El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Monday, May 1st, 2017, 5:30 p.m.
El Camino Hospital, Conference Room E&F
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		ESTIMATED TIMES
1. CALL TO ORDER	David Reeder, Quality Committee Chair		**5:30 – 5:31pm**
2. ROLL CALL	David Reeder, Quality Committee Chair		**5:31 – 5:32pm**
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	David Reeder, Quality Committee Chair		**5:32 – 5:33pm**
4. CONSENT CALENDAR ITEMS: *Any Committee Member or member of the public may remove an item for discussion before a motion is made.*	David Reeder, Quality Committee Chair	*public comment*	**motion required 5:33 – 5:36pm**
Approval a. Minutes of the Open Session of the Quality Committee Meeting (April 3, 2017) ***Information*** b. Research Article c. Patient Story d. FY17 Pacing Plan			
5. REPORT ON BOARD ACTIONS **ATTACHMENT 5**	David Reeder, Quality Committee Chair		**discussion 5:36 – 5:39**
6. QUALITY PROGRAM UPDATE: VASCULAR SURGERY **ATTACHMENT 6**	Tej Singh MD, Medical Director, Vascular Surgery		**discussion 5:39 – 5:59**
7. FY17 QUALITY DASHBOARD **ATTACHMENT 7**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**discussion 5:59 – 6:14**
8. PROPOSED FY18 QUALITY COMMITTEE DATES **ATTACHMENT 8**	David Reeder, Chair Quality Committee	*public comment*	**possible motion 6:14 – 6:19**
9. DRAFT FY18 ORGANIZATIONAL GOALS **ATTACHMENT 9**	Mick Zdeblick, Chief Operating Officer	*public comment*	**possible motion 6:19 – 6:34**

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 ITEM	PRESENTED BY		ESTIMATED TIMES
10. COMMITTEE MEMBERSHIP	David Reeder, Quality Committee Chair		**discussion 6:34 – 6:39**
11. PUBLIC COMMUNICATION	David Reeder, Quality Committee Chair		**information 6:39 – 6:42**
12. ADJOURN TO CLOSED SESSION			**6:42 – 6:43**
13. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	David Reeder, Quality Committee Chair		**6:43 – 6:44**
14. CONSENT CALENDAR *Any Committee Member may remove an item for discussion before a motion is made.*	David Reeder, Quality Committee Chair		**motion required 6:44 – 6:47**
Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (April 3, 2017) ***Information*** b. Quality Council Minutes (February 1, 2017) c. Quality Council Minutes (March 1, 2017)			
15. Report related to the Medical Staff quality assurance matters, Health and Safety Code Section 32155: - CMO Report	William Faber, MD Chief Medical Officer		**discussion 6:47 – 6:57**
16. ADJOURN TO OPEN SESSION	David Reeder, Quality Committee Chair		**motion required 6:57 – 6:58**
17. RECONVENE OPEN SESSION/REPORT OUT	David Reeder, Quality Committee Chair		**6:58 – 6:59**
To report any required disclosures regarding permissible actions taken during Closed Session.			
18. ADJOURNMENT	David Reeder, Quality Committee Chair		**motion required 6:59 – 7:00 pm**

Upcoming FY 17 Quality Committee Meetings

- June 5, 2017

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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

Monday, April 3, 2017
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

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

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 3rd of April, 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. **Katie Anderson joined the meeting @ 5:38pm, and Melora Simon joined the meeting @ 5:41pm. Mikele Bunce left the meeting at 7:00pm.*	***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 February 27, 2017 meeting; policies). **Movant:** Carragee **Second:** Pinsker **Ayes:** Reeder, Davis, Bunce, Carragee, Russell, and Pinsker. **Noes:** None **Abstentions:** None **Absent:** Fung, Simon, Ron, Anderson, and Tsao.	***The Open Minutes of the February 27, 2017 meeting, and policies were approved.***

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Agenda Item	Comments/Discussion	Approvals/Action
	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 highlighted the Board's current priorities to include: • CEO Search with the Russell Reynolds Firm, Preliminary interviews will be occurring this weekend with expected May timeframe for anticipated permanent CEO selection.	***None***
6. **QUALITY PROGRAM UPDATE: ORTHO/NEURO/SPINE SERVIE LINE**	Terry Rutledge, Executive Director of Ortho/Neuro/Spine introduced Pamela Coye RN and Debbie Smyth RN to the committee. He updated the committee on the accomplishments, programs and initiatives of the service line. Mr. Rutledge reported that El Camino Hospital provides state-of-the-art anterior hip replacement and excellent post-operative pain control. The team highlighted the program's quality metrics, which are better than national norms on hip and knee replacement, and the Joint Commission's recent recertification of our disease specific programs in Total Joint Replacement in Mountain View and Los Gatos, Hip Fracture in Mountain View and Spinal Fusion in Los Gatos. Terry asked for feedback and questions from the Committee and a brief discussion ensued.	***None***
7. **PROPOSED FY18 COMMITEEE DATES**	Dr. Will Faber, Chief Medical Officer, reviewed the Proposed FY18 Committee Dates with the Committee and asked for feedback. Dr. Davis mentioned a potential conflict with the November 6th date due to extended holiday travel. The general consensus of the Committee was to accept the proposed dates as detailed in the packet. **Motion:** To approve the Proposed FY18 Committee Dates. **Movant:** Bunce **Second:** Anderson **Ayes:** Reeder, Davis, Bunce, Carragee, Russell, Anderson, Simon, and Pinsker. **Noes:** None **Abstentions:** None **Absent:** Fung, Ron, and Tsao. **Excused:** None **Recused:** None	***The Proposed FY18 Committee Dates were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
8. 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 development of a plan with specific tactics, and monitor the HCAHPs scores for Patient and Family Centered Care. 5. Monitor the impact of the Culture of Safety Campaign with QRR reporting as an improvement metric. (Reportable Safety Event Metric, Simon – can we use both) Dr. Faber explained that the requested Committee corrections and feedback had been incorporated into the goals. **Motion:** To recommend that the Board approve the Proposed FY18 Quality Committee Goals. **Movant:** Simon **Second:** Anderson **Ayes:** Reeder, Davis, Bunce, Carragee, Russell, and Pinsker. **Noes:** None **Abstentions:** None **Absent:** Fung, Simon, Ron, Anderson, and Tsao. **Excused:** None **Recused:** None	***The Proposed FY18 Quality Committee Goals were recommended for approval.***
9. FY17 QUALITY DASHBOARD	Catherine Carson, Senior Director/Chief Quality Officer reviewed the newly annotated FY17 quality dashboard with the committee. Ms. Carson reported that eight metrics remain stable. Surgical Site Infections, Communication with Nurses, and Responsiveness of Staff show room for improvement. Ms. Carson presented improvement plans for these	***None***

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Agenda Item	Comments/Discussion	Approvals/Action
	areas. The committee engaged in a robust conversation about the national opioid addiction epidemic and recognized that inpatient responsiveness to acute, self-limiting pain is a different matter than outpatient management of chronic pain with opioids. Measures to protect our inpatients from over-dosage were also reviewed.	
10. FY18 CORPORATE GOALS	Dr. William Faber presented the Draft FY18 Organizational Goals to the Committee and reviewed each goal along with the benchmark, 2017 ECH baseline, minimum, target, and maximum metrics. Dr. Faber further detailed each goal to include: • The proposed Efficiency goal as reduction of the ratio of average length of stay over mean length of stay, which will take the acuity of patients into account. • The proposed Patient Experience goal which will reinstitute HCAHPs metrics. • The proposed Quality goal will be focused on improving the institutional Culture of Safety, measured by a monthly focused survey. Dr. Faber asked for feedback and questions from the Committee and a brief discussion ensued. **Further discussion agendized for the May 1, 2017 Quality Committee Meeting.*	***None***
11. PUBLIC COMMUNICATION	None	***None***
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:15 p.m. **Movant:** Davis **Second:** Carragee **Ayes:** Reeder, Davis, Carragee, Russell, Anderson, Simon, and Pinsker. **Noes:** None **Abstentions:** None **Absent:** Fung, Bunce, Ron, and Tsao. **Excused:** None **Recused:** None	***A motion to adjourn to closed session at 7:15 p.m. was approved.***

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Agenda Item	Comments/Discussion	Approvals/Action
13. AGENDA ITEM 16 RECONVENE OPEN SESSION/ REPORT OUT	*Agenda Items 13 – 15 were reported in closed session.* Chair Reeder reported that the Closed Session minutes of the February 27, 2017 Quality Committee Meeting were approved. Chair Reeder also noted the upcoming Quality Committee Meeting dates.	***None***
14. AGENDA ITEM 17 ADJOURNMENT	There being no further business to come before the Committee, the meeting was adjourned at 7:39 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

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What is a Vascular Surgeon?

What is a Vascular Surgeon?

What do vascular surgeons do?

Vascular surgeons are specialists who are highly trained to treat diseases of the vascular system. Your blood vessels --arteries carrying oxygen-rich blood and veins carrying blood back to the heart -- are the roadways of your circulatory system. Without smoothly flowing blood, your body cannot function. Conditions such as hardening of the arteries can create “traffic jams” in your circulatory system, obstructing the flow of blood to any part of the body.

A vascular surgeon does far more than surgery.

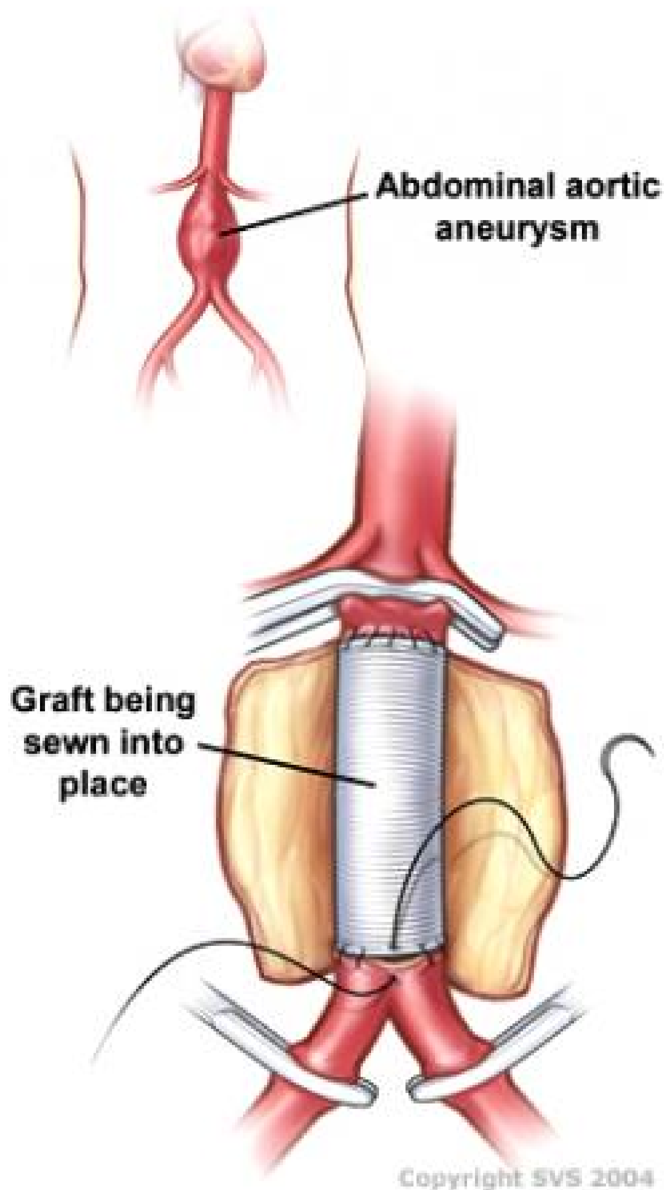
A vascular surgeon makes sure patients with vascular health issues know and understand all their options. In short, vascular surgeons can do surgery, but they see and treat many patients who don't require surgery. Many vascular problems can be treated with medication or exercise. As one vascular surgeon explained – "I spend 80 percent of my time trying to talk my patients out of having surgery."

A vascular surgeon is able to do every kind of procedure.

Some specialists specialize in one or two kinds of vascular interventions, so their patients tend to get those treatments. Vascular surgeons are trained in everything: open, complicated surgery and in minimally invasive, endovascular procedures. Some patients need one, some need the other, while many need no surgery at all. Vascular surgeons are “treatment agnostic,” that is, they don’t prefer any kind of treatment over another. Patients can be assured they will get the best treatment for their particular need.

A vascular surgeon builds relationships with patients.

Some types of surgeons come into your life to perform a procedure, make sure you heal and then leave; that’s their role. A vascular surgeon may be someone who treats you on an ongoing basis for decades. A vascular surgeon very often has long-term relationships with patients because vascular disease can be a long-term condition. If you have vascular disease, you can trust a vascular surgeon to care about your long term health and to consider all your options.



Vascular surgeons manage veins and arteries in every part of the body except the brain and the heart.

For example, vascular surgeons handle blocked carotid arteries in the neck. They treat the problems of the aorta (a large main artery) after it leaves the heart and enters the abdomen. Peripheral vascular disease, which often affects the arteries in the legs and feet, also is treated by a vascular surgeon.

How do I know I need to see a vascular surgeon?

Typically, patients are referred to a vascular surgeon by their primary care physician. Sometimes patients become acquainted with a vascular surgeon after an unexpected event lands them in the hospital. You might be referred to a vascular surgeon if you see your regular doctor for pain in your legs, and learn that you have peripheral arterial disease, for example. If you are in a high risk category: are a

smoker, diabetic, and/or have high blood pressure, you may be a candidate for starting a relationship with a vascular surgeon.

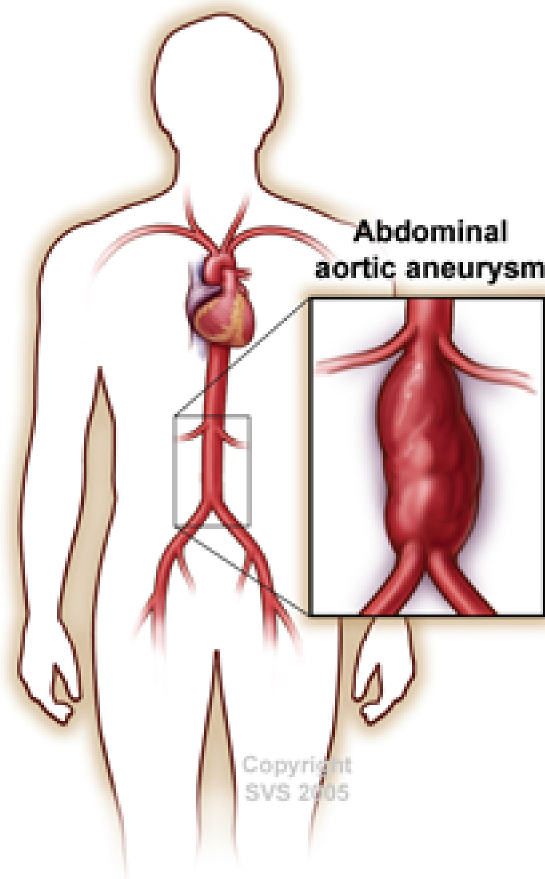
Find a vascular specialist near you

Learn more about vascular disease

What is Vascular Disease?

What is Vascular Disease?

Most Americans are familiar with heart disease and with the consequences of blockages in the vessels that carry blood to and from the heart. But few people realize that blockages caused by a buildup of plaque and cholesterol affect more than coronary arteries. Arteries throughout the body carry oxygen-rich blood away from the heart, so blockages can occur in all arteries with serious effects. Three of the most recognized vascular diseases include:

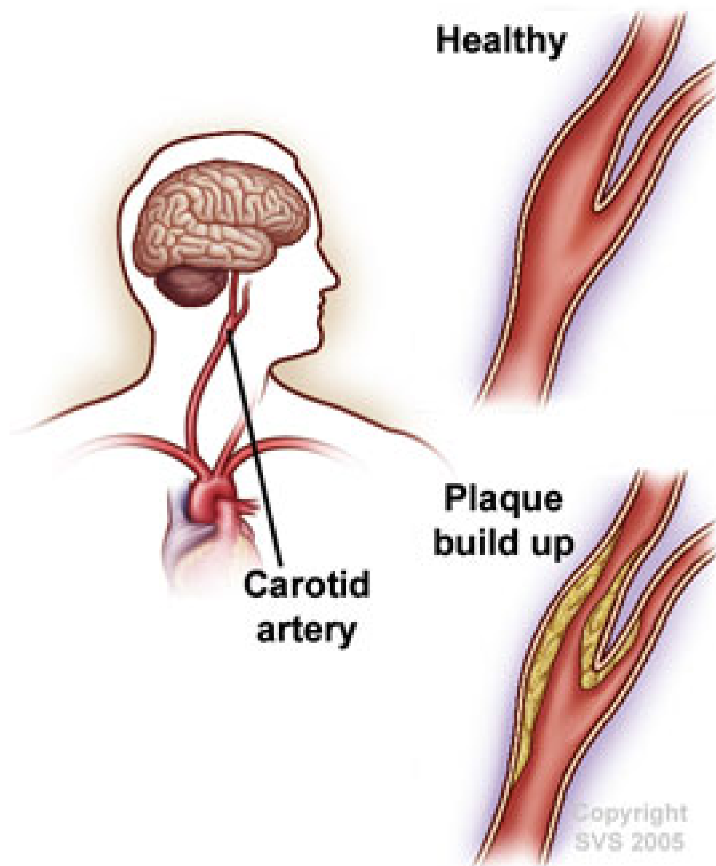


Abdominal Aortic Aneurysm

Abdominal Aortic Aneurysm (AAA) is an enlargement or “bulge” that develops in a weakened area within the largest artery in the abdomen. The pressure generated by each heartbeat pushes against the weakened aortic wall, causing the aneurysm to enlarge. If the AAA remains undetected, the aortic wall continues to weaken, and the aneurysm continues to grow. Eventually, the aneurysm becomes so large, and its wall so weak, that rupture occurs. When this happens there is massive internal bleeding, a situation that is usually fatal. The only way to break this cycle is to find the AAA before it ruptures.

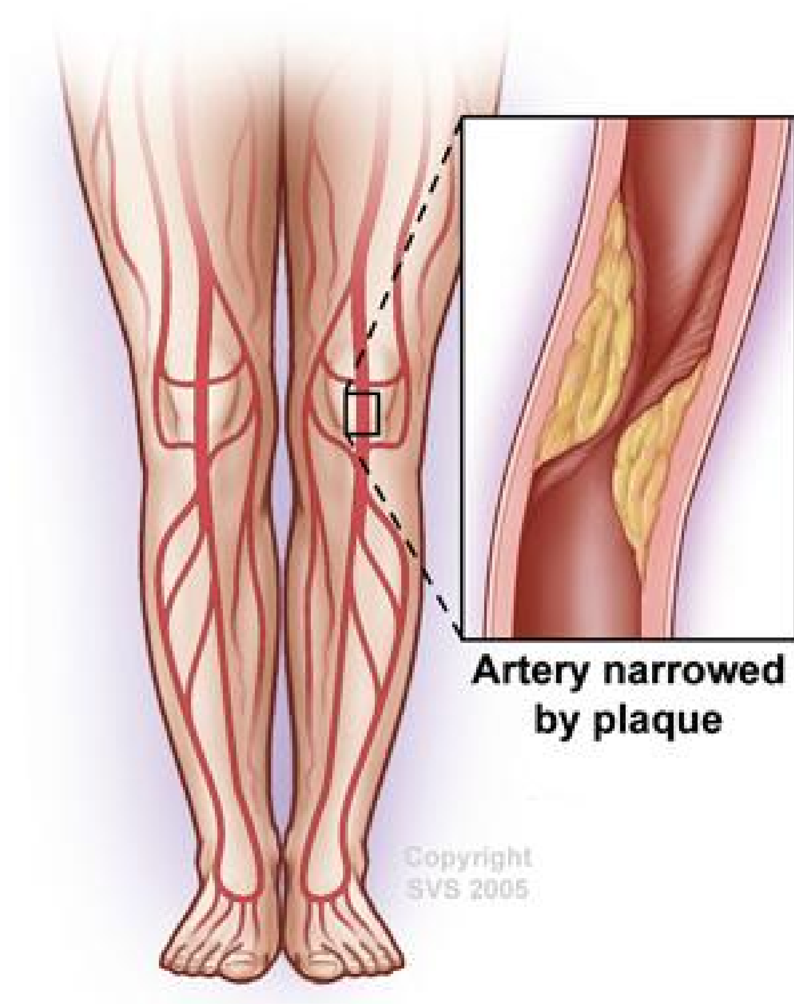
more about aaa

Carotid Artery Disease - Stroke



Carotid arteries occur when the main blood vessels to the brain develop a buildup of plaque caused by atherosclerosis, or hardening of the arteries. When the buildup becomes very severe, it can cause a stroke. A stroke occurs when part of the brain is damaged by these vascular problems; in fact, 80 percent of strokes are “ischemic strokes” where part of the circulation to the brain is cut off, usually due to blockages in the carotid arteries. The process is similar to the buildup of plaque in arteries in the heart that causes heart attacks. Strokes are the third leading cause of death in the United States according to the National Center for Health Statistics.

more about cad more about Stroke



Peripheral Arterial Disease

Peripheral arterial disease (PAD) occurs when atherosclerosis, or hardening of the arteries, causes a buildup of plaque in the blood vessels that carry oxygen and nutrients to all the tissues of the body. As these plaques worsen, they reduce essential blood flow to the limbs and can even cause complete blockages of the arteries. Early on, PAD may only cause difficulty walking, but in its most severe forms, it can cause painful foot ulcers, infections, and even gangrene, which could require amputation. People with PAD are three times more likely to die of heart attacks or strokes than those without PAD.

more about pad

The information contained on Vascular.org is not intended, and should not be relied upon, as a substitute for medical advice or treatment. It is very important that individuals with specific medical problems or questions consult with their doctor or other health care professional.

Patient Story
Quality Committee Meeting
May 1, 2017

████ was a well-known cancer patient for both our Cancer Clinic and our inpatient unit, 4B. He suffered from Stage IV esophageal cancer and fought this disease valiantly. Various treatments, including chemo medications, tube feedings, various drain insertions/removals were all attempted to give him as best quality of life as possible for as long as possible. The patient's wife was a constant bedside companion for her husband and advocated for him the best she was able to. They had one child, a daughter, who was engaged to be married in November.

Mid-week the week of April 3, despite all best efforts, the patient and his family received the news that there was really no more curative treatment that could be offered, and his oncologist felt he had about one week to live. Through discussions with the whole family, it was learned that their wish was to have the patient present for his daughter's wedding. Knowing that a November wedding would not be one that the patient could attend, the family decided that the wedding should take place on April 8. The staff of 4B, led by clinical nurse manager worked side-by-side with the family to plan a wedding in the meditation room at El Camino Hospital, with a reception in our conference rooms. The staff helped dress the patient in a tailored shirt and jacket and propped him up in a special wheelchair, and not only did he attend his daughter's wedding, but he and his wife renewed their wedding vows. These two unforgettable testimonies to love and, truly to "in sickness and in health" were witnessed by friends, family and our El Camino staff.

On April 11, three days after the wedding and renewal of vows, ████ died peacefully on 4B.

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) ▪ Finalize 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~~ (Every other year) ▪ Develop Pacing Calendar for FY18 ▪ Review Draft Management of Serious Safety Events and Red Alert Patient Safety Events Policy **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**

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on Board Actions Quality, Patient Care and patient Experience Committee Meeting Date: May 1, 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: Report on April 2017 Board Actions	

April 2017 ECH Board Actions*

1. April 12, 2017
   a. Approved FY17 Period 8 Financials
   b. Approved Primary Care Physician Replacement for Silicon Valley Primary Care Clinic
   c. Approved Revisions to the Board Director Compensation Policy – Approved Annual Board Chair Stipend of $12,000, payable quarterly and $100 stipend for Committee Chair (Directors only) participation in agenda planning meeting.
   d. Appointment of Executive Compensation Committee Member Pat Wadors
   e. Approved Primary Care Physician Replacement for Silicon Valley Primary Care Clinic
   f. Approved Finance Committee Recommendations:
      i. SVPMG Physician Recruitment – Medical Oncologist
      ii. General Surgery ED Call Panel
      iii. Medical Directorship renewal – Quality and Physician Services
      iv. Capital Funding Request – Women's Hospital Expansion Incremental Funding
      v. Capital Funding Request – Los Gatos Facility Improvement Project

*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.

Quality Vascular Surgery at ECH

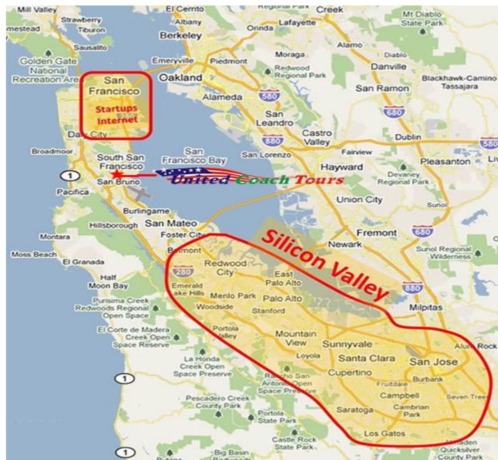
Local, Regional & National Progress on Carotid & Aortic Surgery

Tej M. Singh, MD, MBA

Director Vascular Surgery and Intervention

Co-Director, Wound Clinic

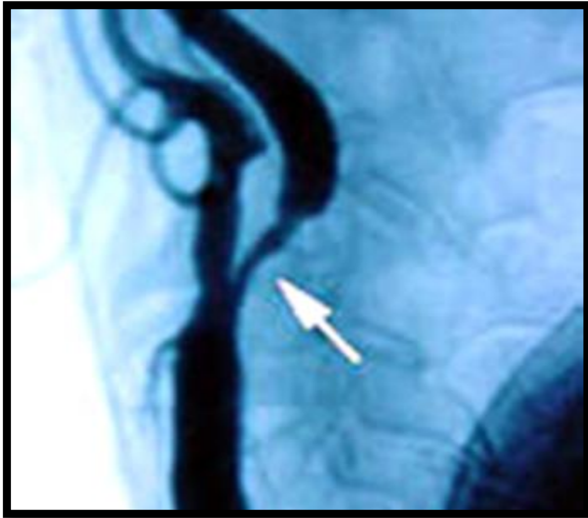
ECH Vascular Program

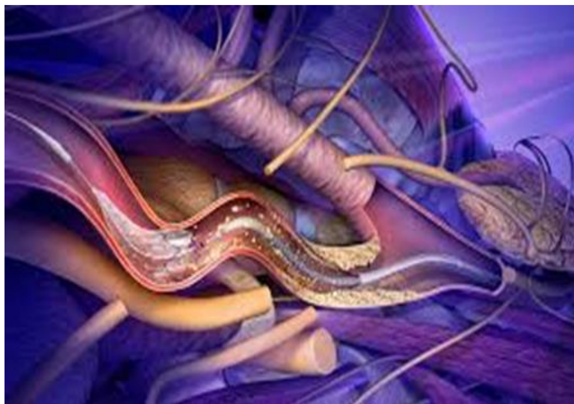


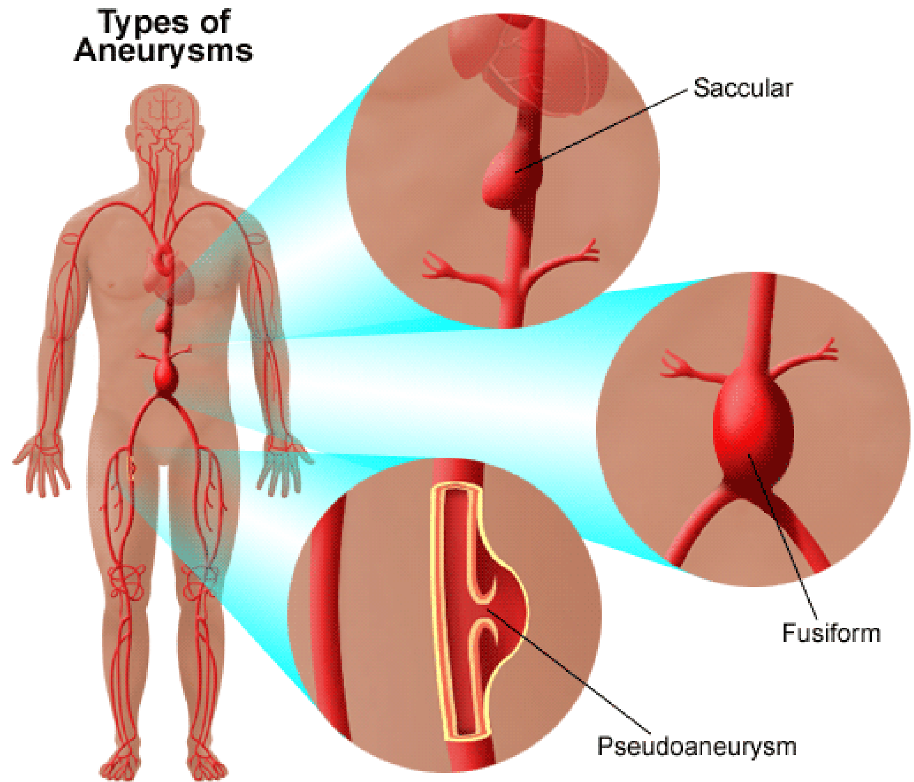
Vascular Care in Silicon Valley

- Formalized in 2006
- Growth in quality and complex procedures
- MDs: top medical schools and training programs in America
- Quality and patient satisfaction priority
- Academic level vascular care in our hospital in Silicon Valley
- Excellent facility and nursing care
- Complete Program!

Today: ECH Stroke & Aneurysm Care







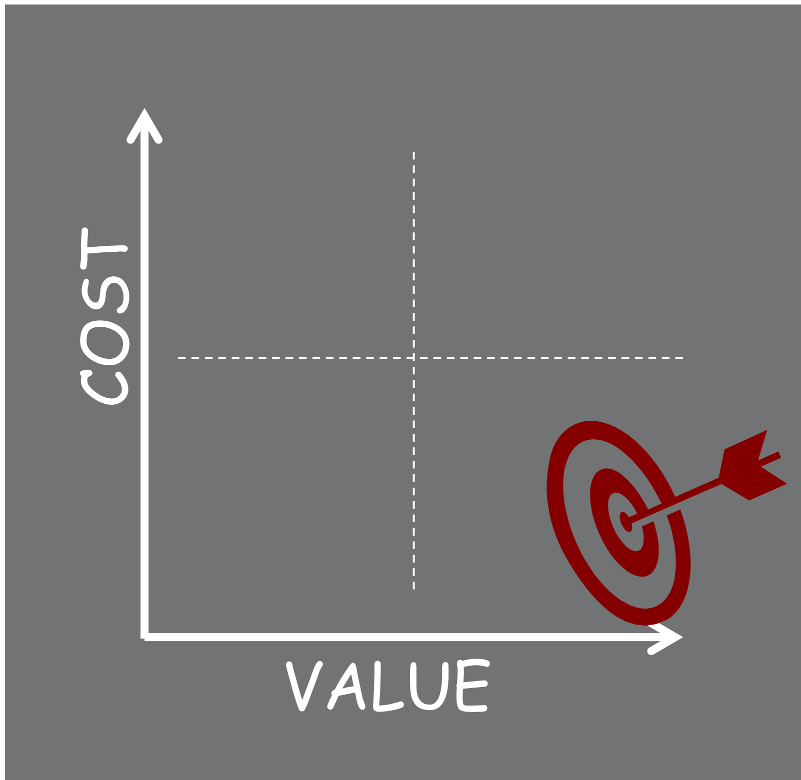
The Fundamental Need

- Ensure patient safety
- Ensure patient quality
- Ensure cost control
- Get DATA:
  - national peripheral vascular registry participation (VQI)

The ‘Typical’ Problem

- Community Hospital
- Multiple Vascular Providers: Interventional Cardiology, Radiology, Vascular Surgery
- Quality and Length of Stay
  - Aortic aneurysms
  - Carotid disease
- Privileges: quality and emergent vascular call duties
- Credentialing that ensures safety and skill

The Era of Pay for Performance



In the era of Pay for Performance, providers must deliver high quality patient care at a low cost

- Optimize Clinical Quality
- Reduce Cost of Care

Vascular Quality Initiative®

EMR Integration

PEER COLLABORATION

DEVICE EVALUATION

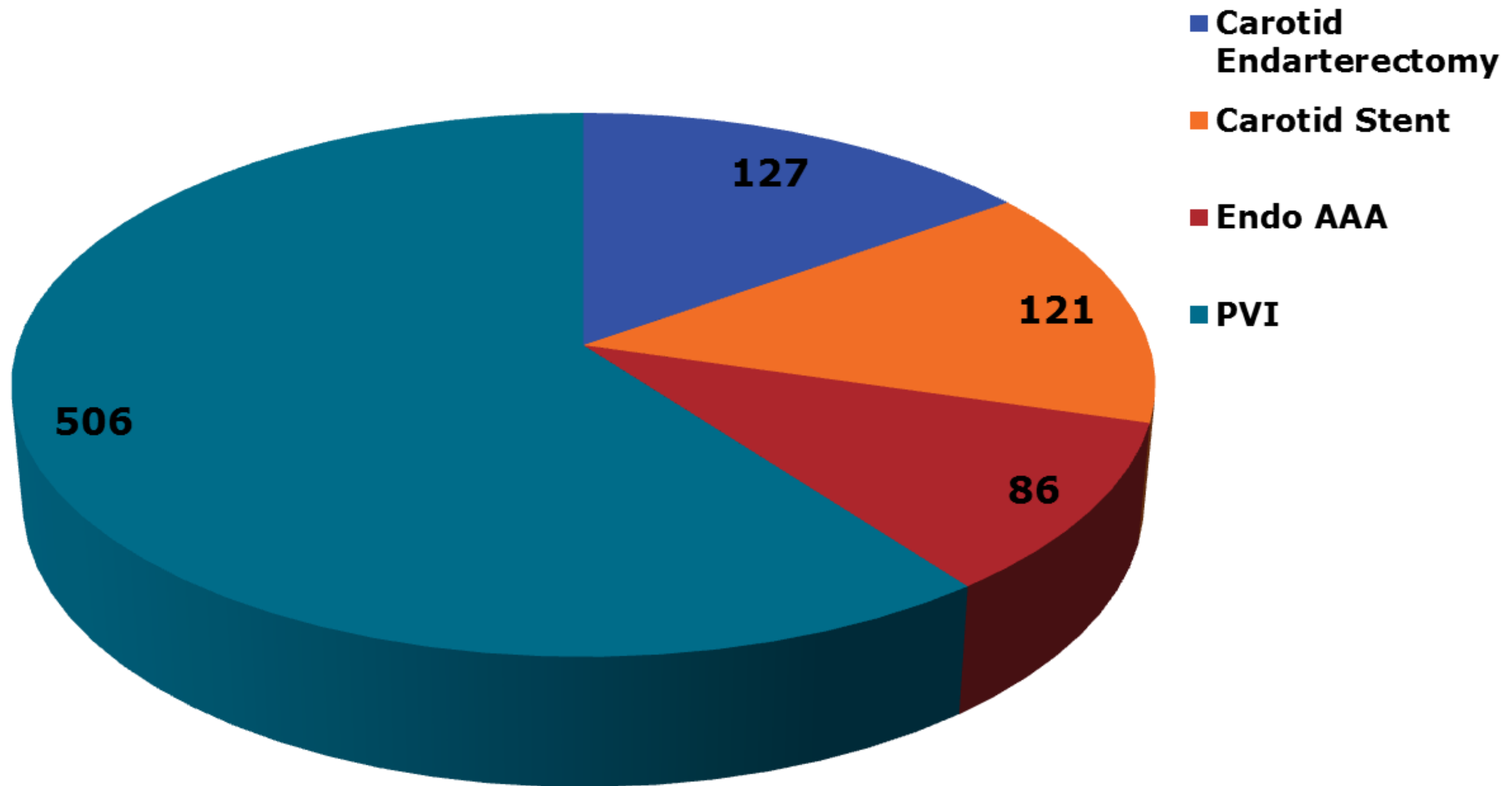
PQRS

CUSTOM REPORTING

ANALYTICS

MIPS QCDR

VQI Volume 4/2014 to 4/2017



ECH and Our Competition

Opportunity

- Evaluate ECH data on carotid and aneurysm care
- Provide high quality clinical care
- Carotid:
  - **Stroke/death rate and length of stay**
- Aneurysm
  - **Large bore policy**
  - **Length of stay**
  - **Cost control**

Endovascular AAA Opportunity & Initiatives

APPENDIX A – PRE-OP ATTESTATION CHECKLIST
VASCULAR
Large Bore Arterial Vascular Attestation (14 French Sheath or Greater)

Date of Exam ______________________ **Time of Exam** ________

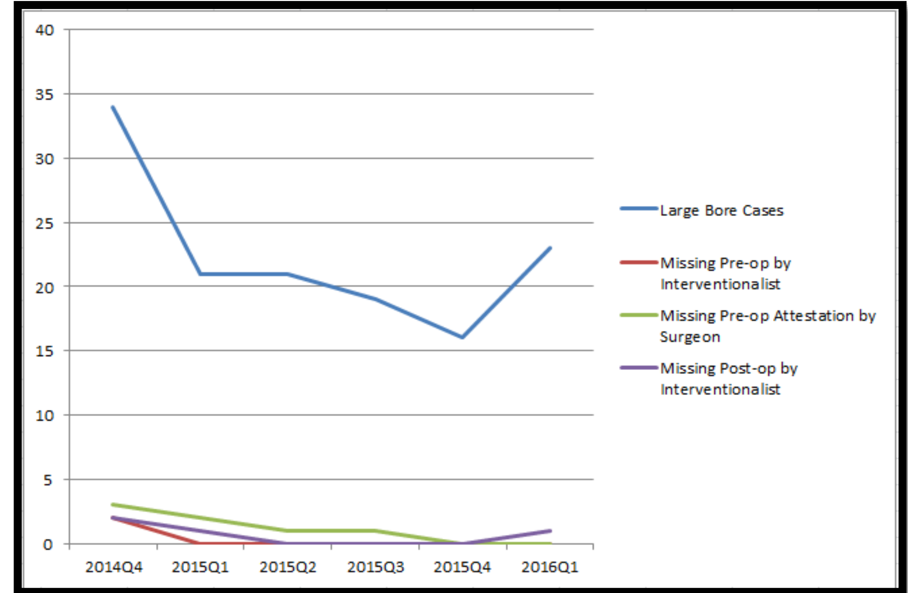
As the Cardiothoracic/Vascular surgeon providing support on the proposed large bore case, I confirm the following:

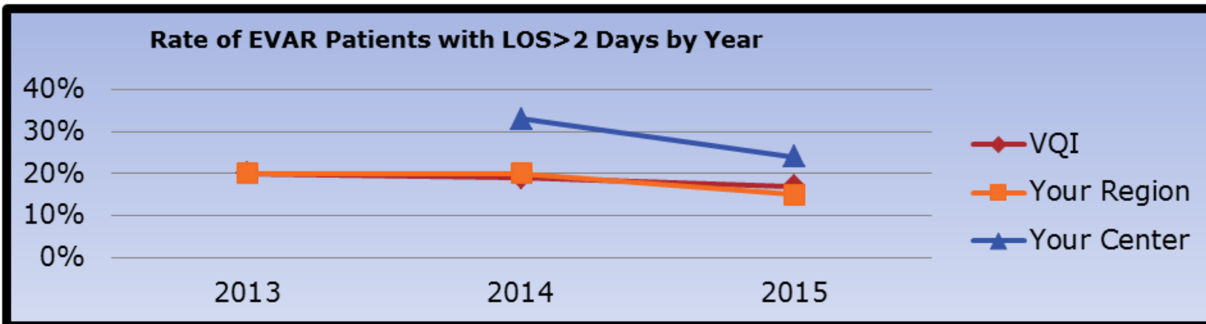
- ☐ I discussed and support the indication for the procedure after case planning with the primary Specialist
- ☐ I have reviewed all necessary and available pre-operative imaging regarding the case
- ☐ I have outlined in discussion with the primary specialist and patient the potential vascular access issues and complications with the case
- ☐ I agree that appropriate informed consent for the procedure has been explained and signed by the patient
- ☐ I have completed a formal pulse exam on the patient
- ☐ I agree to provide immediate vascular surgical support for the case during the perioperative and immediate post-operative period as needed
- ☐ Either I or a designated surgeon in my absence will provide post-operative support for the patient while in the hospital in needed

(All elements must be checked before proceeding with procedure)

Comments:

Physician's Name______________________
Signature ______________________________
Date ________





ECH action on aortic surgery safety and cost control of AAA is recognized nationally as pioneering

Initiatives: Education, credentialing, large bore, QA & cost education

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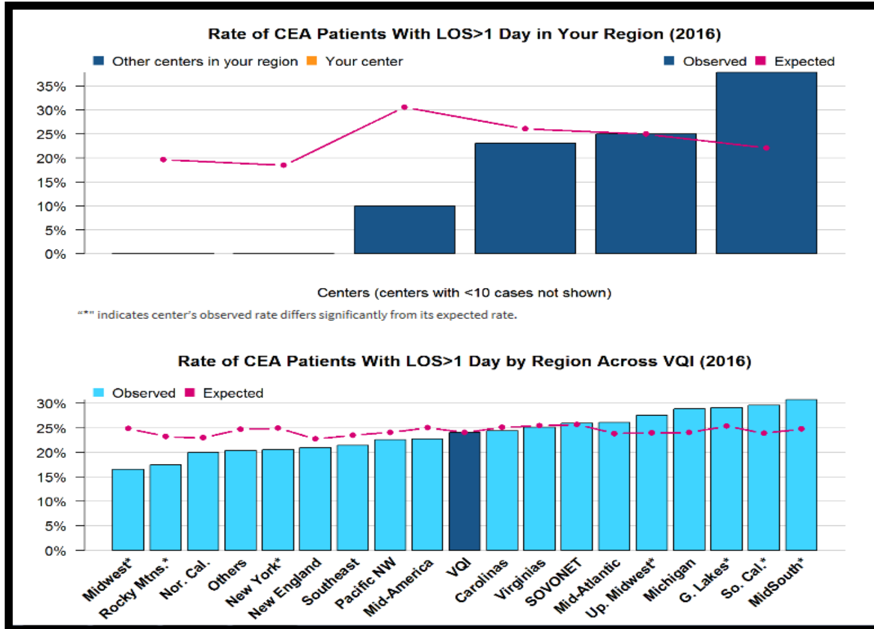
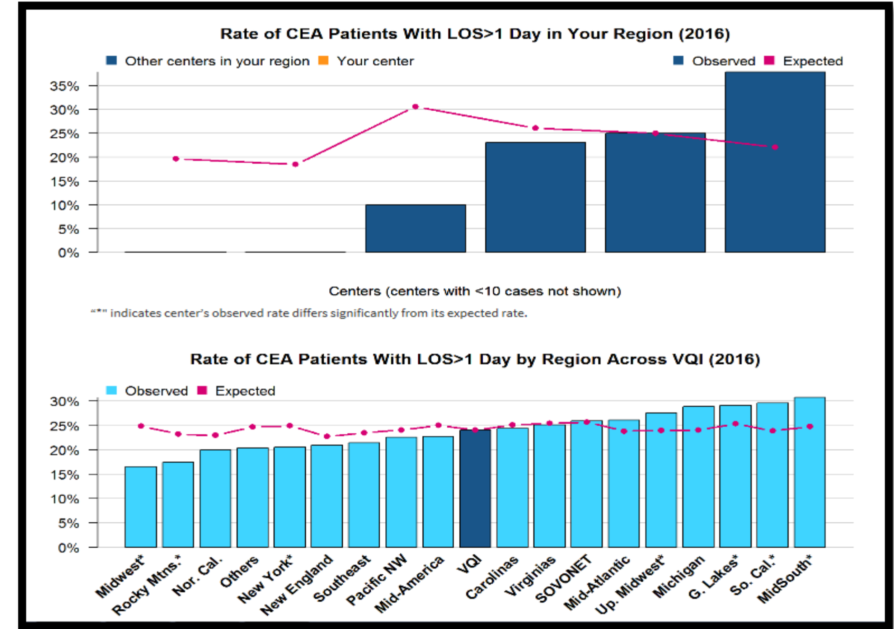
Carotid Opportunity & Initiatives





Initiatives: Data monitoring, refining OR process, education, medical care and cost control, efficient OR surgery times, stroke center nursing

In Northern California carotid surgery and care is better than national performance

New 2017 ECH Wound Care Services

- Comprehensive Wound Care Services
- On campus
- Dedicated wound care specialists and providers
- Growing program and important community resource
- Complex wound care in a super easy environment: LOS, readmissions
- Podiatry, vascular surgery, medical care and plastic surgery

Conclusions

- ECH Vascular Care is patient and quality driven
- We have made major strides in clinical quality
- We are driven by objective data from VQI
- We are focused on patient safety and cost effective care
- We are providing the highest level of carotid and aortic care in the Western States

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Quality and Safety Dashboard (Monthly)

Date Reports Run: 4/11/2017				Baseline	FY17 Goal	Trend	Comments
SAFETY EVENTS		Performance		FY2016	FY2017		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: February 2017*	9/5111	1.76	1.51	1.39 (goal for FY 16)		Falls team evaluating new pajamas with ankle cuffs to avoid pts. tripping on long pant legs. Use of bed and chair alarms reinforced as well as staying with pts while in the bathroom.
2	★Organizational Goal **Pain reassessment within 60 mins after pain med administration** *Date Period: March 2017*	9593/10957	87.6%	56.3% (Jan-Jun 2016)	75% (min) 80% (mid) stretch goal=90%		Key actions taken: 2 months of individual RN coaching, Pt. Ed brochures implemented, Contine weekly unit recognition, nurse badge buddies distributed, Pain website under development, Order sets under review, Pain Mgmgt Pharmacist starts July 31st.
3	**Medication Errors (Overall: reached to patients and near miss)** *Errors / 1000 Adj Total Patient Days* *Date Period: February 2017*	24/13248	1.66	2.68	0.00		Opioid Risk Screeng tool for EPIC under investigation, metric is well underbaseline and continuing to decline.
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: March 2017*	FYTD 3904 March 2017 437	FYTD 4.58 March 2017 4.63	4.78	4.87		LOS goal set April 2016 before Jan-June 2016 ALOS was known. Current average LOS is below the Jan-June 2016 average, and staying lower.
5	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: February 2017*	FYTD 371/3369 Feb 2017 42/425	FYTD 11.01 Feb 2017 9.88	11.53	At or below 12.24		Rate is lower in February, continues to be low in the hospital community.

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: February 2017	Goal: 70% (Min); 75%(Max); 80% (Stretch)				(see table below)	The goal of 80% is exceeded with only 1 case not receiving the fluid order w/I 2 hrs of presentation.

	Apr	May	Jun	Sep	Oct	Nov	Dec	Jan	Feb
Number of Sampled Cases	18	19	21	23	30	30	29	30	30
Cases with 30ml/kg ordered or NICOM with 3 hours TOP	0	0	0	1	0	0	0	2	1
Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17	9	14	17	17	24	21	26
% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%	43%	61%	57%	57%	83%	70%	87%
Min Goal	70%	70%	70%	70%	70%	70%	70%	70%	70%

COMPLICATIONS	Performance		FY 2016	FY 2017		
7 **Surgical Site Infection (SSI)** *SSI per 100 Clean/Clean-contaminated Surgical Procedures* *Date Period: February 2017*	2/604	0.33	0.20	0.18 (goal for FY 16)	2SL=0.51; Avg=0.22; Target=0.18; -2SL=-.08	2 SSIs of 604 surgeries from 29 surgical categories reported to NHSN: 1 Total Hip at MV and 1 Total Knee at LG.
SERVICE	Performance		FY 2016	FY 2017		
8 **Communication with Nurses** *(HCAHPS composite score, top box)* *Date Period: Jan 2017*	210/274	76.7%	78.0%	78.5%	2SL=83.9%; Avg=78.5%; Target=78.5%; -2SL=73.2%	While this is trending down, the score had been above goal until January. ECH opened a command center for 4 days mid-month to handle impacted capacity which included a record # of flu pts.
9 **Responsiveness of Hospital Staff** *(HCAHPS composite score, top box)* *Date Period: Jan 2017*	172/257	66.9%	64.9%	66.8%	2SL=72.1%; Target=66.8%; Avg=65.7%; -2SL=59.4%	January results have recovered above target.
10 ★Organizational Goal **Pain management** (HCAHPS composite score, top box) *Date Period: Jan 2017*	136/179	75.7%	72.5%	73% min 74% max 76% stretch	2SL=80.3%; Avg=74.5%; -2SL=68.8%	Pt./family education brochures were implemented at the end of January. Nursing still expects to see this result trend up to reflect the improved Pain reassessment compliance.
11 **Communication About Medicines** *(HCAHPS composite score, top box)* *Date Period: Jan 2017*	121/180	67.3%	64.7%	68.3%	2SL=75.5%; Target=68.3%; Avg=65.9%; -2SL=56.2%	This score has dropped off with January, but is expected to return to the goal.

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)	**EPIC Chart Review**
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	Michelle Gabriel; 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	Michelle Gabriel	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	Michelle Gabriel; 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**

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Draft #2 - FY 18 Quality Committee Meeting Calendar
(1st or last 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
October 30, 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
April 30, 2018	May 09, 2018
June 4, 2018	June 13, 2018

Yellow highlighting indicates change from April 3rd discussion

FY18 Organizational Goals: For Discussion and Approval

- Format and framework of the organizational goals has been approved by the Executive Compensation Committee of the Board.
- Specifically;
  - a threshold goal based on financial performance to budget
  - three goals that collectively impact the entire organization, generally focused on Quality, Service Affordability, and being Patient Centric
  - ½X, X, 2x format for Minimum, Target and Maximum.
- The Quality Committee of the Board needs to review and recommend to the Board the three specific Quality, Service, Affordability, or Patient Centric goals

FY18 Organizational Goals: For Discussion and Approval

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*	1.100	1.060	0.990	34%	4Q FY18
HCAHPS Service metric: Rate Hospital	External Benchmark	HCAHPS Baseline: 10/2016 - 12/2016: 75.5 1/2017 - 3/2017: 75.1	75.7	76.3	77.5	33%	4Q FY18
Cuture of Safety: Pecent 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

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FY18 Organizational Goals: For Discussion and Approval

- For the last two years we have set internally focused LOS and Readmission goals, i.e. trend improvement. This year we are advancing the concept via an external component, expected GMLOS.
- By using an Observed (actual ECH performance) over Expected (GMLOS) ratio it captures both improvement in LOS management and better coding/ documentation (CDI effort).

				Targeted Improvement	
Medicare	Baseline (7/1/16 - 11/30/16)		Minimum	Target	Maximum
Actual LOS (observed)	5.11		300 days: 5.00	500 days: 4.93	700 days: 4.86
GMLOS (Expected)	4.38		CDI: 4.53	CDI: 4.66	CDI: 4.93
Observed / Expected	1.16		1.10	1.06	0.99

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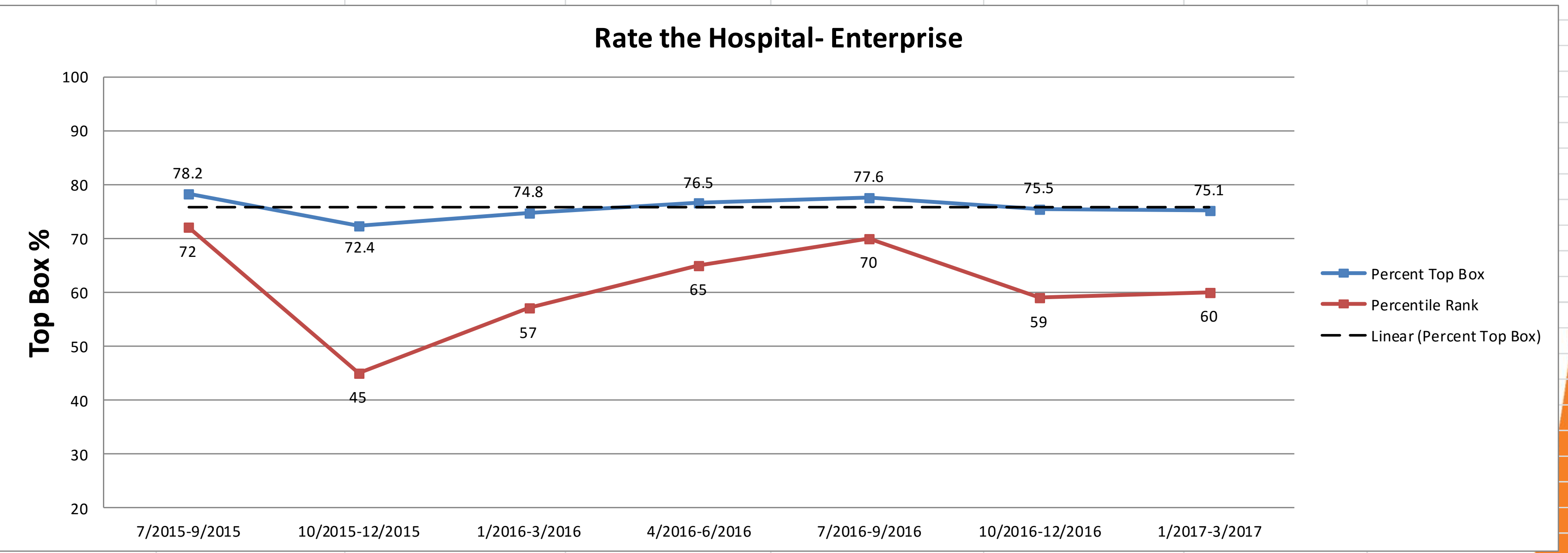
FY18 Organizational Goals: For Discussion and Approval

- We are recommending “Rate the Hospital” CAHPS as the service goal, it allows for multiple interventions and is a very good capstone metric representing our consumers view of our service.

Rate hospital 0-10	7/2015-9/2015	10/2015-12/2015	1/2016-3/2016	4/2016-6/2016	7/2016-9/2016	10/2016-12/2016	1/2017-3/2017
Percent Top Box	78.2	72.4	74.8	76.5	77.6	75.5	75.1
Percentile Rank	72	45	57	65	70	59	60
n	**660**	**543**	**810**	**918**	**866**	**803**	**635**



FY18 Organizational Goals: For Discussion and Approval

- Our Culture of Safety goal is still a work in process as we await our Employee Engagement and Culture of Safety survey results.
- The concept is that we would select 2 - 3 key questions that capture the staff's perception of our culture as it pertains to a safe work environment.
- We would use the initial survey results as the baseline, identify and implement interventions, and monitor improvement via an ad-hoc survey tool.
- The 10% 20%, 40% improvement scale complies with the recommended 1/2x, x, 2x format for minimum, target and maximum .