AGENDA

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

Monday, April 3rd, 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	*public comment*	**Motion Required** 5:33 – 5:36
	Approval: a. Minutes of Quality Committee Meeting - February 27, 2017 b. Policies **Information:** c. Pacing Plan d. Patient Story e. Research Articles			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	David Reeder, Chair Quality Committee		**Discussion** 5:36 – 5:39
6.	**QUALITY PROGRAM UPDATE: ORTHO/NEURO/SPINE SERVICE LINE** **ATTACHMENT 6**	Terry Rutledge, Exec. Director of Ortho/Neuro/Spine Service Line		**Discussion** 5:39 – 5:54
7.	**PROPOSED FY18 COMMITTEE DATES** **ATTACHMENT 7**	William Faber, MD Chief Medical Officer	*public comment*	**Possible Motion** 5:54 – 6:04
8.	**PROPOSED FY18 QUALITY COMMITTEE GOAL** **ATTACHMENT 8**	William Faber, MD Chief Medical Officer	*public comment*	**Possible Motion** 6:04 – 6:14

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

Agenda: El Camino Hospital Quality, Patient Care, and Patient Experience Committee Meeting
April 3, 2017

	AGENDA ITEM	PRESENTED BY		
9.	**FY17 QUALITY DASHBOARD** a. Dashboard b. Opioids Use	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion** 6:14 – 6:29
10.	**FY18 CORPORATE GOALS** **ATTACHMENT 10**	Mick Zdeblick, Chief Operating Officer		**Discussion** 6:29 – 6:44
11.	**PUBLIC COMMUNICATION**	David Reeder, Chair Quality Committee		**Information** 6:44 – 6:47
12.	**ADJOURN TO CLOSED SESSION**			6:47 – 6:48
13.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		6:48 – 6:49
14.	**CONSENT CALENDAR** Any Committee Member may pull an item for discussion before a motion is made.	David Reeder, Chair Quality Committee		**Motion Required** 6:49 – 6:52
	Approval: Meeting Minutes of the Closed Session *Gov't Code Section 54957.2.* - February 27, 2017			
15.	Report related to the Medical Staff quality assurance matters, *Health and Safety Code Section 32155.* Red and Orange Alert/Serious Reportable Events Policy	Shreyas Mallur, MD Associate Chief Medical Officer		**Discussion** 6:52 – 7:12
16.	**RECONVENE OPEN SESSION/REPORT OUT**	David Reeder, Chair Quality Committee		7:12 – 7:14
	To report any required disclosures regarding permissible actions taken during Closed Session.			
17.	**ADJOURNMENT**	David Reeder, Chair Quality Committee		7:15 p.m.

Upcoming FY 17 Quality Committee Meetings

- **May 1, 2017**
- **June 5, 2017**

a. Minutes of Quality Committee Meeting - February 27, 2017

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, February 27, 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; Robert Pinsker, MD; Nancy Carragee, Mikele Bunce, Melora Simon, Wendy Ron, and Katie Anderson.	Jeffrey Davis, MD; Diana Russell, RN; And Alex Tsao.	None

**Dr. Peter Fung joined the meeting @ 5:38pm.Wendy Ron and Melora Simon joined the meeting @ 5:41pm.*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 27th day of February, 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 5:34 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Stephanie Iljin to take a silent roll call.	***None***
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member or anyone in the audience believes that a Committee member may have a conflict of interest on any of the items on the agenda. No conflict of interest was reported.	***None***
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. None were noted. **Motion:** To approve the consent calendar (Open Minutes of the January 30, 2017 meeting were approved). **Movant:** Anderson **Second:** Carragee **Ayes:** Reeder, Fung, Bunce, Anderson, Carragee, and Pinsker. **Noes:** None **Abstentions:** None	***The Open Minutes of the January 30, 2017 meeting were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Absent: Davis, Simon, Russell, Ron, and Tsao. **Excused:** None **Recused:** None	
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	***None***
6. QUALITY PROGRAM UPDATE: INTERVENTIONAL PULMONOLOGY	Dr. Ganesh Krishna, Medical Director of Interventional Pulmonology Services gave an overview of the training program, IP registry, featured publications, and clinical trials of Interventional Pulmonology as further detailed in the packet. He further highlighted that we provide one of the widest spectrums of minimally invasive pulmonary procedures in the world, experience high volume, have several clinical trials and grants, feature publications in reputed journals, are a model program for academic institutions, are performing better than neighborhood academic hospitals, have referrals from out of state, and provide an immersion program for outside physicians in several areas. Dr. Krishna asked for feedback and questions from the Committee and a brief discussion ensued.	***None***
7. PROPOSED FY18 QUALITY COMMITTEE GOALS	Dr. Will Faber, Chief Medical Officer, reviewed the Proposed FY18 Committee Goals to include: 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. 2. Alternately review peer review process and medical staff credentialing process. Monitor & Follow through on the recommendations made through the Greeley peer review process 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. 4. Oversee recruitment of a leader, development of a plan with specific tactics, and monitor the HCAHPs scores for Patient and Family Centered Care.	

Agenda Item	Comments/Discussion	Approvals/Action
	5. Monitor the impact of the Culture of Safety Campaign with QRR reporting as an improvement metric. Dr. Faber asked the Committee for questions and feedback and discussion ensued. **The Committee asked that goal #4 be revised to state "Oversee development of a plan with specific tactics, and monitor the HCAHPs scores for Patient and Family Centered Care", for further discussion of goal #5 and the Patient and Family Centered Theme at the next Committee meeting, and that the QRR Process be added to the pacing plan for FY18.*	
8. 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 seven metrics remain stable; the exceptions being: • Length of Stay possibly due to severe flu season w/88 flu admissions of which many with underlying disease developed organ failure • Patient Falls; Of the 15 falls in December - 2 were assisted, and 7 falls related to policy lapses. Falls Team is reviewing Fall Risk Assessment in use. • Responsiveness of Staff may have been due to increased responsibilities within Patient Experience Dept due to the current turnover within the department. Ms. Carson further reported on the CMS Hospital Compare Report to include our 4 star rating, of which the only local hospitals to receive that rating include El Camino, Stanford and Sequoia hospitals. The common rating is 3 stars nationwide. Ms. Carson asked for feedback and questions from the Committee and a brief discussion ensued. **The Committee asked to add Sepsis to the FY18 Dashboard.* **Mikele Bunce left the meeting @ 6:54pm.*	***None***
9. GREELEY UPDATE	Dr. Dave Francisco, Chairman of the Greeley Subcommittee Greeley, reviewed the final report and proposed changes of Peer Review with the Committee	***None***

Agenda Item	Comments/Discussion	Approvals/Action
	as further detailed in the packet. He reported the identified deficits, process redesign, practitioner performance expectations, revised peer review model, department level action items, and administrative level actions. Dr. Francisco asked for feedback and questions from the Committee and a brief discussion ensued. Chairman Reeder thanked the Subcommittee members for their commitment and follow through with this assignment from the Board. **Item of note to address: How will we know if the revised process really works?*	
10. PUBLIC COMMUNICATION	None	***None***
11. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:37 p.m. **Movant:** Simon **Second:** Anderson **Movant:** Fung **Second:** Simon **Ayes:** Reeder, Fung, Simon, Anderson, Carragee, Ron, and Pinsker. **Noes:** None **Abstentions:** None **Absent:** Davis, Bunce, Russell, and Tsao. **Excused:** None **Recused:** None	***A motion to adjourn to closed session at 7:37 p.m. was approved.***
12. AGENDA ITEM 17 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 11 – 16 were reported in closed session.* Chair Reeder reported that Closed minutes of the January 30, 2017 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.	***None***
13. AGENDA ITEM 18 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:44 p.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

Policies

February 2017 Summary Report Quality Committee

NEW POLICIES			
Policy Name	**Department**	**Date**	**Summary of Policy Changes**

POLICIES WITH MAJOR REVISIONS			
Policy Name	**Department**	**Review or Revised Date**	**Summary of Policy Changes**

POLICIES WITH MINOR REVISIONS			
Policy Name	**Department**	**Review or Revised Date**	**Summary of Policy Changes**
Inspection and Testing	Facilities	1/17	Combined 8 inspection policies into 1
Preventive Maintenance	Facilities	1/17	Combined 9 maintenance policies into 1

POLICIES WITH NO REVISIONS - REVIEWED			
Policy Name	**Department**	**Review or Revised Date**	

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~~ ▪ Use of opioids **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**

Patient Story

Patient Story
Quality Committee Meeting
April 3, 2017

Re: Aortic Valve Replacement Procedure performed on December 12, 2016

There are no words adequate enough to thank you for agreeing to give me this last chance for life, even knowing that it would be very difficult and risky. You are exceptionally gifted, and because of your willingness to try, I am now enjoying a new birth, no pain of any kind, and a precious sense of well- being that I have not had for many years. Dr. [redacted] is very pleased with my progress since the procedure.

I have been blessed with many miracles since birth, but this was truly the greatest of all- My Christmas Miracle! -thanks to you and your amazing team and the excellent Hospital care I received!

God Bless each of you!

Research Articles

Advantages and Disadvantages of Anterior Hip Replacement

www.arthritis-health.com/surgery/hip-surgery/advantages-and-disadvantages-anterior-hip-replacement

Hip Replacement Surgery Video

Anterior hip replacement is an example of how the medical field is continually evolving and trying to improve outcomes for patients. This surgery is the subject of ongoing research and—though thousands are performed every year—it is estimated that only 15% to 20% of hip replacement surgeries in the United States currently use the anterior approach.

In the meantime, patients and doctors must use the knowledge available to make informed choices. The bullet points below summarize much of what we know about the pros and cons of anterior hip replacement surgery.

Potential Advantages of Anterior Hip Replacement

Proponents of anterior hip replacement surgery believe it offers several advantages, including:

Less damage to major muscles. The anterior approach avoids cutting major muscles. There are fewer muscles at the front of the hip, and the surgeon works between them, rather than cutting through muscle fibers or detaching muscles from bones (and then having to make repairs at the end of the surgery).

Less post-operative pain. Because the surgery does not require cutting major muscles, patients typically experience less pain after surgery and require less pain medication.

Faster recovery. After surgery, a patient can bend at the hip and bear weight as soon as it is comfortable. Most anterior hip replacement patients can use crutches or a walker sooner than patients who have had a traditional surgery. Patients may also walk on their own sooner: A 2014 study of 54 patients found that anterior hip replacement patients walked unaided 6 days earlier than other hip replacement patients.[3]

- See Total Hip Replacement Surgery Recovery

Decreased risk of hip dislocation. A major post-surgical worry for most hip replacement patients is that the new hip's ball and socket will dislocate. However, anterior hip replacement surgery does not disturb the muscles and soft tissue structures that naturally prevent the hip from dislocating, therefore anterior surgical patients are less likely to suffer a hip dislocation.

Article continues below

Better range of movement. Patients may bend over or sit with their legs crossed without risking hip dislocations. Most traditional hip replacement patients are told to avoid sitting with legs crossed for at least 6 to 8 weeks following surgery, and, depending on surgeon preference, to avoid deep bending at the hip or extreme internal rotation of the hip from then on.

Shorter hospital stay. A patient who undergoes anterior hip replacement can typically expect a shorter hospital stay than with a traditional approach, but much of this depends on the patient and the frequency of physical therapy sessions that patients are provided in the hospital.

While anterior hip replacement may offer some advantages, there are also potential limitations or disadvantages.

Potential Disadvantages of Anterior Hip Replacement

Anterior hip replacement does have a few limitations. These limitations include:

Obese or very muscular people may not be good candidates. Depending on the surgeon's experience, this surgery may not be appropriate for obese or very muscular patients, because the additional soft tissue can make it difficult for the surgeon to access the hip joint.

It is a technically demanding surgery. Surgeons face a steep learning curve for this procedure. The anterior incision provides a restricted view of the hip joint, making it a technically demanding procedure.

- See Total Hip Replacement Surgical Procedure

There is potential for nerve damage. There is a potential risk of nerve injury with any type of hip replacement approach. In anterior hip replacement, the surgical area is located near the lateral cutaneous femoral nerve, which runs down the front of the pelvis and past the hip to supply sensation to the outer thigh (it does not affect muscle control). Following anterior hip replacement surgery, there is potential for numbness in the thigh, and, in rare cases, a painful irritation of the skin supplied by that nerve, known as *meralgia paresthetica*. This condition is rare and happens in less than 1% of patients.[4]

While research is limited, many studies seem to suggest that the risk of damage to the major nerves near the hip, in particular the sciatic nerve, is lower with the anterior approach than with the traditional approaches.[5,6,7] This is because the sciatic nerve runs behind the hip joint, so it is not exposed when using the anterior approach.

- See Total Hip Replacement Surgery Risks and Complications

There may be wound healing issues. Surgeons who routinely perform the anterior approach recognize that the surgical incisions can get irritated, especially in very large patients or patients with large amount of abdominal fat, because that area can take longer to heal.

For example, one study identified surgical wound complications (e.g. infection where the surgical incision was made) in 1.4% of patients who had undergone anterior hip replacement and 0.2% of patients who had undergone posterior hip replacement.[8] However, these wound-healing issues are usually mild and self-limiting, meaning they typically resolve over time even without medical treatment. To date, there is no evidence to suggest that either approach has a higher or lower incidence of hip joint infection, which is a much more serious issue than incision healing delay.

It is important to remember that a successful hip replacement surgery depends on many factors besides the surgical approach. For example, the knowledge and skill of the surgeon, the type of hip prosthesis used, the patient's weight and build, and the ability and willingness of the patient to participate in surgical preparation and post-surgical rehabilitation are important factors.

- See Indications and Eligibility for Total Hip Replacement Surgery

A patient considering anterior hip replacement surgery should speak with his or her surgeon about potential advantages and disadvantages in the context of the individual's specific circumstances, such as the patient's hip arthritis, anatomy, overall health, and lifestyle.

References:

1. Taunton MJ, Mason JB, Odum SM, Springer BD. Direct Anterior Total Hip Arthroplasty Yields More Rapid Voluntary Cessation of All Walking Aids: A Prospective, Randomized Clinical Trial. J Arthroplasty. 2014 May 25. pii: S0883-5403(14)00340-4. doi: 10.1016/j.arth.2014.03.051. [Epub ahead of print] PubMed PMID: 25007723.
2. Post, ZD, Orozco F, Diaz-Ledezma C, Hozack WJ, and Ong A. Direct anterior approach for total hip arthroplasty: indications, technique, and results. Journal of the American Academy of Orthopaedic Surgeons. 2014;22:595-603.
3. Kennon RE, Keggi JM, et al. Total hip arthroplasty through a minimally invasive anterior surgical approach. Journal of Bone and Joint Surgery. 2013;85-A:39-48.
4. Berend KR, Lombardi, AV, et al. Enhanced early outcomes with the anterior supine intermuscular approach in primary total hip arthroplasty. Journal of Bone and Joint Surgery. 2009;91 Supple:107-20.
5. Matta JM et al. Single-incision anterior approach for total hip arthroplasty on an orthopaedic table. Clinical Orthopaedics and Related Research. 2005;441:115-124.
6. Christensen CP, Karthikeyan T, Jacobs CA. Greater Prevalence of Wound Complications Requiring Reoperation With Direct Anterior Approach Total Hip Arthroplasty. J Arthroplasty. 2014 May 2. pii: S0883-5403(14)00294-0. doi: 10.1016/j.arth.2014.04.036. [Epub ahead of print] PubMed PMID: 24890998.

Next Page: Deciding to Have an Anterior Hip Replacement

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WebMD

Cervical Disc Surgery: Disc Replacement or Fusion?

The vast majority of people -- more than 90% -- with pain from cervical disc disease will get better on their own over time with simple, conservative treatments. Surgery, however, may help if other treatments fail or if symptoms worsen.

Cervical disc disease is caused by an abnormality in one or more discs -- the cushions -- that lie between the neck bones (vertebrae). When a disc is damaged -- due to arthritis or an unknown cause -- it can lead to neck pain from inflammation or muscle spasm. In severe cases, pain and numbness can occur in the arms from pressure on the cervical nerve roots.

Surgery for cervical disc disease typically involves removing the disc that is pinching the nerve or pressing on the spinal cord. This surgery is called a discectomy. Depending on where the disc is located, the surgeon can remove it through a small incision either in the front (anterior discectomy) or back (posterior discectomy) of the neck while you are under anesthesia. A similar technique, microdiscectomy, removes the disc through a smaller incision using a microscope or other magnifying device.

To close the space that's left when the disc is removed and restore the spine to its original height, patients have two options:

- Artificial cervical disc replacement
- Cervical fusion

In 2007, the FDA approved the first artificial disc, the Prestige Cervical disc, which looks and moves much like the real thing but is made of metal. Since then, several artificial cervical discs have been developed and approved. Ongoing research has shown that the artificial disc can improve neck and arm pain as safely and effectively as cervical fusion while allowing for range of motion that is as good or better than with cervical fusion. People who get the artificial disc are often able to return to work more quickly as well. The surgery to replace the disc, however, does take longer and can lead to more blood loss than with cervical fusion. It's also not known how the artificial discs will last over

time. People who get an artificial disc can always opt for cervical fusion later. But if a patient has cervical fusion first, it's not possible to later put an artificial disc in the same spot.

WebMD Medical Reference | Reviewed by Melinda Ratini, DO, MS on July 30, 2016

Sources
SOURCES:
FDA: "FDA Approves First of a Kind Medical Device to Treat Cervical Degenerative Disc Disease."
Hilibrand, A.S. *The Journal of Bone and Joint Surgery, American Volume,* 1999.
Kee Kim, MD, associate professor of neurological surgery and chief of spinal neurosurgery, University of California at Davis.
American Academy of Orthopaedic Surgeons web site: "Implications of Adjacent Segment Disease After Cervical Spine Surgery."
National Institutes of Health.

Not everyone is a candidate for the artificial disc, however. Those with osteoporosis, joint disease, infection, inflammation at the site, or an allergy to stainless steel may not be candidates for disc replacement surgery.

With cervical fusion surgery, the surgeon removes the damaged disc and places a bone graft (which is taken either from the patient's hip or from a cadaver) in the space between the vertebrae. The bone graft will eventually fuse to the vertebrae above and below it. A metal plate may be screwed into the vertebrae above and below the graft to hold the bone in place while it heals and fuses with the vertebrae. Discectomy with cervical fusion can often help relieve the pain of spinal disc disease. The only caveat is that after the surgery, many people find that they lose some degree of movement in their neck.

Risks of Cervical Disc Surgeries

Although cervical disc surgery is generally safe, it does have a few risks, including:

- Infection
- Excessive bleeding
- Reaction to anesthesia
- Chronic neck pain
- Damage to the nerves, spinal cord, esophagus, or vocal cords
- Failure to heal

After cervical fusion surgery, some people develop cervical disc problems above and/or below the previously affected disc. One study found that about 12% of the patients developed new cervical disease that required a second surgery over a 20 year period after the first surgery. It is not yet known if the artificial disc will cause this same problem.

Recovering From Cervical Disc Surgery

You'll likely be able to get up and move around within a few hours of your cervical disc surgery and then either go home from the hospital the same day or the following morning. You'll feel some pain in the area operated on, but it should ease over time.

The fusion can take anywhere from three months to a year to become solid after surgery, and you could still have some symptoms during that time. Your doctor might recommend that you wear a cervical collar to support your neck for the first four to six weeks. You may help speed the process by eating a healthy diet, getting regular exercise, and practicing good posture. Check with your surgeon to see what activity level is right for you before starting any exercise after surgery.

WebMD Medical Reference | Reviewed by Melinda Ratini, DO, MS on July 30, 2016

Sources ^
SOURCES:
FDA: "FDA Approves First of a Kind Medical Device to Treat Cervical Degenerative Disc Disease."
Hilibrand, A.S. *The Journal of Bone and Joint Surgery, American Volume,* 1999.
Kee Kim, MD, associate professor of neurological surgery and chief of spinal neurosurgery, University of California at Davis.
American Academy of Orthopaedic Surgeons web site: "Implications of Adjacent Segment Disease After Cervical Spine Surgery."
National Institutes of Health.

ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Quality, Patient Care and Patient Experience Committee March 16, 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 March 2017 Board Actions	

March 2017 Board Actions*

1. March 3, and 4, 2017 – Board Retreat - Closed session study session on strategic priorities held
2. March 8, 2017 – Hospital Board
    a. 2017 Plan of Finance (Revenue Bonds)
    b. FY17 CMO Incentive Plan Goals
    c. Revised VP, Corporate and Community Health Services, President Concern FY 17 Incentive Goals
    d. Appointment of ECC Member Jaison Layney
3. March 8, 2017 – District Board
    a. Approved the 2017 General Obligation (GO) Bond Refinancing
4. March 14, 2017 – District Board
    a. Approved the District Financials FY17 YTD
    b. Asked the staff to bring back proposals for Community Benefit Advisory Council Structure
    c. Affirmed District Board Officers will be elected through nominations from the floor at its June 20, 2017 meeting
    d. Received Ad Hoc Committee Report: Working with executive recruiting firm to identify candidates for the El Camino Hospital Board of Directors. Expect to bring forward finalists to the District Board for interview on May 22, 2017.

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

Board Quality Committee Presentation

April 3, 2017

Orthopedic Services

Quality Measures and Programs

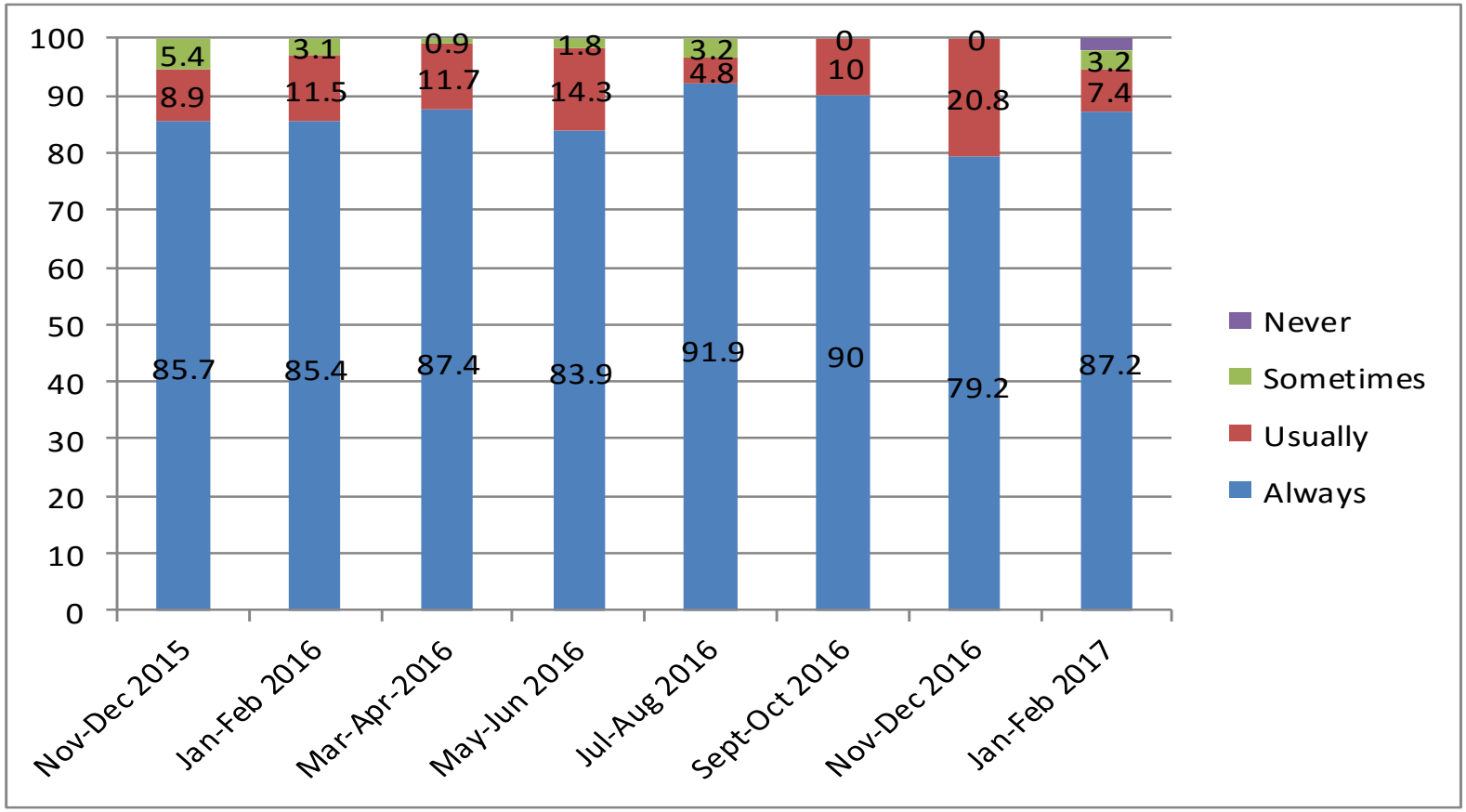
Orthopedic Joint Commission Certifications

- Total Joint Replacement
  - Mountain View and Los Gatos
- Hip Fracture
  - Mountain View
- Spine Fusion
  - Los Gatos

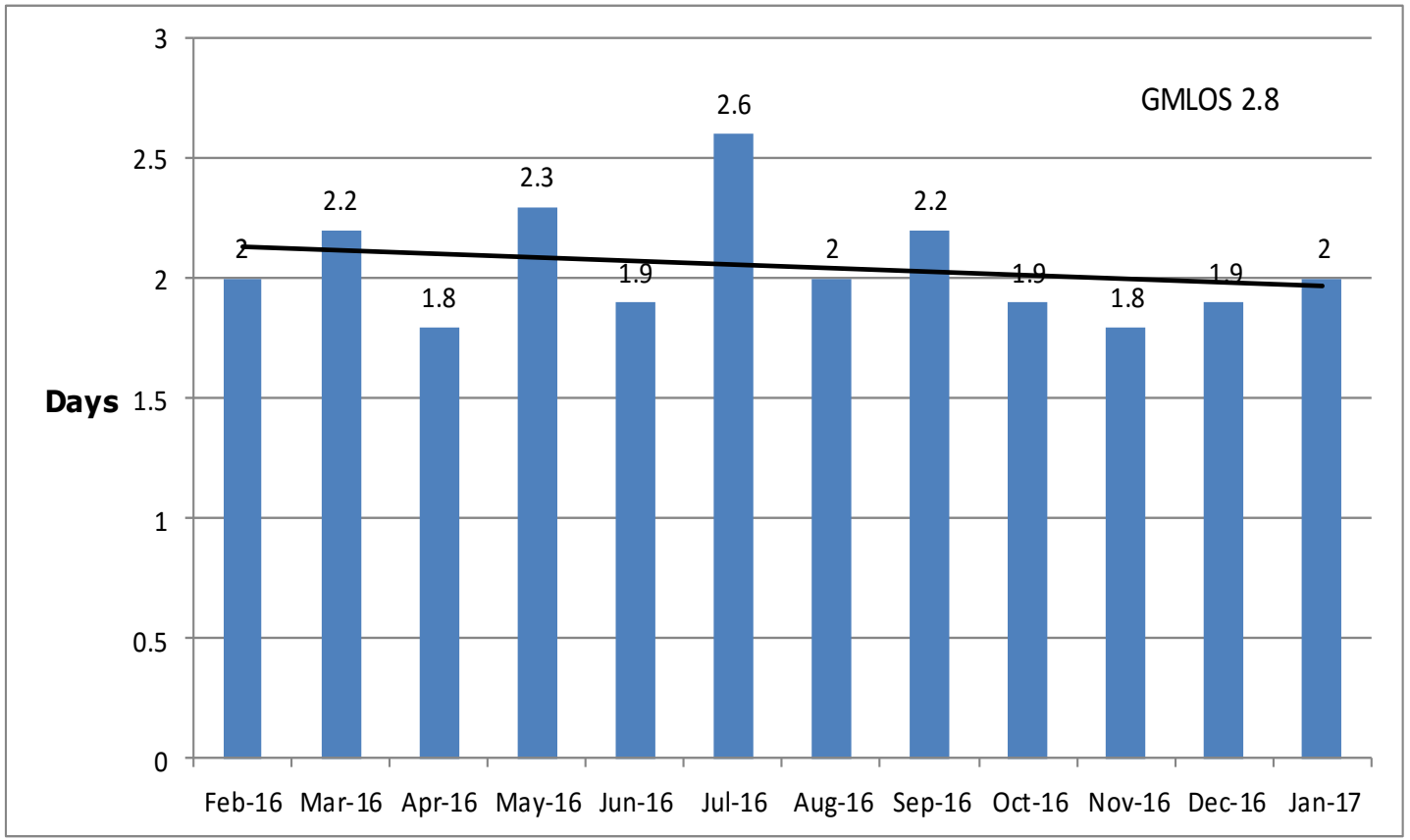
Anterior Hip Replacement Procedure

- Rapidly becoming the procedural hip surgery of choice versus posterior and lateral approach
- Utilized at ECH starting in 2004
- Being utilized for outpatient hip programs across the nation
- Reduces trauma to the muscle and soft tissue
- No precautions post discharge

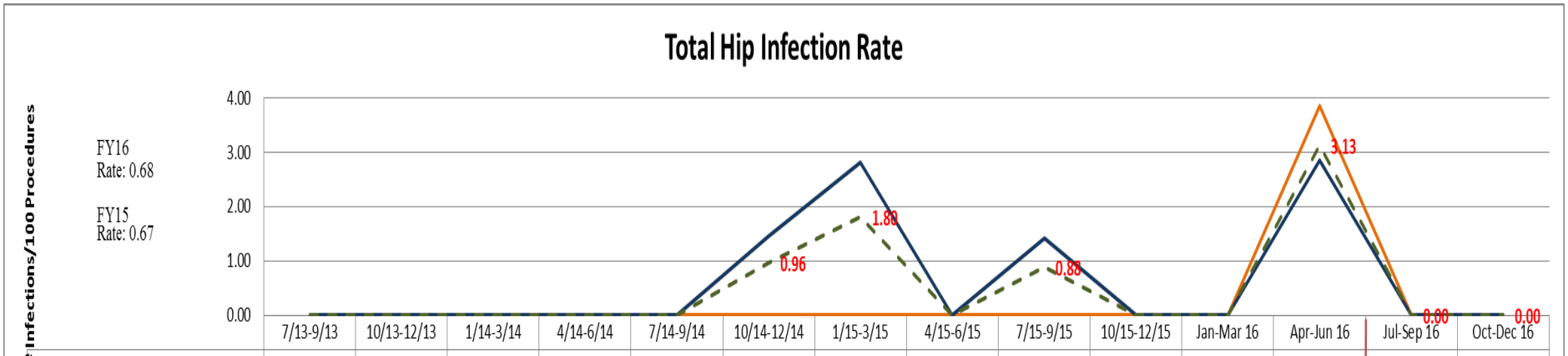
Pain Management Enterprise
Joint Replacement



Enterprise Length of Stay Total Hip Replacement

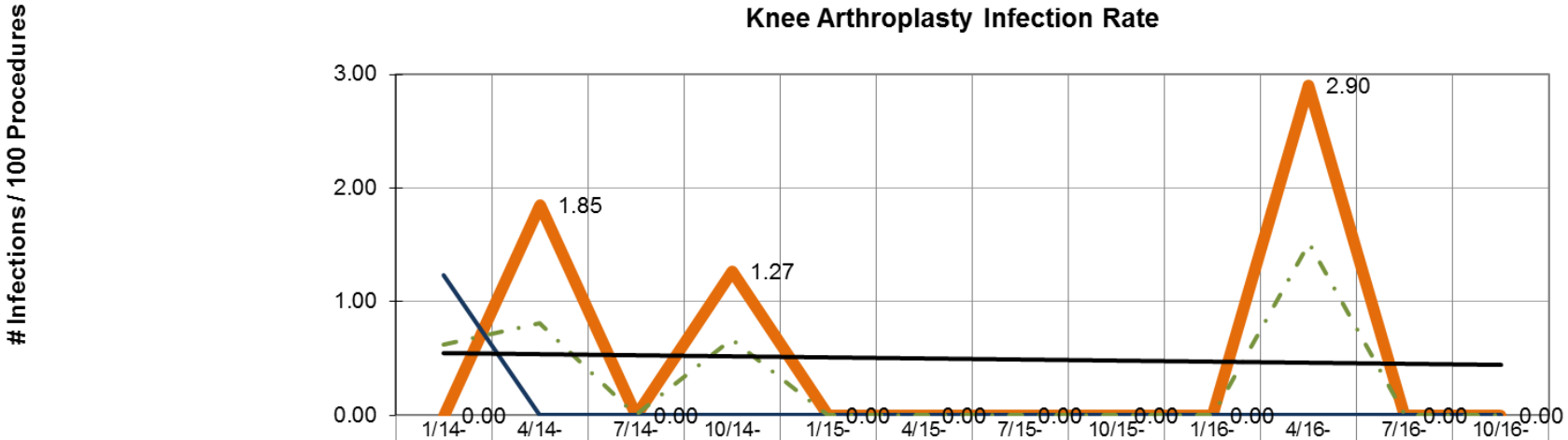


Total Hip Replacement Surgical Site Infection



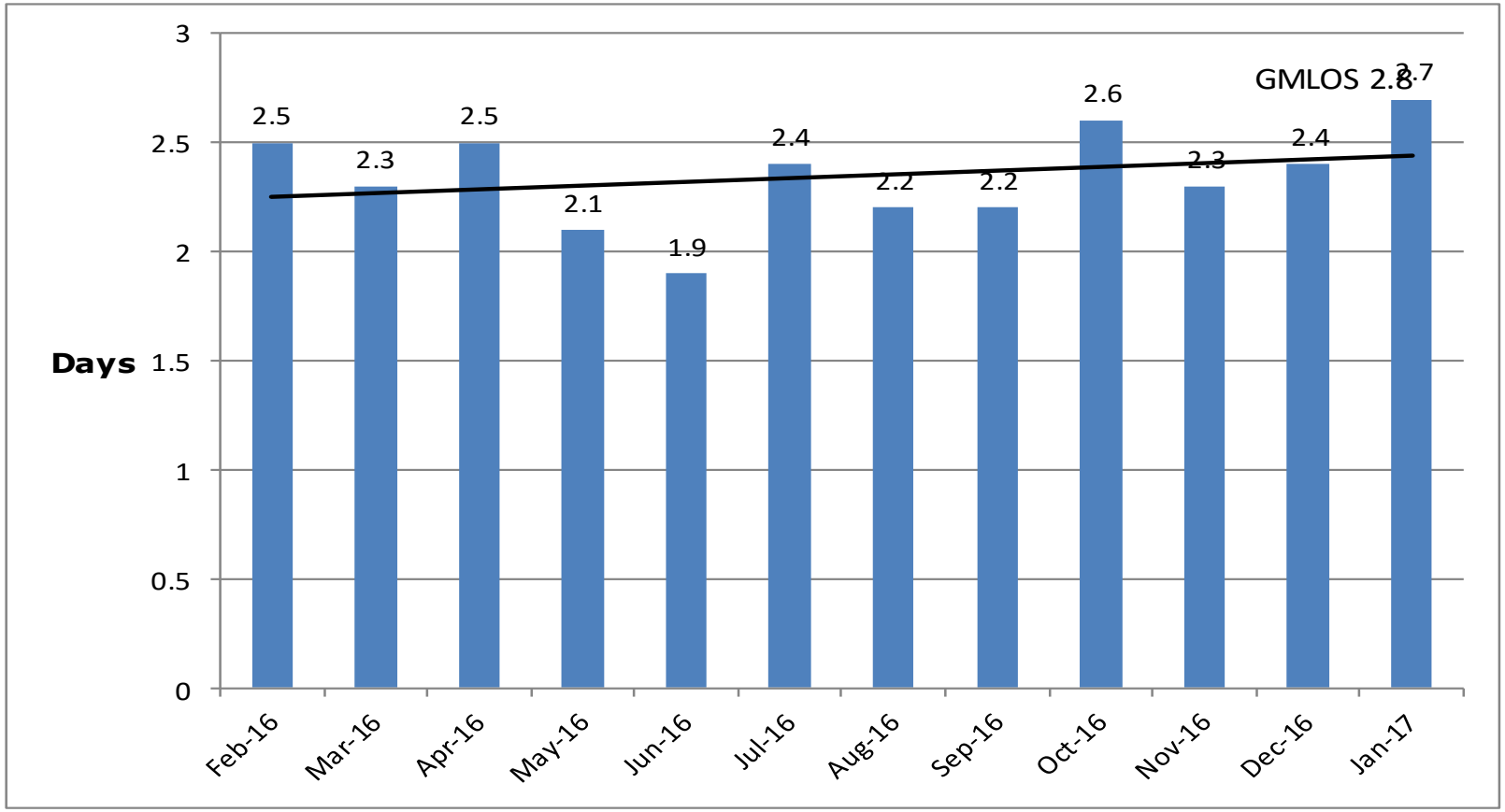
	7/13-9/13	10/13-12/13	1/14-3/14	4/14-6/14	7/14-9/14	10/14-12/14	1/15-3/15	4/15-6/15	7/15-9/15	10/15-12/15	Jan-Mar 16	Apr-Jun 16	Jul-Sep 16	Oct-Dec 16
LG Hip Arthroplasty IR	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.85	0.00	0.00
MV Hip Arthroplasty IR	0.00	0.00	0.00	0.00	0.00	1.45	2.82	0.00	1.41	0.00	0.00	2.86	0.00	0.00
Ent Hip Arthroplasty IR	0.00	0.00	0.00	0.00	0.00	0.96	1.80	0.00	0.88	0.00	0.00	3.13	0.00	0.00
# LG Hip Arthroplasty Procedures	31	30	24	27	26	35	40	45	42	42	26	26	31	26
# MV Hip Arthroplasty Procedures	64	83	90	58	82	69	71	79	71	71	95	70	79	66
# Ent Hip Arthroplasty Procedures	95	113	114	85	108	104	111	124	113	113	121	96	110	92
# LG Hip Arthroplasty Infections	0	0	0	0	0	0	0	0	0	0	0	1	0	0
# MV Hip Arthroplasty Infections	0	0	0	0	0	1	2	0	1	0	0	2	0	0
# Ent Hip Arthroplasty Infections	0	0	0	0	0	1	2	0	1	0	0	3	0	0
LG - SIR	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MV - SIR	0.00	0.00	0.00	0.00	0.00	0.861	0.00	0.00	0.00	0.00	0.57	0.00	0.00	0.00

Total Knee Replacement Surgical Site Infection

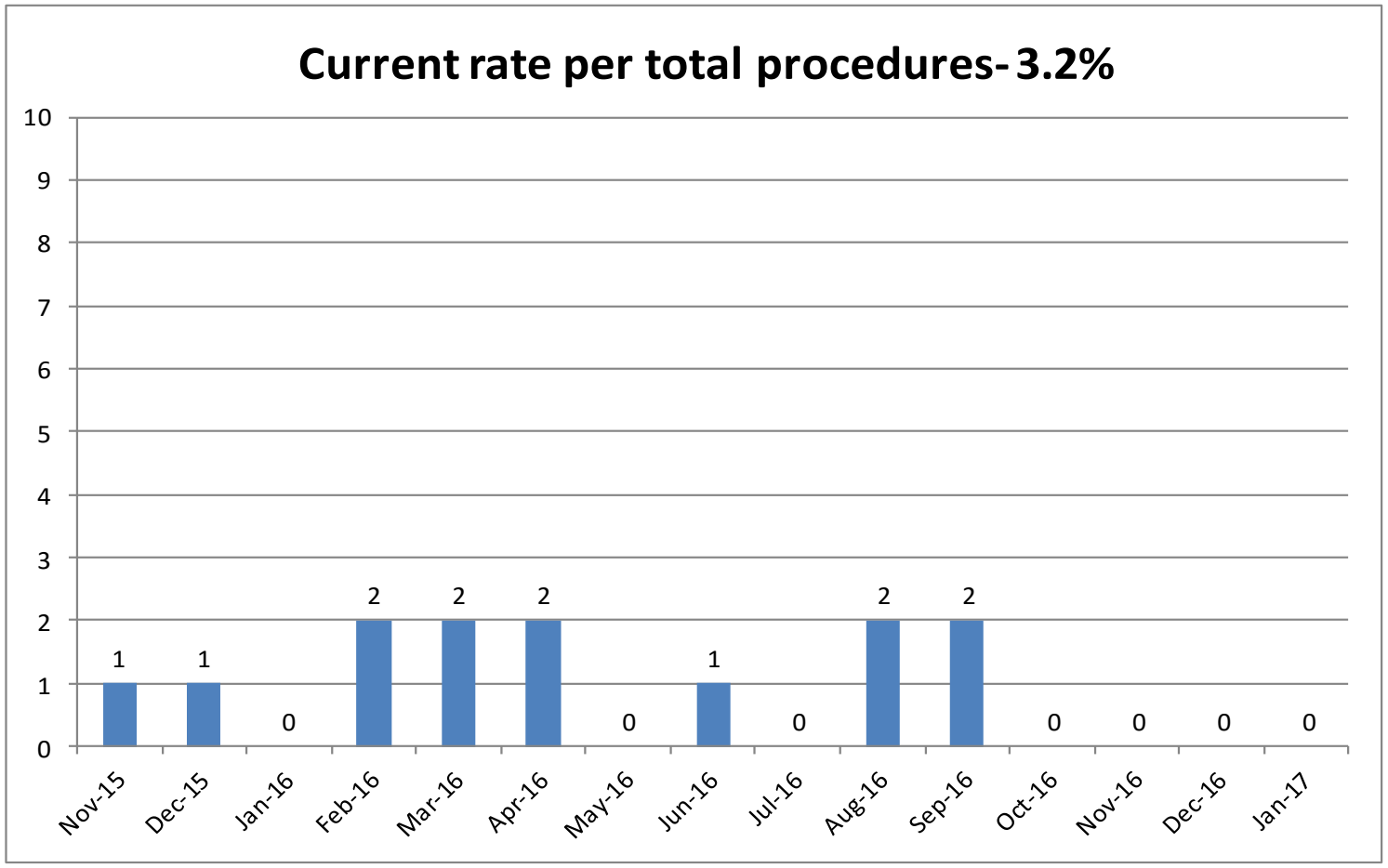


	1/14-3/14	4/14-6/14	7/14-9/14	10/14-12/14	1/15-3/15	4/15-6/15	7/15-9/15	10/15-12/15	1/16-3/16	4/16-6/16	7/16-9/16	10/16-12/16
LG Knee Arthoplasty IR	0.00	1.85	0.00	1.27	0.00	0.00	0.00	0.00	0.00	2.90	0.00	0.00
MV Knee Arthoplasty IR	1.23	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Ent Knee Arthoplasty IR	0.62	0.81	0.00	0.68	0.00	0.00	0.00	0.00	0.00	1.52	0.00	0.00
LG # Knee Infections	0	1	0	1	0	0	0	0	0	2	0	0
MV # Knee Infections	1	0	0	0	0	0	0	0	0	0	0	0
Ent # Knee Infections	1	1	0	1	0	0	0	0	0	2	0	0
LG # Knee Arthroplasty	80	54	80	79	75	83	79	79	73	69	67	65
MV # Knee Arthroplasty	81	69	64	69	73	68	75	75	70	63	59	64
Ent # Knee Arthroplasty	161	123	144	148	148	151	154	154	143	132	126	129
LG - SIR	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MV - SIR	0.69	0.69	0.69	0.69	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

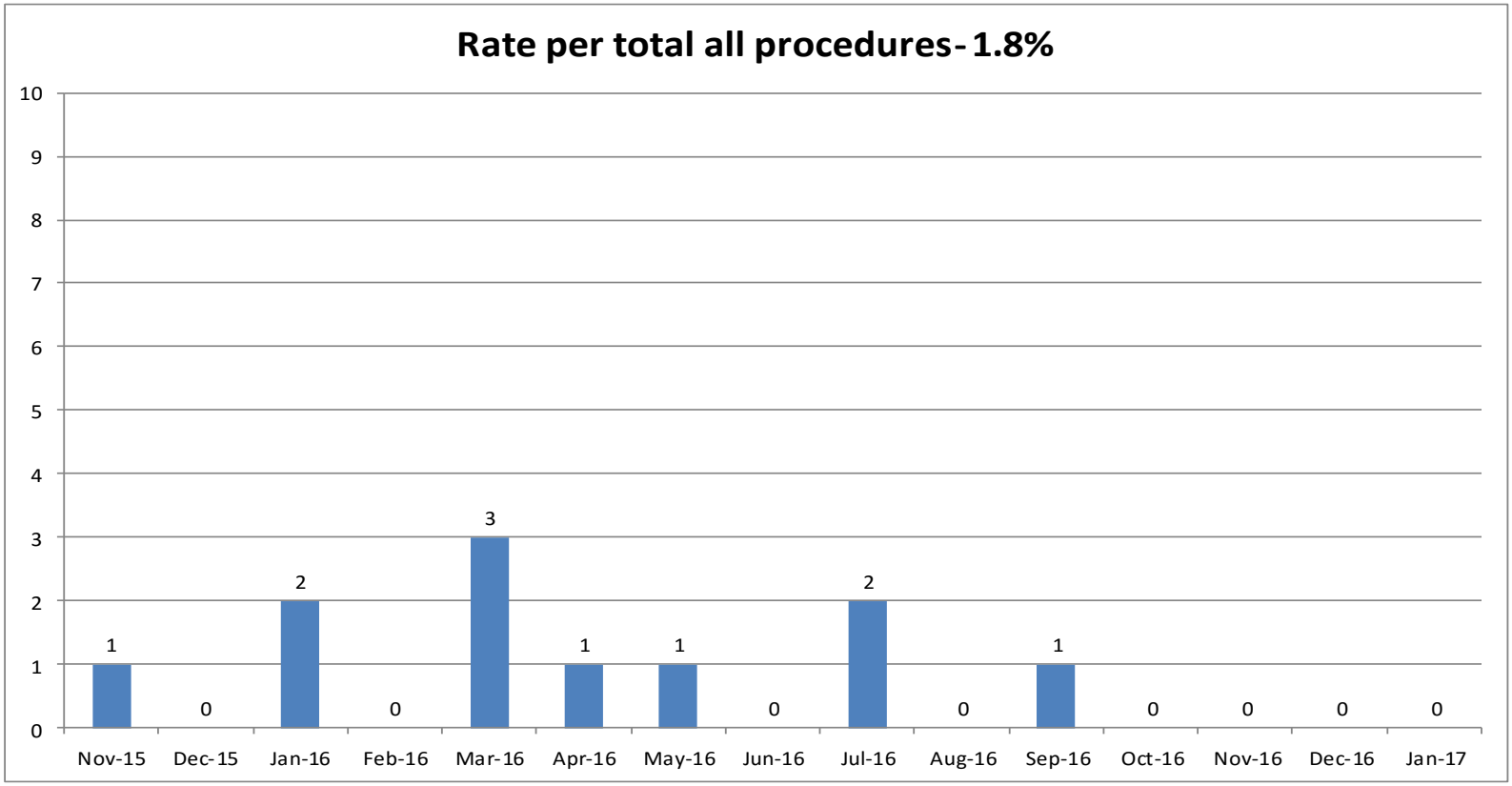
Enterprise Length of Stay
Total Knee Replacement



Total Hip Replacement 30 Day All Cause Readmissions



Total Knee Replacement 30 Day All Cause Readmissions



Spine

- Certified as a Joint Commission program for spine fusion in Los Gatos
- Growth in outpatient spine cases continues allowing patient to recover at home
- Utilization of one and two level disc replacement continues to expand

Bone Health

- Fractures are one of the most difficult disease processes to manage
- Programs under development to improve quality of life by reducing risk of fracture
  - Vitamin D lab testing
  - Vitamin D dosing
- Bone Health presentation with 70 in attendance
- Moving towards utilization of a bone fracture liaison to follow-up Emergency Department fractures

Future Orthopedic Development

- Expand use of the membership in the American Joint Replacement Registry to include quality outcome data
- Improve quality measures thorough teamwork in the orthopedic co-management physician/staff
- Develop Orthopedic Spine Center in Mountain View
- Recruit anterior hip replacement surgeon for Los Gatos

ATTACHMENT 7

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

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

Draft #1 - FY 18 Quality Committee Meeting Calendar
(1st Monday of the Month)

Recommended Quality Committee Date	Corresponding Hospital Board Date
No Meeting	July 2017– No Meetings
August 7, 2017	August 09, 2017
August 28, 2017 – in lieu of Sept	September 13, 2017
October 2, 2017	October 11, 2017
November 6, 2017	November 8, 2017
December 4, 2017	December 2017 – No meetings
No Meeting	January 10, 2018
February 5, 2018	February 14, 2018
March 5, 2018	March 14, 2018
April 2, 2018	April 11, 2018
May 7, 2018	May 09, 2018
June 4, 2018	June 13, 2018

ATTACHMENT 8

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	

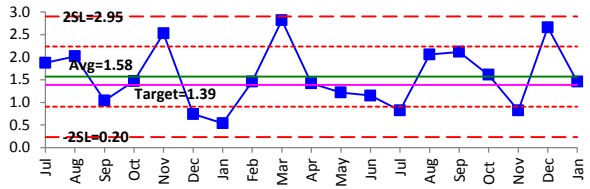
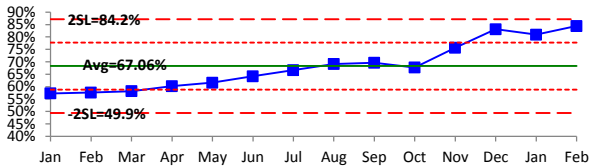
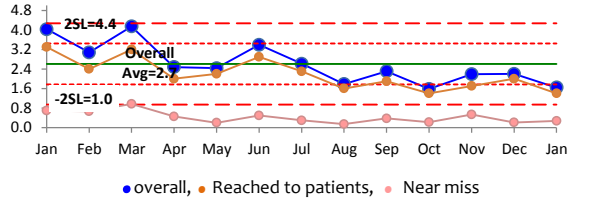
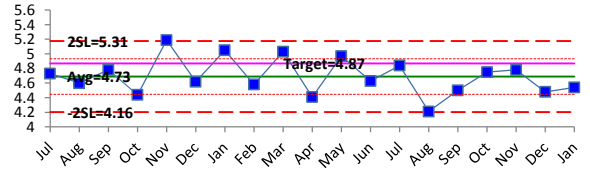
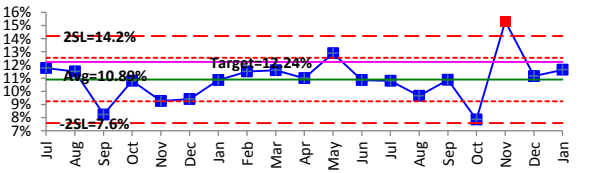
Goals	Timeline by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable.)	Metrics
3. Develop a plan to review the new Quality, Patient Care, and Patient Experience Committee Dashboard and ensure operational improvements are being made to respond to outliers.	▪ Q3	
4. Oversee 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

Dashboard

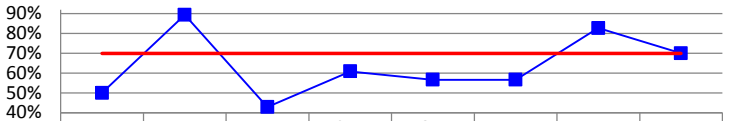
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

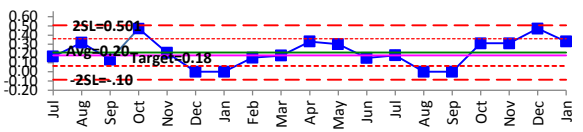
Date Reports Run: 3/12/2017			Baseline	FY17 Goal	Trend	Comments
SAFETY EVENTS	**Performance**		**FY2016**	**FY2017**		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: January 2017*	9/6157	1.46	1.51	1.39 (goal for FY 16)		Rate of falls dropped in January with increased census. Still a volatile measure.
2	★Organizational Goal **Pain reassessment within 60 mins after pain med administration** *Date Period: February 2017*	8136/9636	84.4%	56.3% (Jan-Jun 2016)	75% (min) 80% (mid) stretch goal=90%		Changes made in ED iCare documentation with improved compliance. Trend of continued improvement since October with weekly reporting and feedback.
3	**Medication Errors (Overall: reached to patients and near miss)** *Errors / 1000 Adj Total Patient Days* *Date Period: January 2016*	29/13269	2.19	2.68	0.00		6 data points below the mean indicates a positive trend in the reduction of medication errors.
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: February 2017*	FYTD 3420 Feb 2017 437	FYTD 4.58 Feb 2017 4.65	4.78	4.87		The increase in inpatient volume in Dec/Jan contributes to a reduction in average LOS
5	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: January 2017*	FYTD 329/2944 Jan 2017 60/516	FYTD 11.18 Jan 2017 11.63	11.53	At or below 12.24		The readmission rate continues near the target of 12.24, and ECH is noted to have the lowest 30 readmit rate among local hospitals.

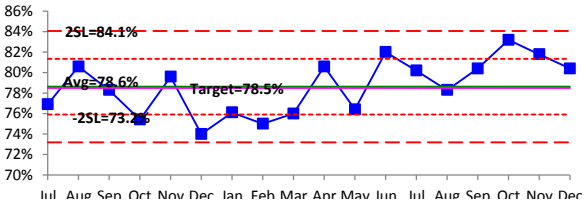
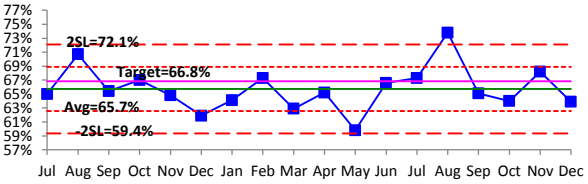
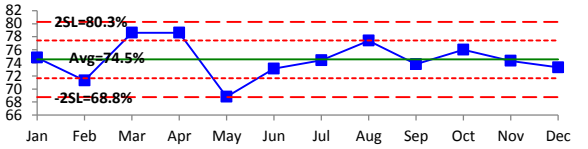
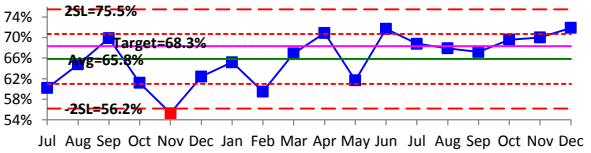
Definitions and Additional Information

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: 3/12/2017		Baseline	FY17 Goal	Trend	Comments
6	★Organizational Goal **IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) Date Period: January 2017			Goal: 70% (Min); 75%(Max); 80% (Stretch) 	Number of Sepsis cases in January all time high of 167 due to Flu cases. Decrease in this metric due to 2 cases in which adequate fluid was ordered within 3 hrs of TOP - not the required 2 hrs. The use of NICOM device to measure suseptibility to fluid resuscitation increased to 30%. The Sepsis Core measure data result was up to 71% - top 10% in the U.S according to S.Townsend, MD (Surving Sepsis)

	Apr	May	Jun	Sep	Oct	Nov	Dec	Jan
Number of Sampled Cases	18	19	21	23	30	30	29	30
Cases with 30ml/kg ordered or NICOM with 3 hours TOP				1	0	0	0	2
Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17	9	14	17	17	24	21
% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%	43%	61%	57%	57%	83%	70%
Min Goal	70%	70%	70%	70%	70%	70%	70%	70%

COMPLICATIONS		Performance		FY 2016	FY 2017		
7	**Surgical Site Infection (SSI)** *SSI per 100 Surgical Procedures* *Date Period: January 2017*	3/606	0.33	0.20	0.18 (goal for FY 16)		2 SSI in Jan: 1 total knee and one lumbar fusion both at Los Gatos. SSI Task Force working w/surgeons and OR staff to address infections.

SERVICE		Performance		FY 2016	FY 2017		
8	**Communication with Nurses** *(HCAHPS composite score, top box)* *Date Period: Dec 2016*	240/299	80.4%	78.0%	78.5%		Results are beginning to trend down, and a continued focus on bedside handoff, manager rounding, and hourly rounding by nursing staff. Increased use of travel and registry nurses.
9	**Responsiveness of Hospital Staff** *(HCAHPS composite score, top box)* *Date Period: Dec 2016*	178/279	63.9%	64.9%	66.8%		Hourly rounding and nurse managaer rounding continues. Flu season was ramping up during the month of December, and we lost some group in January. High census and boarding some pts. in the ED. Expect to the HCAHPS to follow.
10	★Organizational Goal **Pain management** (HCAHPS composite score, top box) *Date Period: Dec 2016*	122/166	73.3%	72.5%	73% min 74% max 76% stretch		Focus on pain management continues for ECH, and the reassessmenet compliance continues to improve. We expect HCAHPS to follow.
11	**Communication About Medicines** *(HCAHPS composite score, top box)* *Date Period: Dec 2016*	142/198	71.9%	64.7%	68.3%		We continue to support the M3 visual cue program on all th eunits which prompts the nurse and patient to discuss the purpose and side effects of medications. Nurses also are discussing pain management medications more frequently with the reassessment which is also helping to improve this score.

Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock	Catherine Carson		Percentage of Randomly Sampled ED Patients (LG & MV) who had IVF >=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate <3 Excluded)		
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**

Opioids Use

SECTION 7

Opioids

Magnitude of the Problem

Prescription opioids are commonly used to treat acute and malignant pain, and, over the last decade, have increasingly been used in the management of chronic pain. Acute and chronic pain affect many Americans every year. Chronic pain alone is reported by more than 100 million Americans annually, with pain affecting more Americans than diabetes, heart disease, and cancer combined [1]. The annual costs of chronic pain, including medical costs of pain care and the economic costs related to disability days, lost wages, and lost productivity, range from $560 billion to $635 billion (in 2010 dollars) [1]. Although opioids are an essential tool for the treatment and management of acute, postoperative, and procedural pain, as well as for chronic pain related to cancer in the palliative care setting [1], use of opioids for chronic pain is more controversial because of the limited evidence surrounding the safety and efficacy of long-term opioid use for chronic pain [2]. Nevertheless, clinical practice guidelines recommend judicious use of opioids in appropriately selected and monitored patients [3].

The use of opioids has increased dramatically over the last decade. Between 1999 and 2010, the number of prescription opioids dispensed roughly doubled and the sales rate of prescription opioids (in kg/10,000 population) increased fourfold [4], with an estimated 201.5 million opioid prescriptions dispensed in 2009 [5]. In 2009, the prescription opioid hydrocodone was the single most commonly prescribed medication in the United States, and opioid analgesics were the third most commonly prescribed class of medications overall, leading the United States to spend approximately $8.4 billion on opioids in 2010 [6]. This increased use of opioids has come with unintended and serious health and social consequences. There is limited evidence on the effectiveness of long-term use of opioids and it is not clear that the dramatic increase in the use of opioids has led to improved treatment of pain overall, especially of chronic pain [7].

Opioids cause a number of ADEs that affect patients in both inpatient and outpatient settings. These ADEs are detrimental to the health and quality of life of patients [8]. Opioid ADEs include oversedation and respiratory depression; gastrointestinal adverse events, such as nausea, vomiting, and constipation; opioid-induced hyperalgesia; pruritus; and immunological and hormonal dysfunction [9]. All these ADEs were considered by the Federal Interagency Workgroup (FIW) for Opioid ADEs as important possible targets of the ADE Action Plan; however, the FIW determined that addressing ADEs related to unintentional opioid overdoses (i.e., oversedation, respiratory depression) were the highest priority because of the associated mortality and morbidity. Opioid overdoses constitute a tremendous public health burden that is potentially amenable to measurable prevention efforts, and a coordinated action plan could aid in prevention.

Prescription opioid–related deaths are considered to be one of the Nation's leading preventable public health problems.

Opioid overdose is a significant cause of drug-related injury and an important cause of adverse drug events. Opioids are central to the ADE Action Plan because they are a common cause of ADEs [10] and the leading cause of pharmaceutical overdose deaths [11]. By 2010, the number of prescription opioid overdose deaths had increased for the 11th straight year to 16,651 deaths [10], which exceeds the number of overdose deaths involving heroin and cocaine combined [10], and represents a quadrupling of the approximately 4,000 prescription opioid-related deaths reported in 1999 [10]. Moreover, the number of emergency department (ED) visits related to opioid misuse and abuse more than doubled from 2004 to more than 420,000 emergency department visits in 2011 [12]. Prescription opioid abuse is estimated to result in more than $72 billion in health care-related costs each year [13].

Access to safe and effective pain care remains an important problem in the United States; efforts to minimize the burden of harms from opioids should be implemented in parallel with efforts to ensure patients suffering from pain receive the most effective and safest treatment available.

The Institute of Medicine report *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research* outlines the challenges faced by Americans affected by pain [1]. The Opioids Section of the ADE Action Plan is informed, in part, by the findings and recommendations of this seminal report. All recommendations in the ADE Action Plan should be taken in the context of improving overall patient care through providing the safest and most effective, evidence-based pain care. In pain care, treatment decisions require that the potential benefits of opioid analgesia be

weighed against the potential safety risks of opioid treatment. Therefore, these recommendations recognize the importance of the clinician's judgment in the context of patient-centered care.

Because the dramatic increase in the use of opioids over the past decades is largely attributed to use for chronic pain, this section's recommendations for safer outpatient opioid treatment will focus on long-term opioids used for chronic pain. However, safe opioid prescribing is needed in all settings, including acute, postoperative, and periprocedural situations.

Distinguishing overdoses that occur during the normal course of care from misuse/abuse will be important in efforts to prevent opioid ADEs.

The ADE Action Plan's Opioids Section targets preventing opioid ADEs in patients prescribed opioids for pain, including patients who are injured through aberrant drug behavior. Discussion of patients who are prescribed opioids for addiction treatment, patients diverting opioids, and patients injured through suicide attempts is outside of the scope of the ADE Action Plan.

Although not specifically addressed in the ADE Action Plan, misuse and abuse of prescription opioids is an important public health problem and is the current target of several Federal and statewide initiatives by agencies such as the Centers for Disease Control and Prevention (CDC), Drug Enforcement Administration (DEA), Food and Drug Administration (FDA), National Institute on Drug Abuse (NIDA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the White House Office of National Drug Control Policy (ONDCP). The FIW for Opioid ADEs acknowledges that there is a continuum of aberrant drug-related behaviors, and misuse and abuse are strong predictors for prescription opioid ADEs. The ADE Action Plan defers to the work of other Federal Agencies with regard to the specific issue of prescription opioid misuse and abuse.

The accurate categorization of opioid-related overdose deaths resulting from therapeutic use, versus misuse and abuse, is extremely challenging from a public health surveillance and epidemiologic perspective. Patients who are appropriately prescribed opioids can gradually drift into the spectrum of misuse/abuse through aberrant drug-related behaviors, such as increasing the dose or frequency of their opioids without consulting their prescriber [14]. This makes it difficult to target patients who are misusing/abusing opioids because it is challenging to identify patients who drift from therapeutic use to misuse/abuse. Aside from the practical difficulties in collecting data that can differentiate opioid ADEs from the normal course of care versus those arising from opioid misuse and abuse, the clinical definitions of addiction, dependence, misuse, and abuse are all still under debate within the pain

community [15]. The ambiguous definitions of misuse/abuse also make it difficult to draw conclusions from available data. As a result, the ADE Action Plan recommendations do not differentiate between patients who may misuse opioids. Instead, the Action Plan recommendations seek to reduce harm in all patients who are prescribed opioids for pain. The Action Plan supports developing a consensus on clinical and surveillance definitions of these terms but recognizes that this is outside of the scope of the plan. The ADE Action Plan does recognize the limitations of the data available and is cautious not to draw conclusions beyond those that the data can explain. For example, the CDC identified more than 16,651 opioid overdose deaths in 2010 [10], but it was not possible to distinguish deaths that occurred in the normal course of care when using medications as prescribed from deaths that resulted from intentional misuse and abuse. SAMHSA's Drug Abuse Warning Network (DAWN) estimated that more than 420,000 ED visits resulted from nonmedical use of prescription pain relievers in 2011 [12]. However, limited data are available about the number of ED visits for opioid ADEs during the normal course of care. Because of these limitations, much of the data cited throughout the opioid section of the ADE Action Plan may include patients who deliberately misuse/abuse opioids. These limitations are noted whenever applicable.

Surveillance

Understanding trends in opioid injuries and safe prescribing practices requires accurate, timely, and adequately representative information on key process and outcome measures—at national, regional, and facility levels.

A number of Federal- and State-based surveillance systems provide data on opioid ADEs. Broadly, these surveillance systems can be categorized as measuring three types of outcomes: (1) clinical (primary) outcomes (e.g., ED visits, deaths); (2) intermediate (surrogate) outcomes (e.g., clinical or laboratory values that precede or lead to clinical outcomes); and (3) process measures, indicators of actions aimed at mitigating the risk for clinical or intermediate outcomes (e.g., use of urine drug tests or State Prescription Drug Monitoring Program [PDMP] data). Clinical outcomes and process outcomes are most applicable to opioid ADEs because the prevention utility and role of intermediate outcomes is not clearly established. The identified Federal surveillance strategies have generally not been designed to assess intermediate outcomes related to opioid ADEs. A summary of Federal surveillance systems and selected State surveillance systems specific to opioid ADEs is presented in **Table 11**.

Currently available Federal surveillance systems outlined in the other sections are also capable of assessing the national opioid ADE burden. Federal systems involved in direct patient care (e.g., IHS, VHA) can capture regional- and facility-level information on the quality of opioid management. **Table 12** provides a summary of opioid ADE-related metrics from currently available Federal surveillance systems.

Table 11. Summary of Opioid ADE Metrics Collected by Federal and Relevant State Surveillance Systems

Source	Overview
National Vital Statistics System (NVSS), CDC	▪ Collects data from all death certificates filed by States and territories in the United States, including deaths involving drugs. ▪ Uses ICD codes to identify the underlying causes of death (e.g., drug overdose) and contributing causes (e.g., specific pharmaceutical or illicit drugs).
Drug Abuse Warning Network (DAWN), SAMHSA	▪ Collects data for drug-related ED visits from a nationally representative sample of U.S. non-Federal, short-stay, general medical and surgical hospitals with one or more EDs open 24 hours a day. ▪ Completed data collection in 2011; data are being incorporated into a larger National Center for Health Statistics (NCHS) survey.
Prescription Behavior Surveillance System (PBSS), CDC, FDA, BJA (under development)	▪ Will collect de-identified data from multiple State Prescription Drug Monitoring Programs (PDMPs). ▪ Number of participating PDMPs continues to increase, with the goal of collecting nationally representative data to develop surveillance reports for each participating State.
Prescription Drug Monitoring Programs (PDMPs)	▪ 49 States have legislative authority for PDMPs, and 47 States have active systems to collect State-level data related to the prescribing and dispensing of controlled substances. ▪ PDMPs collect patient, prescriber, dispensing pharmacy, and drug information.

Abbreviations: ADE = adverse drug event; BJA = Bureau of Justice Assistance; ED = emergency department; DAWN = Drug Abuse Warning Network; DEA = Drug Enforcement Administration; ICD = International Classification of Diseases; NCHS = National Center for Health Statistics; NVSS = National Vital Statistics System; PBSS = Prescription Behavior Surveillance System; PDMP = Prescription Drug Monitoring Program; SAMHSA = Substance Abuse and Mental Health Services Administration

Table 12. Summary of Metrics Related to Opioid ADEs Collected by Federal and Relevant State Surveillance Systems

Geographic Scope	Data Collection Method	Opioid ADEs or Management Metrics: Inpatient Settings	Opioid ADEs or Management Metrics: Outpatient Settings
National ADE Incidence/Rates	Administrative claims and/or EHR data	***AHRQ (NIS):*** ▪ Inpatient stays with ICD-9-CM codes indicative of opioid ADEs	***AHRQ (NEDS):*** ▪ ED visits with ICD-9-CM codes indicative of opioid ADEs ***CMS (Medicare Part D Claims):*** ▪ Outpatient prescribing to detect fraud and abuse
	Medical-record review	***AHRQ (MPSMS):**** ▪ Opioids are not currently captured by MPSMS system, but will be included after the conversion to QSRS.	***CDC (NEISS-CADES):*** ▪ ED visits for opioid overdoses and other ADEs, not related to misuse/abuse ***CDC (NVSS-Mortality):*** ▪ Deaths due to opioid overdose ***SAMHSA (DAWN):***** ▪ ED visits for opioid ADEs
Regional-/ Facility-level ADE Incidence/Rates (Quality Improvement)	Administrative claims and/or EHR data	▪ Not available	***DOD:*** ▪ Outpatient clinic visits, ED visits, hospitalizations with ICD-9-CM codes and/or CPT codes ***VA:*** ▪ VA/DOD guideline-based process measures ▪ Outpatient clinic visits, ED visits, hospitalizations for opioid overdoses & other relevant ADEs per ICD codes and/or CPT codes and prescription data (e.g., naloxone Rx) ***VA/DOD/State PDMP:*** ▪ Number of opioids prescribed linked with patient and prescriber ▪ Number of patients with multiple opioid prescribers ▪ Number of patients on high daily dose of opioids
Spontaneous Reports		***FDA:*** ▪ Clinician-diagnosed or patient-reported ADE	***FDA:*** ▪ Clinician-diagnosed or patient-reported ADE

Abbreviations: ADE = adverse drug event; ARCOS = Automation of Reports and Consolidation Order System; CPT = Current Procedural Terminology; DAWN = Drug Abuse Warning Network; DEA = Drug Enforcement Administration; ED = emergency department; EHR = electronic health record; ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification; PDMP = Prescription Drug Monitoring Program; QSRS = Quality and Safety Review System; SAMHSA = Substance Abuse and Mental Health Services Administration

* In 2015, MSPMS will be replaced by the Quality and Safety Review System (QSRS).

**** Surveillance using DAWN is currently undergoing transition to CDC's National Hospital Care Survey.**

Outcome and process measures related to opioid ADEs are lacking.

Currently, few validated metrics are available to assess national- or facility-level burden of opioid ADEs. Opportunities for improvement include the development and validation of clinical outcome and process measures, standardized definitions for opioid ADEs, requirements for reporting, and research into validated metrics that can reliably identify opioid ADEs.

PDMPs and PBSS represent important opportunities for advancing surveillance to reduce opioid ADEs.

One of the opportunities for advancing surveillance is continuing to develop PDMPs and the PBSS so as to optimally capture the data needed to identify high-risk prescribing patterns and to better understand risk factors for opioid ADEs. Ideally, PDMPs should be able to track patients across settings (including across different States), identify high-risk prescribing practices, and alert prescribers to aberrant drug-related behaviors in patients prescribed opioids.

Future surveillance efforts should capture opioid ADEs on the basis of validated process and outcome measures, differentiate opioid ADEs that occur in the normal course of care from those arising from opioid misuse/abuse, and identify ADEs occurring during transitions of care.

A number of potential process measures—such as number and doses of opioids prescribed, number of patients with multiple prescribers, number of patients on high daily doses of opioids, and number of patients co-prescribed opioids and sedatives—are available through data collection sources, such as EHRs and PDMPs. Federal Agencies should explore the best methods to collect and manage these data to allow for accurate, real-time evaluation of trends in validated process measures. **Figure 19** summarizes the recommendations to advance surveillance strategies for opioid ADEs.

Figure 19. Federal Interagency Workgroup Recommendations for Actions That Can Potentially Advance Surveillance Strategies for Opioid ADEs

Actions That Can Potentially Advance Surveillance Strategies for Opioid ADEs

- **Determine the adequacy of diagnostic and procedural coding for capturing opioid-related overdose events.**
  - Assess specificity, sensitivity, PPV, and NPV of ICD and CPT codes for capturing opioid-related overdose events.
  - Develop, assess, and validate novel measures for identifying and recording opioid ADEs (outlined in **Table 15**).
- **Address strengths and limitations of using process measures to identify opioid ADEs.**
- **Study associations between process measures and risk of opioid ADEs in inpatient and outpatient settings.**
- **Improve access to more integrated EHR data with linked pharmacy and outcomes data.**
- **Identify appropriate ADE surveillance metrics for opioid ADEs in inpatient and outpatient settings.**
- **Develop better surveillance definitions for opioid-related overdose events.**
  - Clarify criteria for identifying opioid ADEs that occur in the normal course of care versus those arising as a result of opioid misuse and abuse.
- **Identify appropriate ADE surveillance metrics for opioid ADEs.**
- **Improve the capabilities and use of PDMPs.**
  - Promote increased use of PDMP systems by providers.
  - Maintain funding for PDMP development at the State and Federal level.
  - Strive for real-time data reporting and cross-setting interoperability for PDMPs.

Abbreviations: ADE = adverse drug event; CPT = Current Procedural Terminology; EHR = electronic health record; ICD = International Classification of Diseases; NPV = negative predictive value; PDMP = Prescription Drug Monitoring Program; PPV = positive predictive value

Evidence-Based Prevention Tools

Many evidence-based guidelines for prescribing opioids for chronic pain address the issue of opioid safety [3, 16, 17, 18, 19]. Specifically, the guidelines make patient-centered care central to the decisionmaking process through assessing patients at risk for opioid ADEs and balancing the goals of pain management with the risk of opioid ADEs. Risk factors for inpatient and outpatient opioid ADEs differ in a number of ways. In inpatient settings, system-wide changes may be the most important target for ADE prevention because many opioid ADEs occur from medication and prescribing errors and inadequate monitoring of patient outcomes. In outpatient settings, safer prescribing and monitoring by providers and patient-centered interventions are critical because problems such as inappropriate

medication use (e.g., inappropriate dose, issues of adherence, aberrant medication-related behavior) are likely to play a far larger role in causing opioid ADEs in these settings than in inpatient settings [14]. Federal Agencies have a number of strategies to promote safe opioid prescribing and reduce opioid ADEs; these can serve as a model for private stakeholders. Federal Agencies should continue to develop, study, and validate opioid ADE prevention strategies and promote the adoption of validated ADE prevention strategies throughout the continuum of care. Current and future Federal assets related to the safe management of opioid therapy are summarized in **Figure 20**.

Figure 20. Federal Assets Related to Safe Management of Opioid Therapy, as Identified by the National Quality Strategy Priorities

Resources for Safer Care—Health Care Provider Knowledge

- **DOD/VA:**
  - **Opioid Prescribing Protocol/ Guidelines**—Includes recommendations for assessing patients for appropriate pain therapy.
  - **Education opportunities**—Provider education Web portal (Talent Management System [TMS]) offers several continuing education courses on pain management, including a course on **"Opioid Therapy for Acute and Chronic Pain."**
  - **Opioid Safe Program** at Womack Army Medical Center (Fort Bragg, North Carolina)—Primary care clinicians provide high-risk patients prescribed opioids with kits containing naloxone, along with training in identifying and responding to overdose symptoms.
- **FDA:**
  - **Risk Evaluation and Mitigation Strategies (REMS)**—Required strategy for extended-release and long-acting opioids; FDA developed a *Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics* and maintains a list of compliant continuing education (CE) programs for prescribers that include this curriculum.
  - **Opioid Dose Conversion Table**—Safe and reliable dose conversion table is based on updated evidence.
- **IHS:**
  - **TeleBehavioral Health Center of Excellence Pain and Addictions course**—15-series Webinar training program provides specialized training on how to treat pain and addictions.
  - **"Pain Champion" Training**—63-hour CE course trains local and regional experts, using the Project ECHO Model, which shares expertise by utilizing telehealth technology to connect an ECHO Team (primary care, specialists, and other providers integral to a patient-centered medical home team) to providers in rural and underserved locations.
- **NIH:**
  - **NIDAMED Physician Education Tools**—The National Institute on Drug Abuse (NIDA) created online tools and resources for medical professionals on safe pain management, including two classes entitled **"Safe Prescribing for Pain"** (2 CME/CE credits) and **"Managing Pain Patients Who Abuse Rx Drugs"**[i] (1.75 CME/CE credits). In addition to these two pain-focused educational resources, NIDA has developed an additional resource, **"Substance Use Disorders in Adolescents: Screening and Engagement in Primary Care Settings,"** which can be used by health care professionals to screen adolescents for aberrant prescription drug use and substance abuse disorders.
- **SAMHSA:**
  - **Opioid Overdose Prevention Toolkit**—Equips communities and local governments with materials to develop policies and practices to help prevent opioid-related overdoses and deaths, and addresses issues for first responders, treatment providers, and those recovering from opioid overdose.[ii]

[i] Available at: http://www.drugabuse.gov/nidamed/etools

[ii] Available at: http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742

Inpatient Settings

In 2001, the Joint Commission developed standards for pain treatment to promote access to adequate pain management. In that context, The Joint Commission also identified opioids as an important cause of inpatient ADEs, with the most dangerous ADE being respiratory depression. The 2011 Joint Commission Sentinel Event Alert "Safe Use of Opioids in Hospitals" recommended improved assessment and management of pain to avoid accidental opioid overdose [20]. Accepted standards of care recommend a systematic approach to patient assessment and patient monitoring. Federal Agencies, including VA and DOD, have identified the following potential targets for reducing opioid ADEs: initiating patients on a high dose of opioids, converting between opioid formulations, and opioid dose titration. **Figure 21** outlines opportunities to advance ADE prevention strategies/tools in inpatient settings organized around the National Quality Strategy framework.

Figure 21. Opportunities for Advancing Opioid ADE Prevention Strategies/Tools, as Identified by the National Quality Strategy Priorities—Inpatient Settings

Safer Care	▪ Expand dissemination of evidence-based opioid guidelines/ protocols (e.g., dosing changes, management of high-risk individuals)
Patient and Family Engagement	▪ Promote patient education to improve the safety of care transition
Effective Communication and Coordination of Care	▪ Develop more optimal and integrated health IT opioid management tools ▪ Coordinate care through practices such as medication reconciliation and discharge counseling
Science-Driven Prevention and Treatment	▪ Promote systematic and coordinated care ▪ Promote safe practices at point of initiation of inpatient opioids ▪ Promote the use of evidence-based tools for morphine equivalent dose (MED) and transitions between formulations
Promotion of Best Practices Within Communities	▪ Use metrics to monitor the use of opioid safety "best practices" ▪ Promote the use of evidence-based guidelines for monitoring

Abbreviations: MED = morphine equivalent dose

Outpatient Settings

Opioid ADEs in outpatient settings are a multifaceted problem. Although the ADE Action Plan does not directly address the issue of misuse/abuse, it does advocate for steps to improve prescribing behaviors

to prevent patients who are prescribed opioids from abusing opioids. Although the factors driving opioid overdoses are not completely understood, a number of factors have been associated with increased risk for opioid overdose in the outpatient setting, based on varying degrees of evidence, and can serve as targets for outpatient opioid overdose prevention. These risk factors are: concomitant use of central nervous system (CNS) depressants (especially benzodiazepines) [14, 20, 21], high daily opioid dose [22, 23, 24, 25, 26], recent initiation of opioid therapy in treatment-naive patients [20, 27, 28], multiple opioid prescribers [14, 29], mental health disorder co-morbidities [14, 20, 21, 28, 30], medical co-morbidities (e.g., sleep apnea) [3], active or history of substance abuse [20, 21, 28, 29], aberrant medication-related behaviors [14, 28, 31, 32], and higher risk formulations (e.g., methadone) [33]. Federal Agencies can play an essential role in promoting evidence-based strategies to address opioid overdose risk factors and promote safe practices. **Figure 22** presents opportunities to advance ADE prevention strategies/tools in outpatient settings organized around the National Quality Strategy Priorities.

Figure 22. Opportunities for Advancing Opioid ADE Prevention Strategies/Tools, as Identified by the National Quality Strategy Priorities—Outpatient Settings

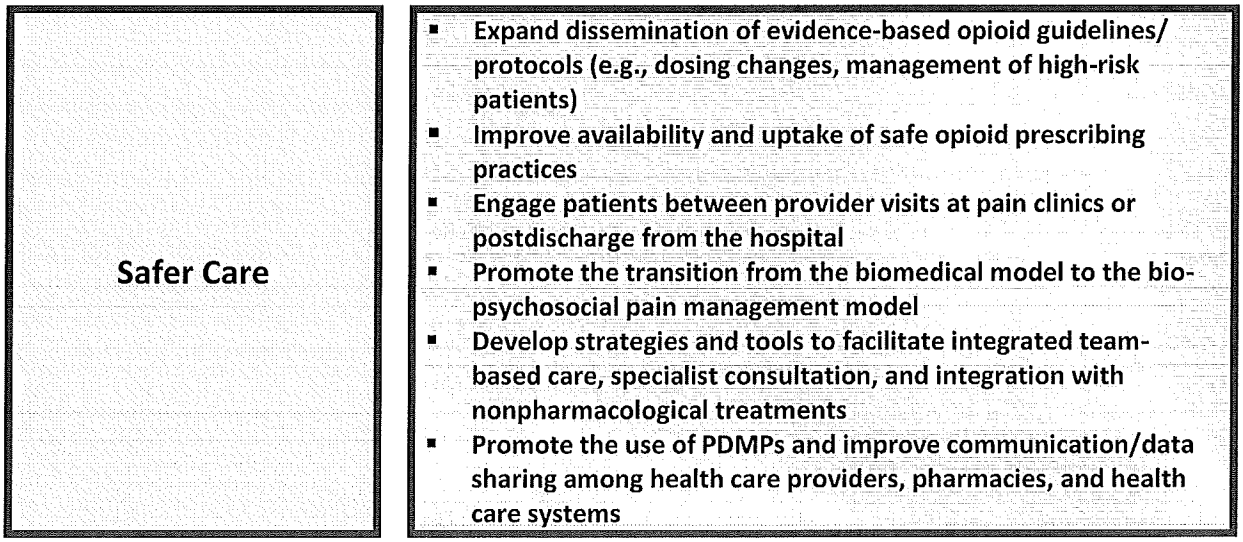


Figure 22. Opportunities for Advancing Opioid ADE Prevention Strategies/Tools, as Identified by the National Quality Strategy Priorities—Outpatient Settings (continued)

Patient and Family Engagement	▪ Develop and distribute patient education materials and strategies, using the principles of health literacy and theories of behavioral change ▪ Spread public health messages promoting safe opioid storage, use, and disposal, and not sharing opioids with friends or family ▪ Educate patients and their families to recognize early signs of dependence
Effective Communication and Coordination of Care	▪ Develop more optimal and integrated health IT opioid management tools ▪ Integrate opioid-specific targets into care transition models
Science-Driven Prevention and Treatment	▪ Promote systematic and coordinated care through strategies such as team-based care and medication reconciliation ▪ Promote the use of evidence-based strategies for managing risk factors associated with opioid overdoses ▪ Increase availability of mental health and substance use disorder treatment for patients on opioid therapy ▪ Promote the use of health IT tools to identify high-risk opioid prescribing practices
Promotion of Best Practices Within Communities	▪ Use metrics to monitor the use of opioid safety "best practices" ▪ Promote effective strategies identified by Federal Agencies that engage in patient care

Federal Agencies should explore ways to improve uptake of evidence-based strategies for safe opioid prescribing, including increased use of prescribing guidelines for chronic pain treatment and didactic provider training on opioid prescribing for both trainees and fully qualified clinicians (e.g., continuing education). More importantly, Federal Agencies should support training methods, interventions, and tools to encourage, model, and facilitate safe opioid prescribing.

Opioid prescribing guidelines for the treatment of chronic pain promote assessment of patient risk factors prior to initiating opioid therapy and recommend continued assessment of patient therapy goals and outcomes to determine the effectiveness and appropriateness of therapy. Prescribing guidelines also provide consensus-based strategies on how to reduce the risk for opioid ADEs. Knowledge of these strategies is necessary, although not sufficient for appropriate opioid prescribing; Federal Agencies should continue to work to educate clinicians on safe and appropriate opioid prescribing, and use available mechanisms to promote clinician education and effective behavior change. Federal Agencies

should work to develop, evaluate, and disseminate (1) training methods that include modeling, practice, expert collaboration, and/or feedback on real-patient cases (e.g., Project ECHO, Academic Detailing, expert consultation and mentoring); (2) interventions to identify and address high-risk cases (e.g., aberrant drug-related behavior or risk factor screening and intervention, high-risk patient treatment program, audit and feedback, or panel management systems); and (3) reminders and tools that guide clinicians in real time (e.g., computerized decision support systems, clinical reminders, dose determination tools).

Federal Agencies should promote patient-centered, multimodal, team-based care, from the health system level down to the clinician level, to personalize pain management, properly manage patients with high-risk medical and mental health co-morbidities, and intensively manage patients at high risk for opioid overdose.

Federal Agencies should promote evidence-based practices for pain management, including but not limited to opioid therapy. Federal Agencies should promote practices and services that identify and properly manage co-morbidities that increase the risk of opioid ADEs. This includes management of behavioral, mental health, and medical risk factors for unintentional and intentional opioid overdose and opioid abuse, as well as use of nonopioid pharmacological therapies and nonpharmacological therapies as part of an overall pain management plan. Currently, there is limited access to multimodal, evidence-based pain management and treatment of medical and psychiatric co-morbidities. Federal Agencies should promote access to evidence-based, multimodal, and interdisciplinary care for the management of chronic pain and co-morbidities. The Affordable Care Act provisions that support Mental Health parity may improve access to services that address mental health co-morbidities. Increased uptake of existing Health and Behavioral Assessment and Intervention CPT codes may also address this challenge.

Federal Agencies should develop and encourage the use of patient education materials and tools, in accordance with health literacy principles, to empower the patient to use opioids safely and encourage patient engagement.

Patients can play a major role in increasing the safe use of prescription opioids. To promote safe opioid use at home, patients should be educated about the safe and proper use of opioids for pain management, not sharing opioids, secure storage of opioids, and safe disposal of any opioids that are not used as part of therapy. Patient education materials, including materials the prescriber provides, should be developed using principles of health literacy to ensure that the patient understands the messages presented.

Patient education should also include ways to identify signs of misuse, abuse, dependence, and addiction, and to identify and treat an overdose. Federal Agencies should help develop, evaluate, and disseminate effective training, tools, and programs to provide patients with the skills and resources necessary to safely respond to moderate to severe pain and signs of misuse, abuse, and overdose, as well as to manage opioid therapy (e.g., medication take-back programs, overdose education and naloxone distribution programs, electronic tracking and reminder tools, suicide hotlines, and relaxation skills training).

Federal Agencies involved in patient care play an important role in assessing and promoting best practices for pain management and opioid safety.

BOP, DOD, IHS, and VA, all of which provide direct patient care, have taken steps to advance the practice of pain management and improve opioid safety. Because DOD and VA serve active-duty service members and military veterans who often have injuries requiring pain management, these agencies have been actively pursuing evidence-based pain management and systems to promote opioid safety. **Table 13** outlines the initiatives that are currently underway in VA and DOD systems and can be evaluated, modeled, and expanded to the private sector. DOD and VA have developed their own opioid prescribing guidelines for chronic pain [15] and have developed system-based methods to measure how the guidelines are followed and monitor trends associated with the use of opioid prescribing guidelines; however, prescriber adherence to the prescribing guidelines could be optimized with a system of continuous improvement. These agencies can serve as a model for the private sector as a system of continuous improvement and a system that promotes evidence-based pain management and evidence-based opioid ADE prevention strategies.

ATTACHMENT 10

ECH FY18 Organizational Goals

DRAFT

Organizational Goals FY18	Benchmark	2017 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe
Threshold Goals							
Budgeted Operating Margin	90% threshold *[Recommended by Exec Comp Consultant (FY16)]*	Achieved Budget	90% of Budgeted			Threshold	FY 18
Arithmetic Observed LOS Average / Geometric LOS Expected for Medicare population (ALOS / GMLOS)	External : Quality Advisor via Permier	*7/1/16 - 11/30/16 = 1.166 ALOS = 5.11 / GMLOS 4.38 12/1/15 - 6/30/16 = 1.205*	1.140	1.120	1.080	34%	4Q FY18
HCAHPS Service metric: TBD	External Benchmark	HCAHPS Baseline				33%	3Q & 4Q FY18
Cuture of Safety: Percent Improvement in Staff perception of Culure of Safety	internal benchmark	Culture of Safety Survey 5/2017 as baseline, plus bi-monthly survey of Staff via ad-hoc survey tool	10%	20%	40%	33%	4Q FY18

2.25 out of 5 score: 20% improvement would be 2.7

2.70

PRESS GANEY

CAHPS

Inpatient

All My Sites

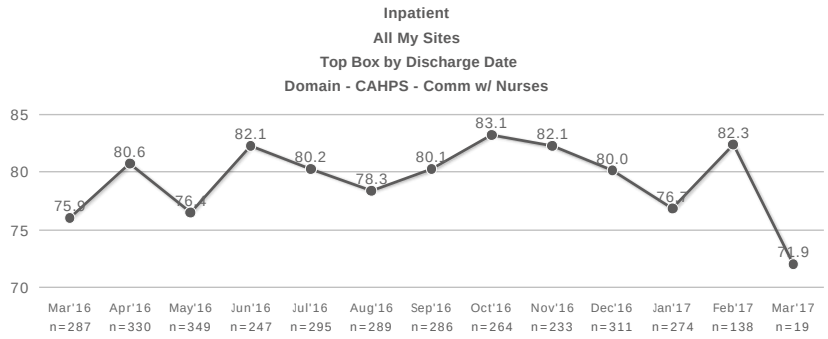
CAHPS	Dec '16	Jan '17	Feb '17
	Top Box	Top Box	Top Box
Rate hospital 0-10	73.1 ▼	75.3 ▲	72.3 ▼
Recommend the hospital	81.4 ▼	79.6 ▼	78.8 ▼
Cleanliness of hospital environment	72.6 ▼	76.2 ▲	74.1 ▼
Quietness of hospital environment	56.9 ▼	58.1 ▲	63.2 ▲
Comm w/ Nurses	80.0 ▼	76.7 ▼	82.3 ▲
Response of Hosp Staff	63.4 ▼	66.9 ▲	62.9 ▼
Comm w/ Doctors	85.7 ▲	81.7 ▼	83.4 ▲
Hospital Environment	64.8 ▼	67.1 ▲	68.6 ▲
Pain Management	73.2 ▼	75.7 ▲	73.2 ▼
Comm About Medicines	71.4 ▲	67.3 ▼	64.1 ▼
Discharge Information	88.1 ▼	87.8 ▼	81.5 ▼
Care Transitions	56.4 ▼	54.2 ▼	57.0 ▲

Displayed by Discharge Date and Total Sample

Combined Big 3

Satisfaction Timeframe: Monthly

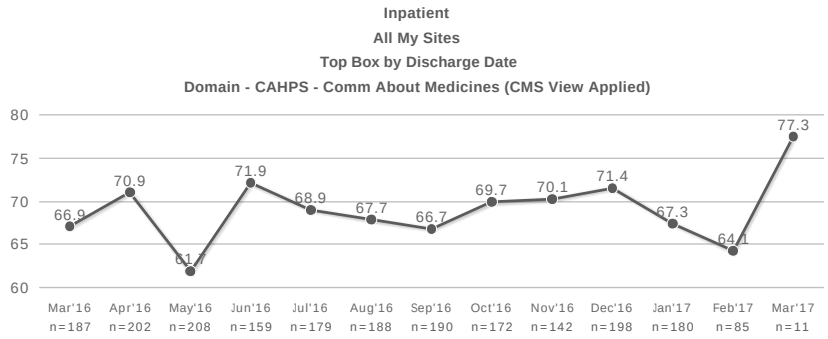
CAHPS - Comm w/ Nurses



Improvement Resources

- O.P.E.N. Communication Styles
- HCAHPS Solutions Starter
- Clear The Debris
- Nurses Listen Carefully to You
- Nurses Explain in Way You Understand

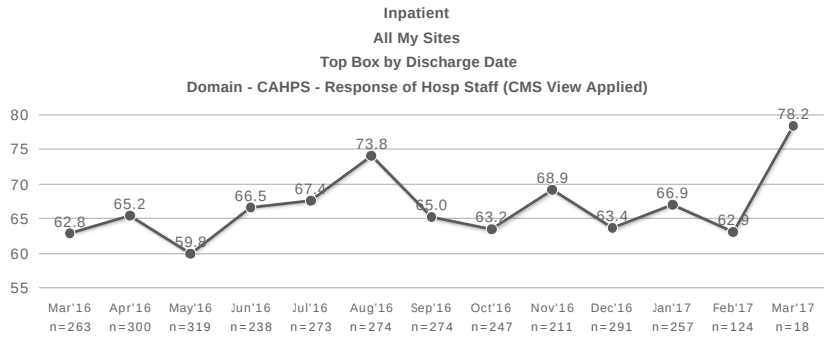
CAHPS - Comm About Medicines



Improvement Resources

- Medication Review Worksheet
- Challenge with Numbers: Tips for Improving Communication about Medication
- Teach Back Techniques for Improving Communication About Medication
- Staff Describe Medicine Side Effect
- Creating Take-Home Medication Information

CAHPS - Response of Hosp Staff



Improvement Resources

- Help Toileting Soon as You Wanted
- UP Webinar: HCAHPS Responsiveness of Staff Domain
- UP Webinar: HCAHPS Communication with Nurses Domain
- HCAHPS Solutions Starter
- Five Foot Rule

PRESS GANEY

CAHPS

Inpatient

El Camino Hospital Mountain View

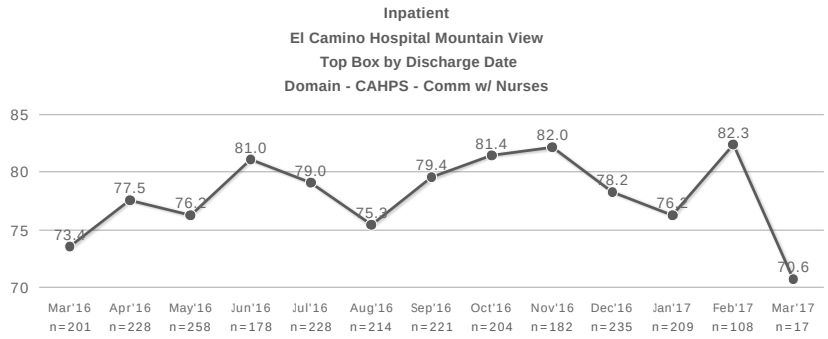
CAHPS	Dec '16	Jan '17	Feb '17
	Top Box	Top Box	Top Box
Rate hospital 0-10	73.1 ▼	75.5 ▲	73.8 ▼
Recommend the hospital	83.1 ▼	81.1 ▼	83.2 ▲
Cleanliness of hospital environment	70.8 ▼	75.4 ▲	71.4 ▼
Quietness of hospital environment	57.3 ▼	57.7 ▲	63.5 ▲
Comm w/ Nurses	78.2 ▼	76.2 ▼	82.3 ▲
Response of Hosp Staff	61.3 ▼	64.1 ▲	59.9 ▼
Comm w/ Doctors	87.1 ▲	81.2 ▼	84.5 ▲
Hospital Environment	64.1 ▼	66.5 ▲	67.4 ▲
Pain Management	71.5 ▼	75.7 ▲	72.4 ▼
Comm About Medicines	70.7 ▲	67.8 ▼	62.3 ▼
Discharge Information	87.1 ▼	87.5 ▲	80.9 ▼
Care Transitions	55.0 ▼	53.3 ▼	59.9 ▲

Displayed by Discharge Date and Total Sample

Mountain View Big 3

Satisfaction Timeframe: Monthly

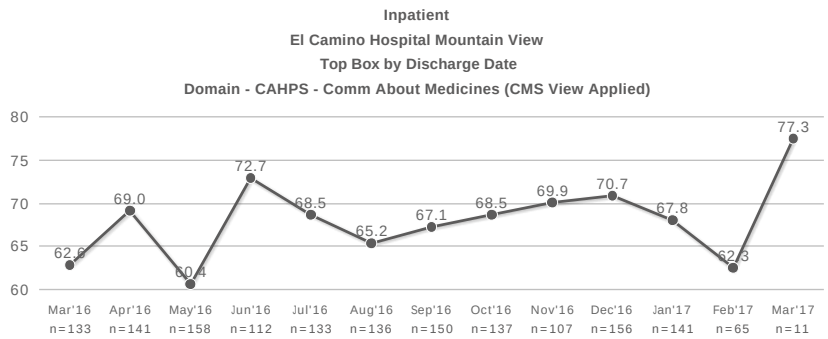
CAHPS - Comm w/ Nurses



Improvement Resources

- O.P.E.N. Communication Styles
- HCAHPS Solutions Starter
- Clear The Debris
- Nurses Listen Carefully to You
- Nurses Explain in Way You Understand

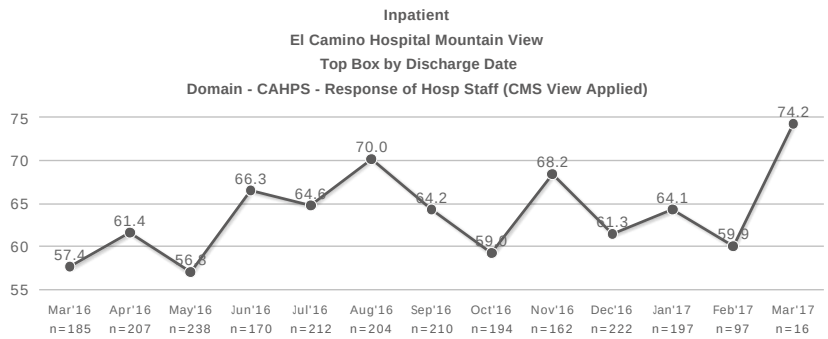
CAHPS - Comm About Medicines



Improvement Resources

- Medication Review Worksheet
- Challenge with Numbers: Tips for Improving Communication about Medication
- Teach Back Techniques for Improving Communication About Medication
- Staff Describe Medicine Side Effect
- Creating Take-Home Medication Information

CAHPS - Response of Hosp Staff



Improvement Resources

- Help Toileting Soon as You Wanted
- UP Webinar: HCAHPS Responsiveness of Staff Domain
- UP Webinar: HCAHPS Communication with Nurses Domain
- HCAHPS Solutions Starter
- Five Foot Rule

PRESS GANEY

CAHPS

Inpatient

El Camino Hospital Los Gatos

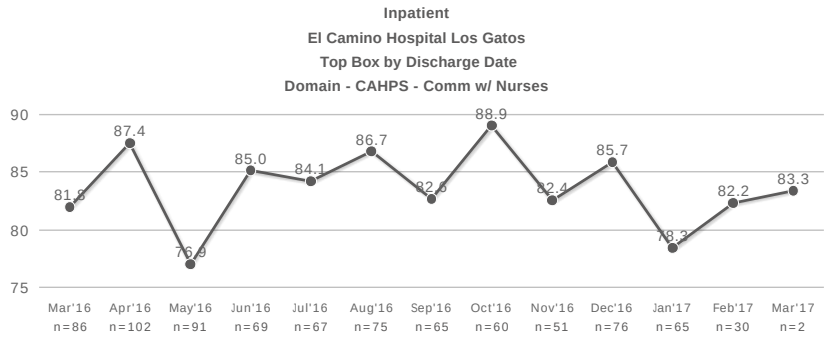
CAHPS	Dec '16	Jan '17	Feb '17
	Top Box	Top Box	Top Box
Rate hospital 0-10	73.3 ▼	74.6 ▲	66.7 ▼
Recommend the hospital	76.0 ▼	75.0 ▼	63.3 ▼
Cleanliness of hospital environment	78.4 ▼	79.0 ▲	83.3 ▲
Quietness of hospital environment	55.4 ▼	59.4 ▲	62.1 ▲
Comm w/ Nurses	85.7 ▲	78.3 ▼	82.2 ▲
Response of Hosp Staff	69.9 ▼	76.3 ▲	72.6 ▼
Comm w/ Doctors	81.3	83.2 ▲	79.3 ▼
Hospital Environment	66.9 ▼	69.2 ▲	72.7 ▲
Pain Management	77.8 ▼	75.8 ▼	76.1 ▲
Discharge Information	91.4 ▲	88.6 ▼	83.5 ▼
Care Transitions	61.1 ▲	56.9 ▼	47.2 ▼
Comm About Medicines	73.8 ▲	65.4 ▼	70.0 ▲

Displayed by Discharge Date and Total Sample

Los Gatos Big 3

Satisfaction Timeframe: Monthly

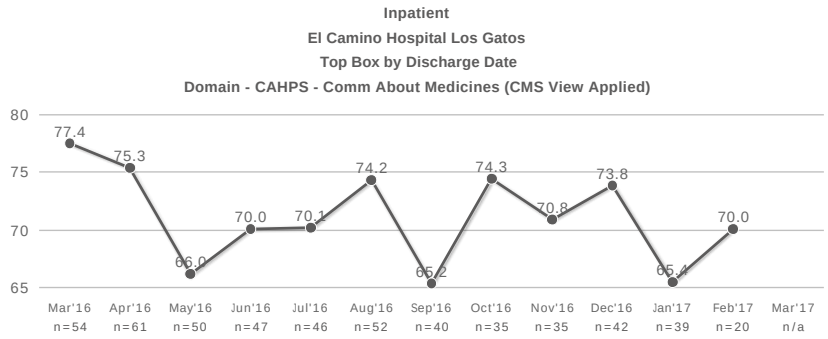
CAHPS - Comm w/ Nurses



Improvement Resources

- O.P.E.N. Communication Styles
- HCAHPS Solutions Starter
- Clear The Debris
- Nurses Listen Carefully to You
- Nurses Explain in Way You Understand

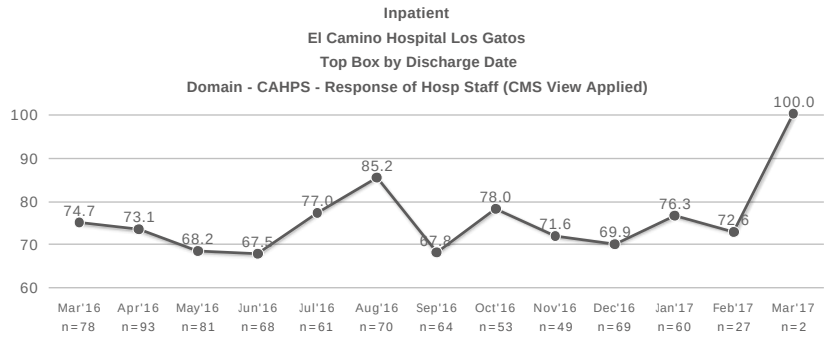
CAHPS - Comm About Medicines



Improvement Resources

- Medication Review Worksheet
- Challenge with Numbers: Tips for Improving Communication about Medication
- Teach Back Techniques for Improving Communication About Medication
- Staff Describe Medicine Side Effect
- Creating Take-Home Medication Information

CAHPS - Response of Hosp Staff



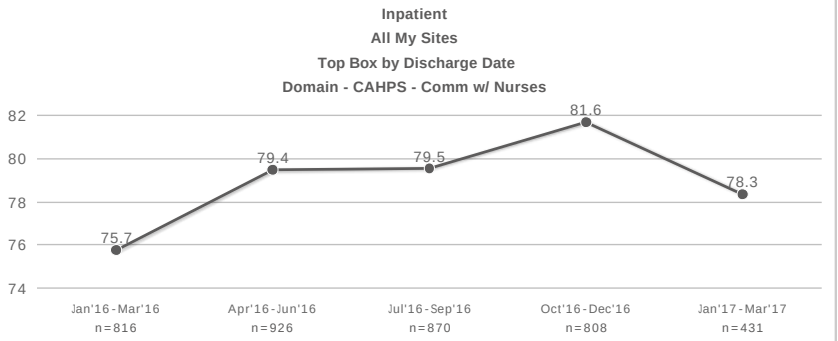
Improvement Resources

- Help Toileting Soon as You Wanted
- UP Webinar: HCAHPS Responsiveness of Staff Domain
- UP Webinar: HCAHPS Communication with Nurses Domain
- HCAHPS Solutions Starter
- Five Foot Rule

Comm w/ Nurses

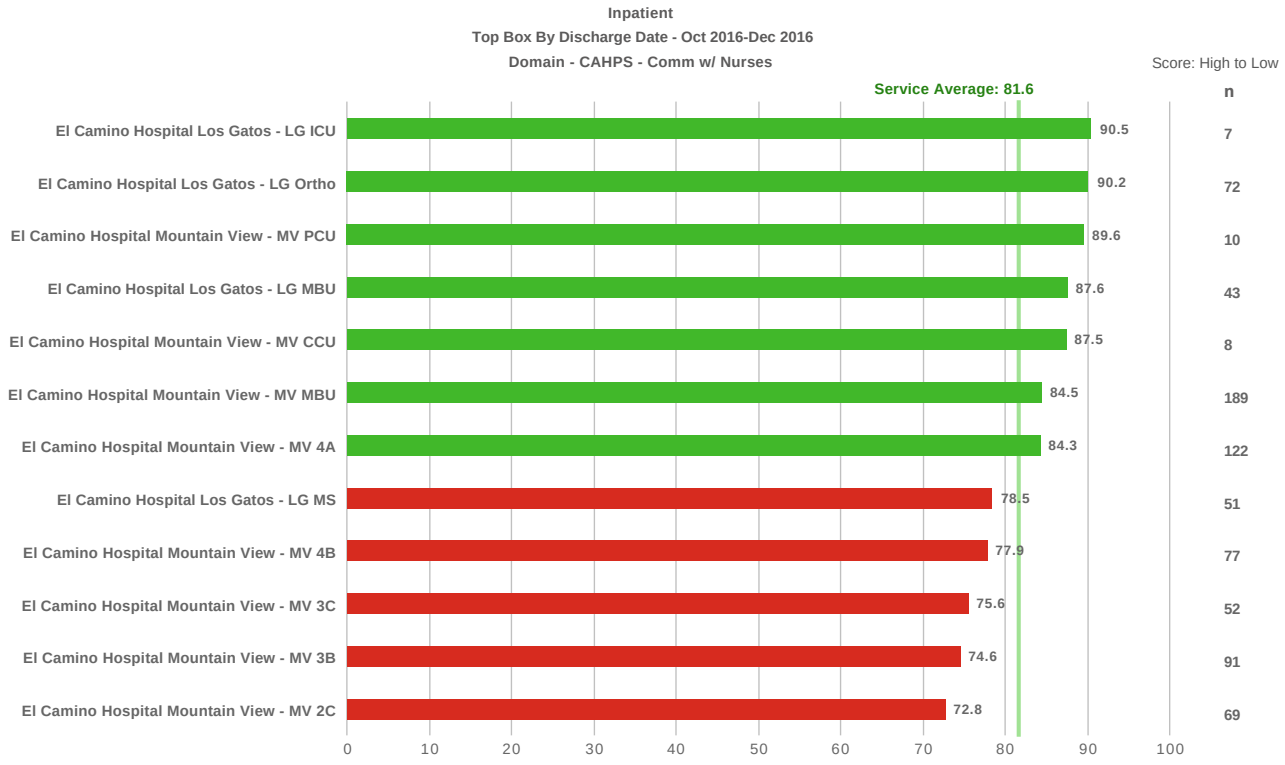
Satisfaction Timeframe: Quarterly

CAHPS - Comm w/ Nurses



Improvement Resources

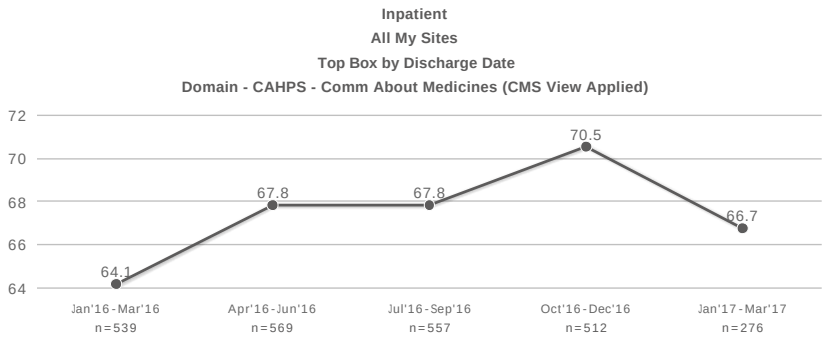
- O.P.E.N. Communication Styles
- HCAHPS Solutions Starter
- Clear The Debris
- Nurses Listen Carefully to You
- Nurses Explain in Way You Understand



Comm about Meds

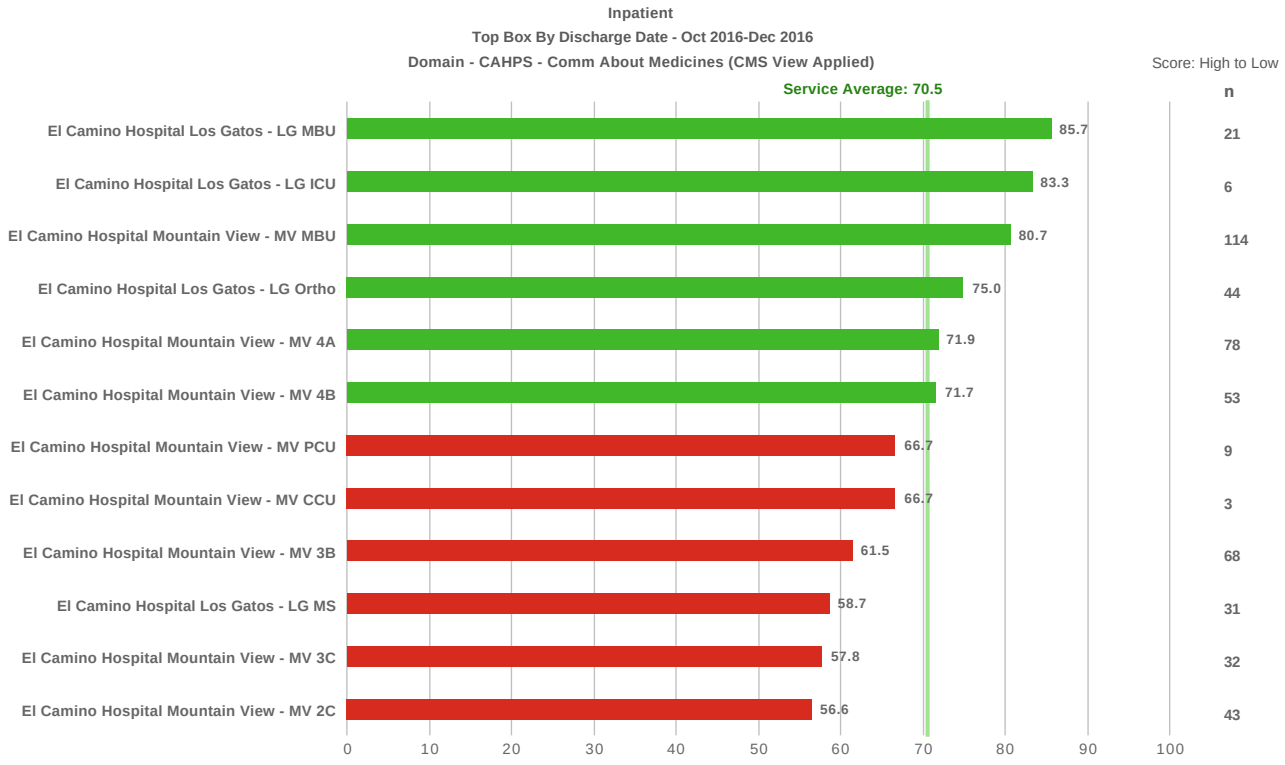
Satisfaction Timeframe: Quarterly

CAHPS - Comm About Medicines



Improvement Resources

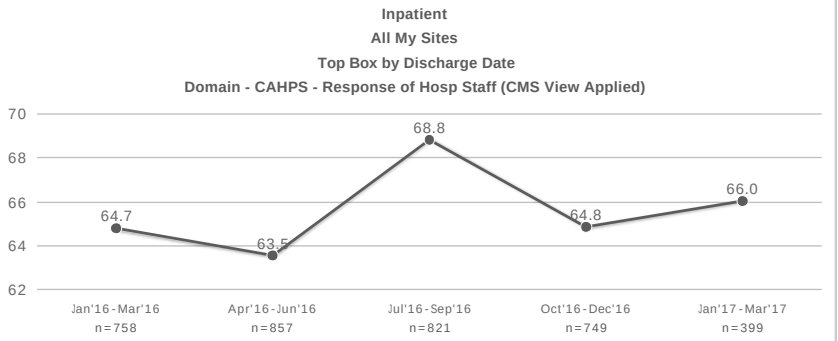
- Medication Review Worksheet
- Challenge with Numbers: Tips for Improving Communication about Medication
- Teach Back Techniques for Improving Communication About Medication
- Staff Describe Medicine Side Effect
- Creating Take-Home Medication Information



Responsiveness

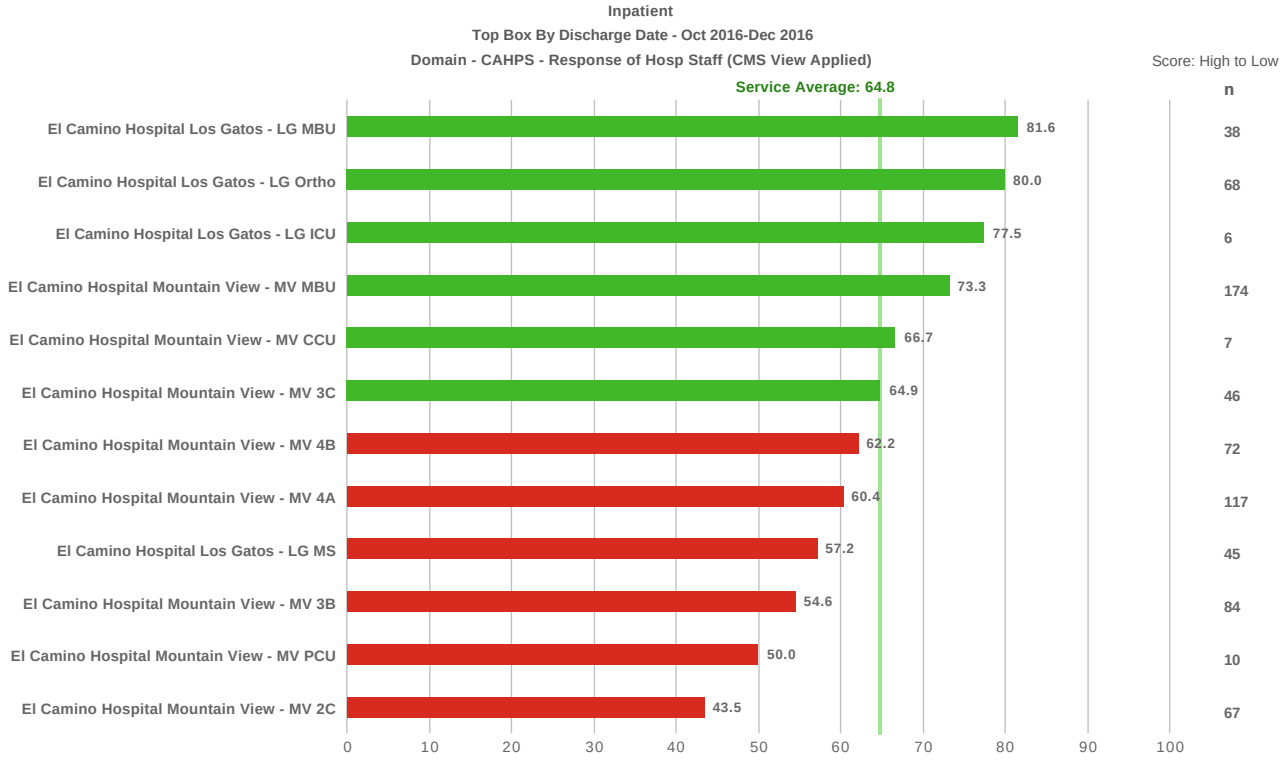
Satisfaction Timeframe: Quarterly

CAHPS - Response of Hosp Staff



Improvement Resources

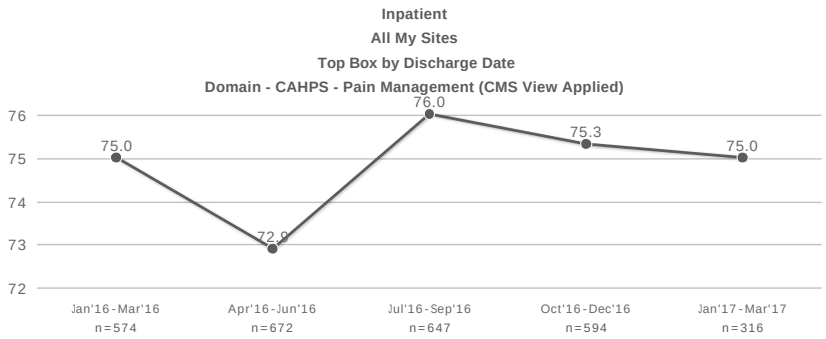
- Help Toileting Soon as You Wanted
- UP Webinar: HCAHPS Responsiveness of Staff Domain
- UP Webinar: HCAHPS Communication with Nurses Domain
- HCAHPS Solutions Starter
- Five Foot Rule



Pain

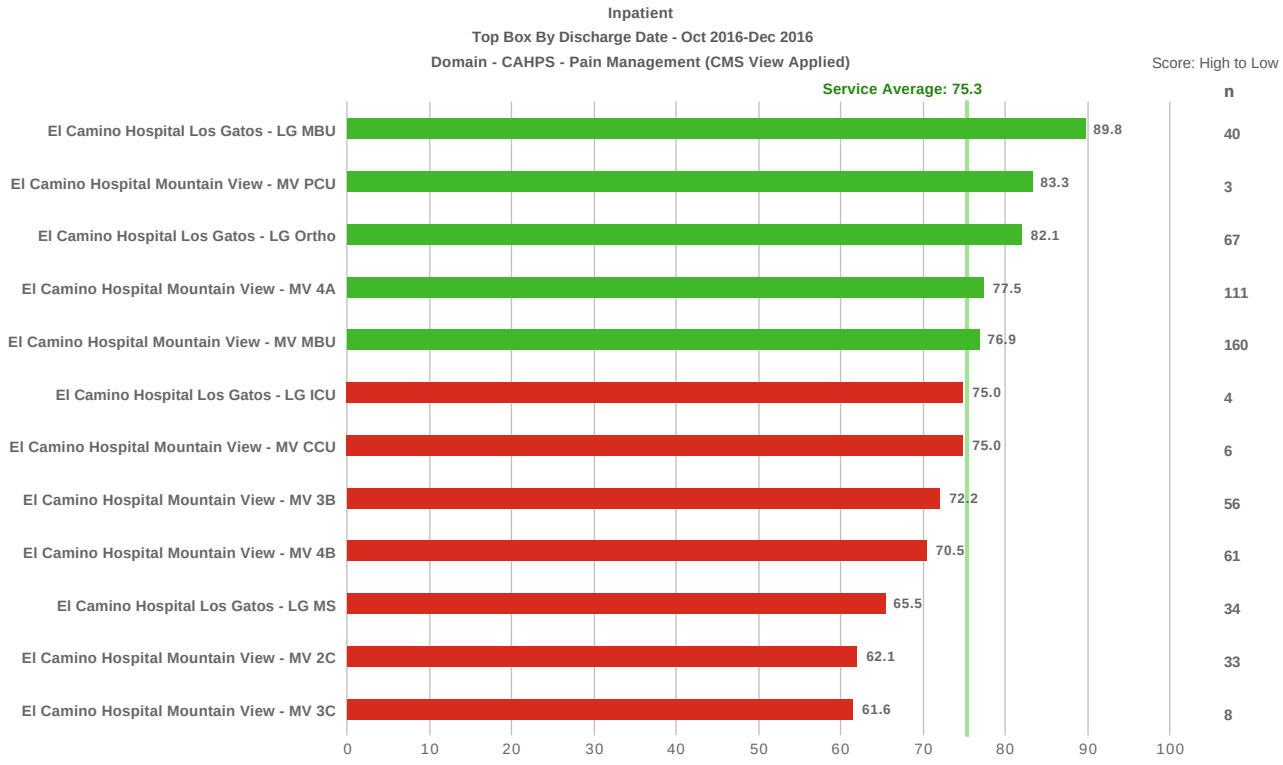
Satisfaction Timeframe: Quarterly

CAHPS - Pain Management



Improvement Resources

- Pain Management: Establish a Comfort-Function Goal
- Pain Management: A Standardized Approach
- Preparing the Environment to Reduce Anxiety to Manage Pain
- UP Webinar: HCAHPS Pain Management Domain
- Staff Do Everything Help with Pain



PRESS GANEY

Overall Top Box Scores

Emergency Department

El Camino Hospital Los Gatos

Standard Scores	Dec '16		Jan '17		Feb '17	
	Score	n	Score	n	Score	n
Overall	67.4 ▼	39	66.3 ▼	56	67.8 ▲	33
Arrival	59.1 ▼	38	59.6 ▲	56	62.7 ▲	33
Nurses	72.7 ▼	39	68.1 ▼	56	67.3 ▼	33
Doctors	75.7 ▼	38	69.1 ▼	55	68.2 ▼	33
Tests	76.1 ▼	27	75.3 ▼	39	78.0 ▲	22
Family or Friends	62.9 ▼	33	75.9 ▲	40	66.1 ▼	19
Overall Assessment	73.3 ▼	38	71.2 ▼	56	74.2 ▲	33
Personal Issues	58.5 ▼	39	55.2 ▼	56	61.9 ▲	33
Personal/Insurance Info	63.0 ▼	38	65.6 ▲	54	71.9 ▲	32

Displayed by Visit Date and Total Sample

PRESS GANEY

Overall Top Box Scores

Emergency Department

El Camino Hospital Mountain View

Standard Scores	Dec '16		Jan '17		Feb '17	
	Score	n	Score	n	Score	n
Overall	55.1 ▼	113	60.3 ▲	112	58.1 ▼	74
Arrival	50.3 ▼	112	46.1 ▼	111	48.9 ▲	73
Nurses	56.5 ▼	113	67.3 ▲	111	60.2 ▼	72
Doctors	59.7 ▼	107	68.1 ▲	108	65.0 ▼	72
Tests	56.8 ▼	87	69.3 ▲	86	59.2 ▼	58
Family or Friends	61.0 ▼	88	64.9 ▲	84	70.1 ▲	50
Overall Assessment	54.5 ▼	112	58.9 ▲	111	59.5 ▲	74
Personal Issues	48.3 ▼	112	49.4 ▲	110	48.8 ▼	68
Personal/Insurance Info	57.1 ▼	109	62.7 ▲	106	60.9 ▼	69

Displayed by Visit Date and Total Sample