).
    f. Approved Orthopedic Co-Management Agreement.
    g. Approved funding for replacement of 28 Ventilators.

2. February 15, 2017 – Hospital Board
    a. Closed session study session on strategic priorities.

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

This document will be made available when ready

ATTACHMENT 7

Quality, Patient Care and Patient Experience Committee
Goals for FY 2018 - PROPOSED

Purpose

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

Staff: Will Faber, MD, Chief Medical Officer

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

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care, and Patient Experience Committee.	▪ Q1 – Goals ▪ Q3 - Metrics	▪ Review, complete, and provide feedback given to management, the governance committee, and the board.
2. Alternately review peer review process and medical staff credentialing process. Monitor & Follow through on the recommendations made through the Greeley peer review process	▪ Every other year	

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Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
3. Develop a plan to review the new Quality, Patient Care, and Patient Experience Committee Dashboard and ensure operational improvements are being made to respond to outliers.	▪ Q3	
4. Oversee recruitment of a leader, development of a plan with specific tactics, and monitor the HCAHPs scores for Patient and Family Centered Care.	▪ Q2	▪ Review the plan and approve.
5. Monitor the impact of the Culture of Safety Campaign with QRR reporting as an improvement metric.		

Submitted by:
Dave Reeder, Chair, Quality Committee
Will Faber, MD, Executive Sponsor, Quality Committee

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

Purpose

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

Staff: Chief Medical Officer

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Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
1. Review the hospital's organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to the Quality, Patient Care, and Patient Experience Committee.	▪ Q1 – Goals ▪ Q3 - Metrics	▪ Review, complete, and provide feedback given to management, the governance committee, and the board.
2. Biannually review peer review process and medical staff credentialing process.	▪ Every other year	
3. Develop a plan to review exceptions for goals that are being monitored by the management team and report those exceptions to the El Camino board of directors.	▪ Q3	

Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
4. Review and oversee a plan to ensure the safety of the medication delivery process. The plan should include a global assessment of adverse events and it should include optimizations to the medication safety process using the new iCare tool.	▪ Q2	Review the plan and approve.
5. Further investigate Patient and Family Centered Care and develop an implementation plan.	▪ Q2	Review the plan and approve.

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

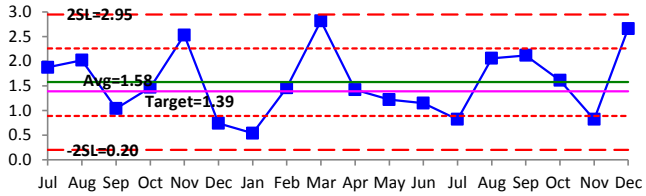
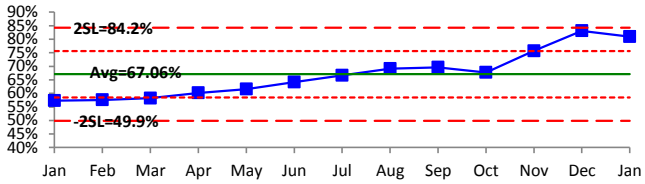
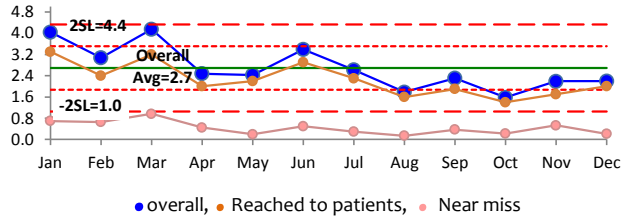
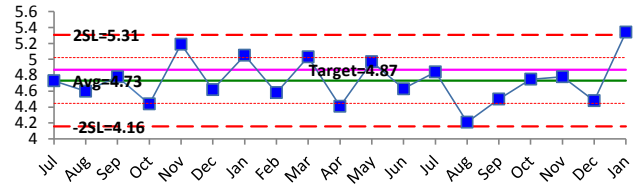
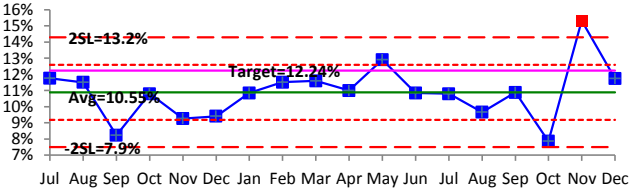
Approved by the Board of Directors June 8, 2016

Dashboard

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

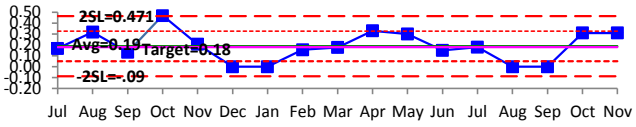
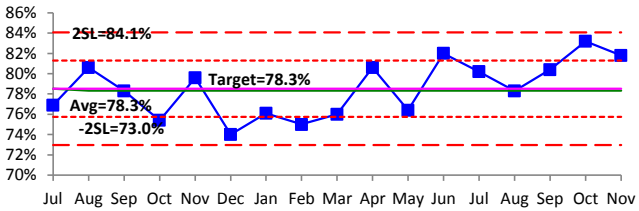
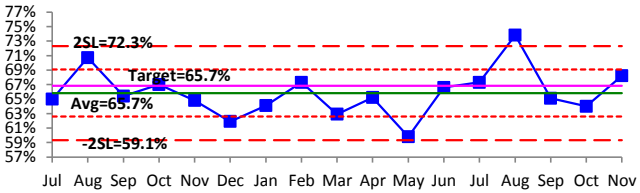
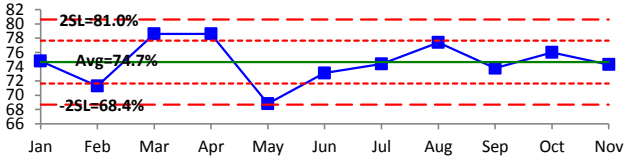
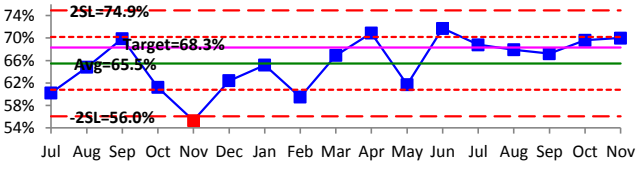
Quality and Safety Dashboard (Monthly)

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: December 2016*	15/5631	2.66	1.51	1.39 (goal for FY 16)		Of the 15 falls in December, 2 were assisted, with 1 slight injury (elbow abrasion). 7 falls related to policy lapses; no bed alarm, wrong alarm zone, left alone in BR. Message to Mgrs/staff: Engage bed/chair alarms always; set bed alarm zone correctly; never leave the patient alone in the bathroom; use "rescue" equipment such as Fall Prevention Chair; and use visual monitoring, PSA when available. Falls Team is reviewing Fall Risk Assessment in use.
2	★Organizational Goal **Pain reassessment within 60 mins after pain med administration** *Errors / 1000 Adj Total Patient Days*	8172/10107	80.9%	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. Nursing Mgrs. Taught how to run these reports in January.
3	**Medication Errors (Overall: reached to patients and near miss)** *Errors / 1000 Adj Total Patient Days* *Date Period: December 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. Rate is stabilizing.
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: January 2017*	FYTD 2767 Jan 2017 318	FYTD 4.67 Jan 2017 5.34	4.78	4.87		January increase in LOS due to severe flu season w/88 flu admissions of which many with underlying disease developed organ failure. In addition, many of these refused palliative care and have long lengths of stay.
5	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: December 2016*	FYTD 270/2411 Dec 2016 56/477	FYTD 11.20 Dec 2016 11.74	11.53	At or below 12.24		In December, the readmission rate returned below the goal and close to the average rate.

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	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients experience an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment, including bedside mat). All falls are reported and described by level of injury or no injury, and circumstances (observed, assisted, restrained at the time of the fall). Include Assisted Falls (when staff attempts to minimize the impact of the fall, it is still a fall). *Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.*		**QRR Reporting and Staff Validation**
Pain Reassessement 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	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 *Near miss and reached patients.*		**QRR Reporting and Staff Validation**
Average Length of Stay	Cheryle Reinking; Mick Zdeblick	LOS Steering Committee	Average LOS of Medicare FFS, Paitents discharged from an Acute Care or Intensive Care unit. Excludes expired patients. Includes final coded patients aged 65 an older at the time of the encounter. The baseline period is from Jan-June 2015 and the performance period is from Jan-June 2016.		**EDW Data Pull, Department of Clinical Effectiveness**
30-Day Readmission (LOS-Focused)	Margaret Wilmer; Cheryle Reinking	Readmission Committee	Percent of Medicare inpatient discharges return for an unplanned IP stay for any reason within 30 days, aged ≥65. Excludes patients who die, leave AMA or are transferred to another acute care facility; excludes admits to ECH Rehab and Psych admissions and for medical treatment of cancer.		**EDW Data Pull, Department of Clinical Effectiveness**

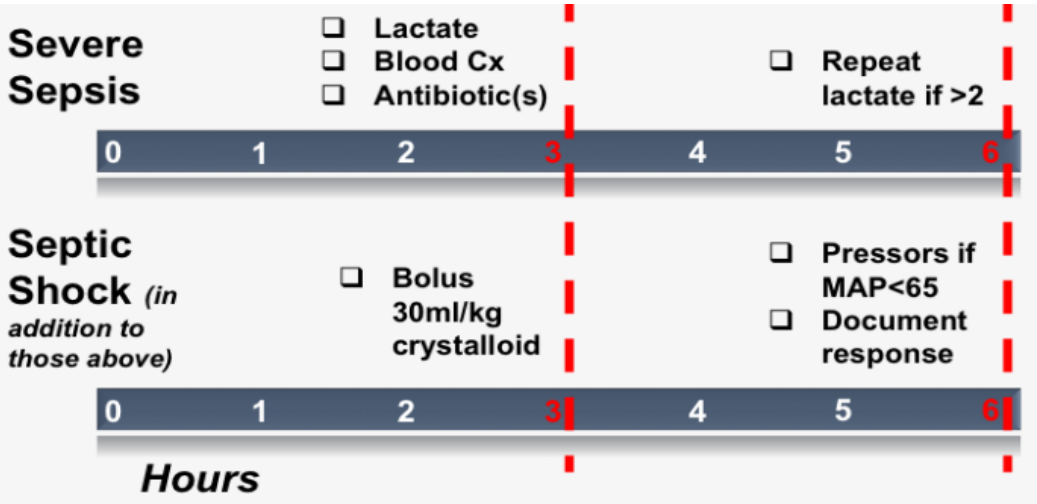
Date Reports Run: 1/6/2017			Baseline	FY17 Goal	Trend	Comments
COMPLICATIONS	Performance		FY 2016	FY 2017		
6 **Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: November 2016*	2/639	0.31	0.20	0.18 (goal for FY 16)		November: 2 cases: 1 Colon w/ resection and tumor debulking, developed abscess & perforated bowel. 1 Exp.Lag w/hernia repair, developed necrotic abd. Wound.
SERVICE	Performance		FY 2016	FY 2017		
7 **Communication with Nurses** *(HCAHPS composite score, top box)* *Date Period: Nov 2016*	187/228	81.8%	78.0%	78.5%		Trending up over last 4 months, may be related to increased communication by nurses regarding pain reassessment.
8 **Responsiveness of Hospital Staff** *(HCAHPS composite score, top box)* *Date Period: Nov 2016*	137/201	68.2%	64.9%	66.8%		Turnover in Pt.Experience Dept may have impacted this, team distracted with increased responsibility and maynot have been as responsive as in past.
9 ★Organizational Goal **Pain management** (HCAHPS composite score, top box) *Date Period: Nov 2016*	129/174	76.0%	72.5%	73% min 74% max 76% stretch		Lean A3 efforts to improve Pain Reassessment as well as new pain education brochures were implemented in November related to improved results.
10 **Communication About Medicines** *(HCAHPS composite score, top box)* *Date Period: Nov 2016*	93/133	70.0%	64.7%	68.3%		Results beginning to trend up, Pain Reassessment efforts should impact this measure, becoming stable.

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**

Sepsis Update

CMS Sepsis Core Measure: SEP-1

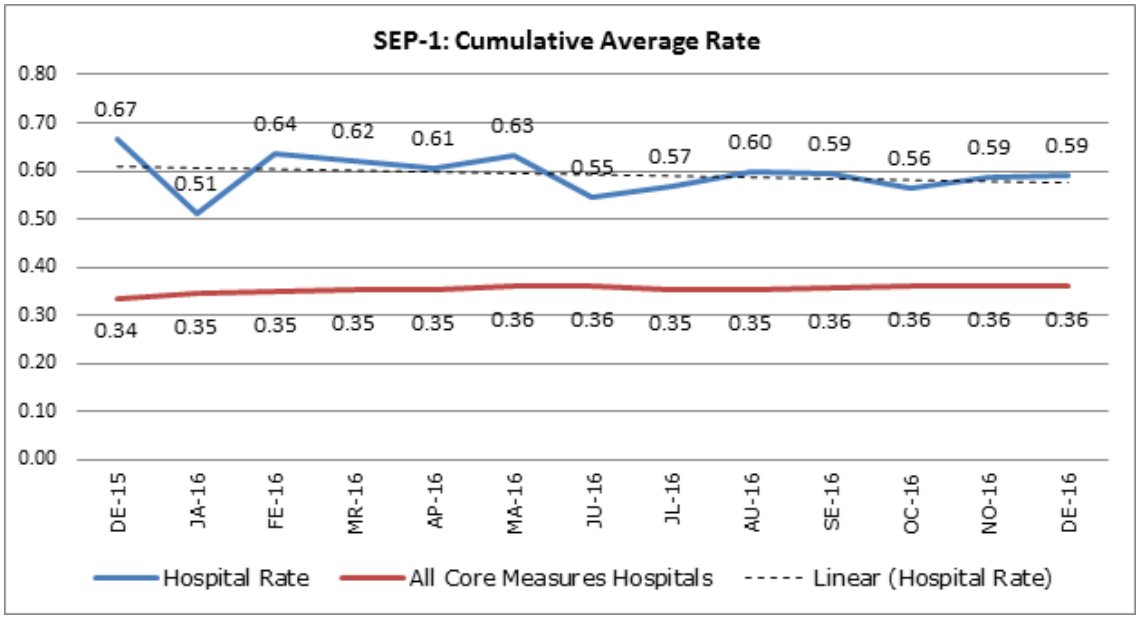
The Sepsis Core Measure involves minimum sets of actions required by 3-hour and 6-hour time points after a patient reaches severe sepsis or septic shock (figure).



December results:

Indicator	Indicator Description	Denominator Count	Measure Failure Case Count	% of Measure Failure Cases	Measure Success Case Count	% of Measure Success Cases
SEP-1	Early Management Bundle	16	9	56.25%	7	43.75%

December 2015 - December 2016



CMS Hospital Compare Star Report

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	CMS Hospital Compare Report Quality Committee Meeting Date: February 27, 2016
	Responsible party:	Catherine Carson, Sr. Director/Chief Quality Officer
	Action requested:	For Information
	Background: CMS advises patients through public reporting to use the Hospital Compare overall ranking to compare a hospital to others locally and nationwide. This overall rating summarizes up to 57 quality measures reflecting common conditions that hospitals treat and ranges from one to five stars. The common rating is 3 stars nationwide. This is the second release of this new statistical model using seven groups of measures: mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.	
	Other Board Advisory Committees that reviewed the issue and recommendation, if any: None.	
	Summary and session objectives : • Provide second Hospital Compare Star Rating for El Camino Hospital • Demonstrate ECH rating compared to 11 local hospitals	
	Report Summary: • El Camino Hospital has received a 4 Star rating with this report through December 2016 discharges • Of local hospitals, only Stanford Health Care and Sequoia Hospitals received 4 Stars, ○ Santa Clara Valley Medical Center – 2 Stars ○ Good Samaritan Hospital – 2 Stars ○ Regional Medical Center of San Jose = 2 Stars ○ O'Connor Hospital – 2 Stars ○ Kaiser Santa Clara – 3 Stars ○ San Mateo Medical Center – 3 Stars ○ Kaiser Foundation Fremont – 3 Stars ○ Kaiser Foundation San Jose – 3 Stars ○ Kaiser Foundation Redwood City – 3 Stars	
	Proposed Committee motion, if any: None.	
	LIST OF ATTACHMENTS: CMS Hospital Compare Report: Improving Care Through Information: Inpatient	

Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Structural Measures: First Quarter 2015 through Fourth Quarter 2015 Discharges

Reporting Period for Clinical Process Measures: Third Quarter 2015 through Second Quarter 2016 Discharges

050308 - EL CAMINO HOSPITAL

Address: 2500 GRANT ROAD
City, State, ZIP: MOUNTAIN VIEW, CA 94040
Phone Number: (650) 940-7000
County Name: SANTA CLARA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

Overall Hospital Quality Star Rating

Your Hospital's Overall Star Rating	4	
Your Hospital's Summary Score	0.67	

Overall Hospital Quality Star Rating Group Scores

Group	Number of Measures	Weight	Group Score	National Average Group Score	Performance Category
Mortality	7	22	0.24	0.00	Same as the national average
Safety of care	8	22	1.03	-0.03	Above the national average
Readmission	8	22	1.70	-0.04	Above the national average
Patient experience	11	22	0.08	-0.12	Same as the national average
Effectiveness of care	10	4	-0.39	0.00	Same as the national average
Timeliness of care	5	4	-0.23	0.05	Same as the national average
Efficient use of medical imaging	3	4	0.46	0.01	Same as the national average

Structural Measures (SM)

SM-3	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Yes
SM-4	Participation in a Systematic Clinical Database Registry for General Surgery	Yes
SM-5	Safe Surgery Checklist Use	Yes

Footnote Legend

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2 . Data submitted were based on a sample of cases/patients.
3 . Results are based on a shorter time period than required.
4 . Data suppressed by CMS for one or more quarters.
5 . Results are not available for this reporting period.
7 . No cases met the criteria for this measure.
13 . Results cannot be calculated for this reporting period.
16 . There are too few measures or measure groups reported to calculate a star rating or measure group score.
17 . This hospital's star rating only includes data reported on inpatient services.

Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Clinical Process Measures: Third Quarter 2015 through Second Quarter 2016 Discharges

	Hospital Quality Measures	Your Hospital Performance Aggregate Rate for All Four Quarters	10% of All Hospitals Submitting Data Scored Equal to or Better Than	State Performance	National Performance
Stroke (STK)					
STK-4	Thrombolytic Therapy	93% of 41 patients	100%	94%	87%
Venous Thromboembolism (VTE)					
VTE-5	Venous Thromboembolism Warfarin Therapy Discharge Instructions	81% of 42 patients(2)	100%	95%	93%
VTE-6	Hospital Acquired Potentially-Preventable Venous Thromboembolism	0% of 18 patients(2)	0%	1%	2%
Emergency Department (ED)					
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients	319 Minutes based on 470 patients(2)	176 Minutes	Low Volume: 272 Minutes Medium: 305 Minutes High: 358 Minutes Very High: 421 Minutes Overall Average: 339 Minutes	Low Volume: 212 Minutes Medium: 258 Minutes High: 295 Minutes Very High: 335 Minutes Overall Average: 275 Minutes
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients	122 Minutes based on 470 patients(2)	39 Minutes	Low Volume: 91 Minutes Medium: 122.5 Minutes High: 159 Minutes Very High: 192 Minutes Overall Average: 141 Minutes	Low Volume: 58 Minutes Medium: 88 Minutes High: 116 Minutes Very High: 134 Minutes Overall Average: 99 Minutes
Emergency Department Volume					
		Category			
EDV-1	Emergency Department Volume	High			
Immunization (IMM)					
IMM-2	Influenza Immunization	95% of 474 patients(2)	100%	94%	94%
Perinatal Care (PC)					
PC-01	Elective Delivery	0% of 119 patients(2)	0%	2%	2%

Footnote Legend

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Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Third Quarter 2015 through Second Quarter 2016 Discharges

Reporting Period for HCAHPS Star Ratings: Third Quarter 2015 through Second Quarter 2016 Discharges

050308 - EL CAMINO HOSPITAL

Address: 2500 GRANT ROAD
City, State, ZIP: MOUNTAIN VIEW, CA 94040
Phone Number: (650) 940-7000
County Name: SANTA CLARA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

HCAHPS Survey Completion, Response Rate and Summary Star Rating	
Number of Completed Surveys*	1208
Survey Response Rate	28
HCAHPS Summary Star Rating	3 stars

HCAHPS Composites and Individual Items

		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
HCAHPS Composites		**Star Rating (Out of 5)**	**Linear Score (0-100)**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**
Composite 1 (Q1 to Q3)	Communication with Nurses	3	91	4	18	78	6	19	75	4	16	80
Composite 2 (Q5 to Q7)	Communication with Doctors	3	92	4	15	81	6	16	78	4	14	82
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	3	85	9	27	64	12	27	61	8	23	69
Composite 4 (Q13 & Q14)	Pain Management	4	89	5	23	72	8	24	68	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	3	80	16	20	64	20	19	61	17	18	65
Hospital Environment Items		**Star Rating (Out of 5)**	**Linear Score (0-100)**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**	**% Sometimes to Never**	**% Usually**	**% Always**

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6 . Fewer than 100 patients completed the HCAHPS survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
10 . Very few patients were eligible for the HCAHPS survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.
11 . There were discrepancies in the data collection process.
15 . The number of cases/patients is too few to report a star rating.

Star Ratings Legend
More stars are better
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures: Third Quarter 2015 through Second Quarter 2016 Discharges

Reporting Period for HCAHPS Star Ratings: Third Quarter 2015 through Second Quarter 2016 Discharges

050308 - EL CAMINO HOSPITAL

Q8	Cleanliness of Hospital Environment	4	89	7	19	74	10	19	71	8	18	74
Q9	Quietness of Hospital Environment	3	82	10	33	57	16	32	52	9	28	63

Discharge Information Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Yes	%No	% Yes	%No	% Yes	%No
Composite 6 (Q19 & Q20)	Discharge Information	3	86	86	14	85	15	87	13

Care Transition Composite		Star Rating (Out of 5)	Linear Score (0-100)	% Disagree to Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree	% Disagree or Strongly Disagree	% Agree	% Strongly Agree
Composite 7 (Q23 to Q25)	Care Transition	3	82	5	42	53	7	44	49	5	43	52

HCAHPS Global Items

		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q21	**Overall Rating of Hospital**	**Star Rating (Out of 5)**	**Linear Score (0-100)**	**% 0 to 6 rating**	**% 7 or 8 rating**	**% 9 or 10 rating**	**% 0 to 6 rating**	**% 7 or 8 rating**	**% 9 or 10 rating**	**% 0 to 6 rating**	**% 7 or 8 rating**	**% 9 or 10 rating**
Overall Rating of Hospital (0= Worst Hospital 10= Best Hospital)		4	91	6	17	77	9	23	68	7	21	72

		HCAHPS Star Rating		Your Hospital's Adjusted Score			State Average			National Average		
Q22	**Willingness to Recommend this Hospital**	**Star Rating (Out of 5)**	**Linear Score (0-100)**	**%No: Definitely or Probably Not Recommend**	**%Yes: Probably Recommend**	**%Yes: Definitely Recommend**	**%No: Definitely or Probably Not Recommend**	**%Yes: Probably Recommend**	**%Yes: Definitely Recommend**	**%No: Definitely or Probably Not Recommend**	**%Yes: Probably Recommend**	**%Yes: Definitely Recommend**
Willingness to Recommend this Hospital		4	92	3	16	81	7	24	69	5	23	72

*When HCAHPS scores are based on fewer than 25 completed surveys, scores WILL NOT be reported on Hospital Compare.

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Star Ratings Legend
More stars are better
"For additional Information on HCAHPS Star Ratings and Linear Scores, please see www.hcahpsonline.org."

Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2012 through Second Quarter 2015 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2014 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

Address: 2500 GRANT ROAD
City, State, ZIP: MOUNTAIN VIEW, CA 94040
Phone Number: (650) 940-7000
County Name: SANTA CLARA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

30-Day Risk-Standardized Condition-Specific Mortality Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	No Different than the National Rate	229	13.1% (10.4%, 16.2%)	14.1		in the **Nation** that Performed…	57	2375	24	1909
							in the **State** that Performed…	6	201	1	109
Chronic Obstructive Pulmonary Disease (COPD)											
MORT-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	No Different than the National Rate	299	7.8% (6.0%, 10.3%)	8.0		in the **Nation** that Performed…	57	3580	107	899
							in the **State** that Performed…	8	233	17	74
Heart Failure (HF)											
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	No Different than the National Rate	490	11.9% (9.8%, 14.2%)	12.1		in the **Nation** that Performed…	168	3510	89	873
							in the **State** that Performed…	28	238	5	61

Footnote Legend
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13 . Results cannot be calculated for this reporting period.

Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2012 through Second Quarter 2015 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2014 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Pneumonia (PN)											
MORT-30-PN	Pneumonia 30-Day Mortality Rate	No Different than the National Rate	926	16.2% (14.4%, 18.3%)	16.3		in the **Nation** that Performed…	252	3783	267	387
							in the **State** that Performed…	46	228	19	41
Stroke (STK)											
MORT-30-STK	Acute Ischemic Stroke (STK) 30-Day Mortality Rate	No Different than the National Rate	333	14.5% (11.9%, 17.6%)	14.9		in the **Nation** that Performed…	70	2615	76	1704
							in the **State** that Performed…	9	221	5	87

30-Day Risk-Standardized Procedure-Based Mortality Measure

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Mortality Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
MORT-30-CABG	30-Day All-Cause Mortality Following Coronary Artery Bypass Graft (CABG) Surgery	No Different than the National Rate	83	3.1% (1.5%, 6.1%)	3.2		in the **Nation** that Performed…	14	1015	21	144
							in the **State** that Performed…	0	96	0	31

Footnote Legend

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Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2012 through Second Quarter 2015 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2014 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

30-Day Risk-Standardized Condition-Specific Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Acute Myocardial Infarction (AMI)											
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	No Different than the National Rate	235	17.6% (14.8%, 20.7%)	16.8		in the **Nation** that Performed…	12	2181	26	2008
							in the **State** that Performed…	1	189	2	120
Chronic Obstructive Pulmonary Disease (COPD)											
READM-30-COPD	Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	No Different than the National Rate	339	18.4% (15.7%, 21.4%)	20.0		in the **Nation** that Performed…	30	3698	82	835
							in the **State** that Performed…	0	260	2	72
Heart Failure (HF)											
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	Better than the National Rate	572	17.8% (15.4%, 20.5%)	21.9		in the **Nation** that Performed…	89	3590	129	831
							in the **State** that Performed…	9	257	6	59
Pneumonia (PN)											
READM-30-PN	Pneumonia 30-Day Readmission Rate	No Different than the National Rate	953	16.0% (13.9%, 18.2%)	17.1		in the **Nation** that Performed…	79	4044	186	383
							in the **State** that Performed…	6	278	13	38

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2012 through Second Quarter 2015 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2014 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Stroke (STK)											
READM-30-STK	Stroke (STK) 30-Day Readmission Rate	No Different than the National Rate	317	11.4% (9.2%, 14.1%)	12.5		in the **Nation** that Performed…	7	2634	50	1722
							in the **State** that Performed…	0	231	0	91

30-Day Risk-Standardized Procedure-Based Readmission Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Coronary Artery Bypass Graft (CABG)											
READM-30-CABG	30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	No Different than the National Rate	81	14.0% (10.7%, 18.1%)	14.4		in the **Nation** that Performed…	5	1027	7	154
							in the **State** that Performed…	1	93	0	33

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for 30-Day Mortality, Readmission Condition-Specific and Procedure-Based Measures: Third Quarter 2012 through Second Quarter 2015 Discharges

Reporting Period for 30-Day Risk-Standardized Hospital-Wide Readmission Measure: Third Quarter 2014 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hip/Knee											
READM-30-HIP-KNEE	30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No Different than the National Rate	929	4.8% (3.8%, 6.1%)	4.6		in the **Nation** that Performed…	48	2740	31	654
							in the **State** that Performed…	7	205	0	83
30-Day Risk-Standardized Hospital-Wide Readmission Measure											
	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's Risk-Standardized Readmission Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hospital Wide											
READM-30-HOSPWIDE	30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	Better than the National Rate	4636	14.2% (13.5%, 15.3%)	15.6		in the **Nation** that Performed…	214	4074	283	175
							in the **State** that Performed…	22	288	13	11

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Complication Outcome Measures: Second Quarter 2012 through First Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

Risk-Standardized Complication Measures

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Complication Rate (Lower Limit, Upper Limit of 95% Interval Estimate)	National Rate		Number of Hospitals…	Better than National Rate	No Different than National Rate	Worse than National Rate	Number of Cases Too Small
Hip/Knee Complication											
COMP-HIP-KNEE	Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	No Different than the National Rate	865	3.4% (2.5%, 4.7%)	3.0		in the **Nation** that Performed…	62	2693	49	679
							in the **State** that Performed…	6	205	1	85

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Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Payment

Reporting Period for 30-Day Condition-Specific Payment Measures: Third Quarter 2012 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

30-Day Condition-Specific Payment Measures

	Hospital Quality Measures	Your Hospital's Payment Category	Your Hospital's Number of Eligible Medicare Admissions	Your Hospital's Risk-Standardized Payment (Lower Limit, Upper Limit of 95% Interval Estimate)	National Average Payment		Number of Hospitals…	Greater Than National Average Payment	No Different Than National Average Payment	Less Than National Average Payment	Number of Cases Too Few To Report	Value of Care Category
PAYM-30-AMI												
PAYM-30-AMI	Risk-Standardized Payment Associated with a 30-Day AMI Episode-of-Care for Acute Myocardial Infarction	No Different than the National Average Payment	221	$23688 ($21739, $25704)	$22760		in the **Nation** whose payment was…	255	1971	182	1912	Average mortality and average payment
							in the **State** whose payment was…	33	166	8	108	
PAYM-30-HF												
PAYM-30-HF	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure	No Different than the National Average Payment	451	$16150 ($15191, $17148)	$15959		in the **Nation** whose payment was…	617	2702	377	939	Average mortality and average payment
							in the **State** whose payment was…	83	163	18	67	
PAYM-30-PN												
PAYM-30-PN	Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia	No Different than the National Average Payment	468	$15141 ($14265, $15982)	$14817		in the **Nation** whose payment was…	541	2968	673	498	Average mortality and average payment
							in the **State** whose payment was…	63	176	34	61	

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Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2013 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

Address: 2500 GRANT ROAD
City, State, ZIP: MOUNTAIN VIEW, CA 94040
Phone Number: (650) 940-7000
County Name: SANTA CLARA

Type of Facility: Short-term
Type of Ownership: Government - Hospital District or Authority
Emergency Service Provided: Yes

AHRQ Measures – Patient Safety Indicators

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
Individual Patient Safety Indicators (PSIs)											
PSI-3	Pressure Ulcer Rate	No Different than the National Rate	2974	0.35 (0.00, 1.04)	0.48		in the **Nation** that Performed…	4	3068	141	115
							in the **State** that Performed…	0	277	15	7
PSI-4	Death among surgical inpatients with serious treatable complications Rate	No Different than the National Rate	134	128.36 (88.60, 168.13)	136.48		in the **Nation** that Performed…	26	1791	41	1018
							in the **State** that Performed…	2	158	2	107
PSI-6	Iatrogenic pneumothorax, adult Rate	No Different than the National Rate	9809	0.33 (0.07, 0.58)	0.41		in the **Nation** that Performed…	3	3333	29	42
							in the **State** that Performed…	0	299	2	1

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8 . The lower limit of the confidence interval cannot be calculated if the number of observed infections equals zero.
12 . This measure does not apply to this hospital for this reporting period.
13 . Results cannot be calculated for this reporting period.

Report Run Date: 01/10/2017

Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2013 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000	Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
PSI-7	Central Venous Catheter-Related Bloodstream Infections Rate	No Different than the National Rate	6552	0.23 (0.00, 0.47)	0.17	in the **Nation** that Performed…	0	3294	55	59
						in the **State** that Performed…	0	295	5	4
PSI-8	Postoperative Hip Fracture Rate	No Different than the National Rate	1938	0.06 (0.06, 0.06)	0.06	in the **Nation** that Performed…	0	2959	0	242
						in the **State** that Performed…	0	286	0	6
PSI-12	Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate	No Different than the National Rate	3939	3.80 (1.66, 5.95)	5.31	in the **Nation** that Performed…	124	2788	180	140
						in the **State** that Performed…	11	271	8	3
PSI-13	Postoperative Sepsis Rate	No Different than the National Rate	577	9.51 (3.63, 15.39)	10.21	in the **Nation** that Performed…	12	2327	33	568
						in the **State** that Performed…	0	198	4	71

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for AHRQ Patient Safety Indicators: Third Quarter 2013 through Second Quarter 2015 Discharges

050308 - EL CAMINO HOSPITAL

	Hospital Quality Measures	Your Hospital's Performance	Your Hospital's Number of Eligible Medicare Discharges	Your Hospital's PSI Rate (Lower Limit, Upper Limit of 95% Confidence Interval)	National Rate per 1,000		Number of Hospitals…	Better than National Rate / Value	No Different than National Rate / Value	Worse than National Rate / Value	Number of Cases Too Small
PSI-14	Postoperative wound dehiscence Rate	No Different than the National Rate	523	1.84 (0.00, 3.92)	2.32		in the **Nation** that Performed…	0	2603	1	435
							in the **State** that Performed…	0	234	0	52
PSI-15	Accidental puncture or laceration Rate	No Different than the National Rate	10345	1.11 (0.54, 1.69)	1.43		in the **Nation** that Performed…	98	3084	182	43
							in the **State** that Performed…	6	284	10	2
Composite Patient Safety Indicator (PSI)											
PSI-90	Complication/patient safety for selected indicators (composite)	No Different than the National Rate	N/A	0.71 (0.50, 0.92)	0.90		in the **Nation** that Performed…	104	3112	195	N/A
							in the **State** that Performed…	9	283	12	N/A

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Associated Infection Measures: Third Quarter 2015 through Second Quarter 2016 Discharges

050308 - EL CAMINO HOSPITAL

Healthcare Associated Infection

Hospital Quality Measures	Your Hospital's Reported Number of Infections	Device or Patient Days /Procedures	Your Hospital's Predicted Number of Infections	Ratio of Reported to Predicted Infections (SIR) (Lower Limit, Upper Limit of 95% Interval Estimate)	Your Hospital's Performance	State Standardized Infection Ratio, State Lower Limit, State Upper Limit of 95% Interval Estimate	National Standardized Infection Ratio
Healthcare Associated Infection Measures							
Central Line Associated Bloodstream Infection (ICU + select Wards)	1	11028	8.215	0.122(0.006,0.600)	Better than the National Benchmark	0.984 (0.940, 1.030)	0.980
Catheter Associated Urinary Tract Infections (ICU + select Wards)	7	16674	12.861	0.544(0.238,1.077)	No Different than National Benchmark	1.092 (1.049, 1.135)	0.965
SSI-Colon Surgery	2	248	6.098	0.328(0.055,1.084)	No Different than National Benchmark	1.022 (0.951, 1.097)	0.971
SSI-Abdominal Hysterectomy	1	272	2.026	0.494(0.025,2.434)	No Different than National Benchmark	1.000 (0.869, 1.146)	0.944
MRSA Bacteremia	2	76867	3.097	0.646(0.108,2.134)	No Different than National Benchmark	0.983 (0.915, 1.055)	1.308
Clostridium Difficile (C.Diff)	22	72127	32.563	0.676(0.434,1.006)	No Different than National Benchmark	1.142 (1.120, 1.164)	0.965

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Hospital Compare Preview Report: Improving Care Through Information – Inpatient

Hospital Performance

Reporting Period for Healthcare Personnel Influenza Vaccination: Fourth Quarter 2015 through First Quarter 2016

050308 - EL CAMINO HOSPITAL

Healthcare Personnel Influenza Vaccination

Hospital Quality Measures	Your Hospital's Reported Adherence Percentage	Your Hospital's Performance	State Reported Adherence Percentage	National Reported Adherence Percentage
Healthcare Personnel Influenza Vaccination	78%	N/A	82%	86%

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ATTACHMENT 9

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Greeley Committee Final Report
Quality Committee

February 27, 2017

Dave Francisco, MD, PhD
Chairman of Greeley Subcommittee

The Greeley Subcommittee Charge

- Review the findings and recommendations in the Greeley Report and prioritize and operationalize improvements
- Evaluate the current ECH peer review process
- Clarify what constitutes peer review, where peer review occurs in the organization and the roles and responsibilities of entities involved in peer review

Selected Identified Deficits

- Peer review at ECH is almost solely conducted through case review of adverse events.
- ECH does not have a functional OPPE process.
- Cases often take more than 90 days to be finalized.
- Reviewers have no formal training in peer review.
- No standard peer review form is used at ECH.
- Department-specific criteria for case review and peer review have not been developed.

Recommended Process Redesign

- Develop a single scoring form for case review and utilize it consistently across all departments.
- Ensure all individuals involved in peer review receive training to conduct of peer review.
- Standardize the process of peer review across all department and peer review entities.
- Consistently apply clear criteria that trigger case review.

Recommended Process Redesign (continued)

- Redesign OPPE to provide more meaningful data.
- Adopt rule and rate based indicators for case review.
- Integrate current performance data gathered in some service lines to the peer review process.
- Develop a comprehensive list of currently used metrics.
- Periodically review physician performance metrics and provide feedback to providers on performance.

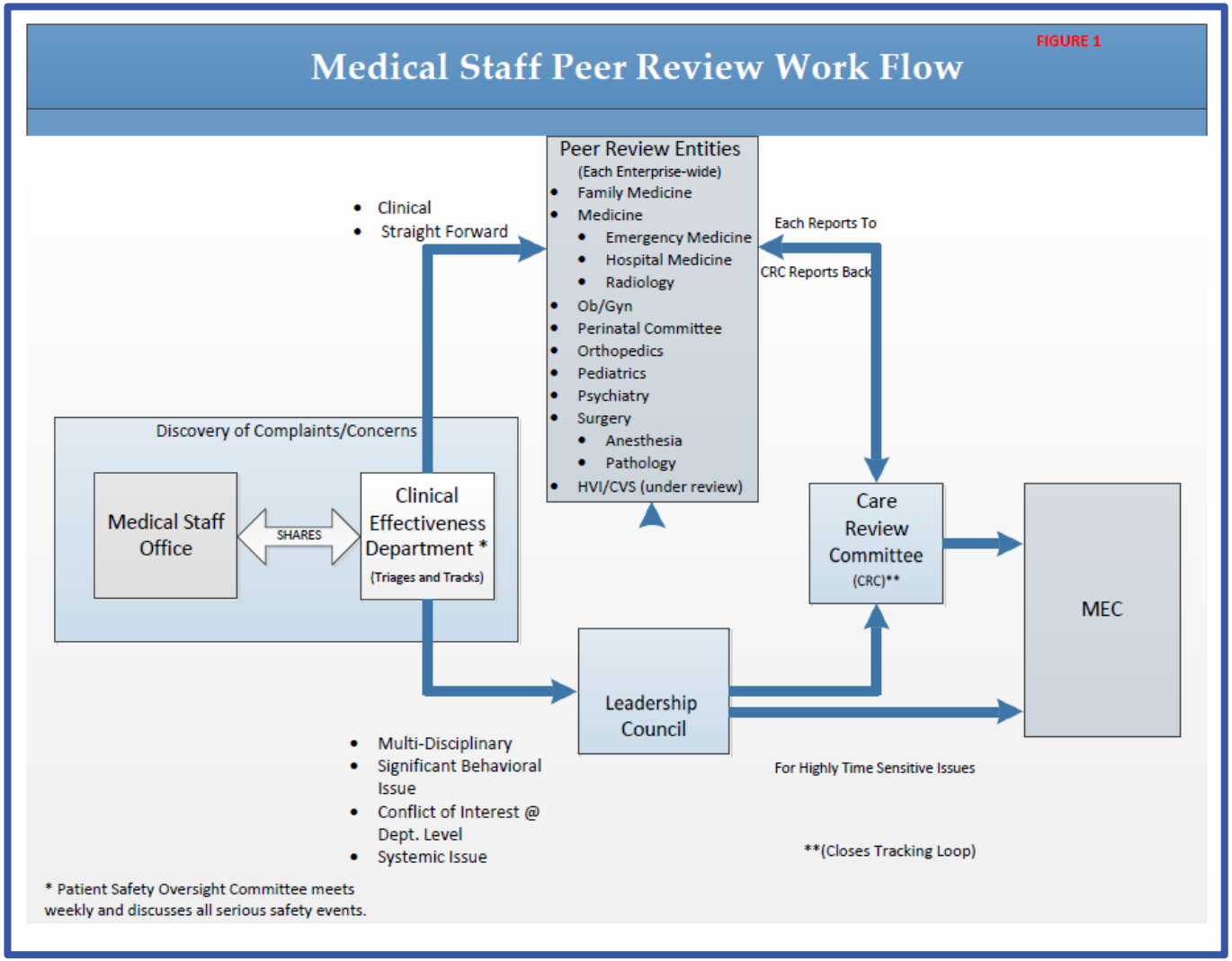
Recommended Process Redesign (continued)

- Continue to use QRRs for case finding as appropriate.
- Clarify how peer review is distinct from serious event cause analysis.
- Re-evaluate the role of the Leadership Council.
- Evaluate the medical staff's oversight of peer review activities.

Practitioner Performance Expectations

- Establish a more robust Code of Conduct, rather than relying solely on the broad terms of the compact.
- Enhance reporting of perceived conduct policy violations, and protect nurses and others from retaliation.
- More effectively address chronic conduct issues with the small number of chronic offenders.

Revised Peer Review Model



Department-Level Action Items

- Make peer review clinical departments enterprise-wide.
- Use the standard peer review form in all departments.
- Train all reviewers on how to do peer review.
- Orient peer review participants to the new form and policy.
- Develop specialty-specific metrics for prospective peer review and OPPE.
- Complete peer review in a timely fashion.

Medical Staff-Level Action Items

- Create the standardized peer review form.
- Revise the peer review policy and submit it for approval.
- Codify the peer review duties of the Leadership Committee and Care Review Committee.
- Obtain MEC approval to revise the membership of the Care Review Committee.
- Revise the bylaws as needed.
- Ensure the CRC chair reviews departmental conclusions.
- Clarify which peer review entities may implement FPPEs.
- Use automated data reporting as a tool in the peer review process.

Administration-Level Action Items

- Hire additional peer review support staff to:
  - Manage prospective quality monitoring
  - Attend all peer review meetings
  - Assist in the completion of the peer review form
  - Assure all information is entered into the peer review data base
- Purchase the Morrisey Peer Review Manager software to support and implement the new peer review process.
- Use Premier Physician Focus and Quality Advisor to integrate a standard set of physician metrics across all specialties for the basic OPPE report.
- Evaluate the use of EPIC to provide additional quality data.