El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Monday, August 7th, 2017, **5:30 p.m.**
El Camino Hospital, Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

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

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER**	David Reeder, Chair Quality Committee		**5:30 – 5:31pm**
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 or member of the public 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 the Open Session of the Quality Committee Meeting (May 1, 2017) b. Minutes of the Open Session of the Quality Committee Meeting (June 5, 2017) ***Information*** c. Research Article d. Patient Story e. FY18 Pacing Plan f. Approved FY18 Committee Goals			
5.	**APPOINTMENT OF VICE CHAIR**	David Reeder, Chair Quality Committee		**Discussion 5:36 – 5:38**
6.	**REPORT ON BOARD ACTIONS ATTACHMENT 6**	David Reeder, Chair Quality Committee		**Discussion 5:38 – 5:41**
7.	**QUALITY PROGRAM UPDATE: CARDIO THORACIC SURGERY ATTACHMENT 7**	Pei Tsau, MD Cardio Thoracic Surgeon		**Discussion 5:41 – 6:01**
8.	**FY17 QUALITY DASHBOARD ATTACHMENT 8**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 6:01 – 6:11**
9.	**COMMITTEE RECRUITMENT**	Cheryl Reinking, Chief Nursing Officer		**Possible Motion 6:11 – 6:21**
10.	**FY17 ORGANIZATIONAL GOAL ACHIEVEMENT UPDATE ATTACHMENT 10**	Cheryl Reinking, Chief Nursing Officer		**Discussion 6:21 – 6:26**

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
11.	**REVIEW PROPOSED NEW FORMAT FOR QUARTERLY QUALITY AND SAFETY REVIEW** **ATTACHMENT 11**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion 6:26 – 6:41**
12.	**PATIENT AND FAMILY CENTERED CARE UPDATE** **ATTACHMENT 12**	Michelle Gabriel, Director of Performance Improvement		**Discussion 6:41 – 6:51**
13.	**BPCI PROGRAM** **ATTACHMENT 13**	Grace Benlice, Director of Care Coordination		**Discussion 6:51 – 7:06**
14.	**PUBLIC COMMUNICATION**	David Reeder, Chair Quality Committee		**Information 7:06 – 7:09**
15.	**ADJOURN TO CLOSED SESSION**	David Reeder, Chair Quality Committee		**Motion Required 7:09 – 7:10**
16.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	David Reeder, Chair Quality Committee		**7:10 – 7:11**
17.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	David Reeder, Chair Quality Committee		**Motion Required 7:11 – 7:12**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (May 1, 2017) b. Minutes of the Closed Session of the Quality Committee Meeting (June 5, 2017) ***Information*** c. Quality Council Minutes (May 3, 2017)			
18.	*Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - CMO Report	William Faber, MD, Chief Medical Officer		**Discussion 7:12 – 7:17**
19.	*Health and Safety Code Section 32155,* report related to Medical Staff quality assurance matters: - Red/Orange Alert and RCA Updates	William Faber, MD, Chief Medical Officer		**Discussion 7:17 – 7:27**
20.	**ADJOURN TO OPEN SESSION**	David Reeder, Chair Quality Committee		**Motion Required 7:27 – 7:28**
21.	**RECONVENE OPEN SESSION/REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	David Reeder, Chair Quality Committee		**7:28 – 7:29**
22.	**ADJOURNMENT**	David Reeder, Chair Quality Committee		**Motion Required 7:29 – 7:30pm**

Upcoming FY 18 Meetings (*tentative upon Board approval)*

- August 28, 2017
- October 2, 2017
- October 30, 2017
- December 4, 2017
- February 5, 2018
- March 5, 2018
- April 2, 2018
- April 30, 2018
- June 4, 2018

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, May 1, 2017
El Camino Hospital, Conference Rooms E&F
2500 Grant Road, Mountain View, California

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

**Melora Simon joined the meeting at 5:41pm*
**Wendy Ron joined the meeting at 5:43pm*
**Mikele Bunce left the meeting at 6:55pm*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 1st of May, 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 5:36 p.m.	
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Mick Zdeblick, Chief Operating Officer, introduced Michelle Gabriel, Director of Performance Improvement	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Reeder asked if any Committee member may have a conflict of interest with any of the items on the agenda. No conflict of interest was reported.	
4. CONSENT CALENDAR ITEMS	Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed. **Motion:** To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meeting (April 3, 2017). **Movant:** Davis **Second:** Anderson **Ayes:** Anderson, Bunce, Carragee, Davis, Fung, Reeder, Russell **Noes:** None **Abstentions:** None **Absent:** Pinsker, Ron, Simon,Tsao **Excused:** None **Recused:** None	***Consent Calendar approved***

Agenda Item	Comments/Discussion	Approvals/Action
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and highlighted the Board's current priorities to include: • The Board and Leadership Team are revising the Strategic Plan with the help of a consultant. • CEO interviews will be occurring this week for anticipated permanent CEO selection. • The District Board will consider revising the Hospital Board structure and adding additional subject matter experts at a Special Meeting on May 15th. Public comment is encouraged.	
6. QUALITY PROGRAM UPDATE: VASCULAR SURGERY	Tej Singh, MD, Medical Director, Vascular Surgery, updated the Committee on the accomplishments of the Vascular Surgery program. Dr. Singh reported that El Camino Hospital provides an excellent facility and nursing care to the community. He highlighted that the program's safety on aortic and cost control of AAA (Abdominal Aortic Aneurysm) surgery is recognized nationally as pioneering. He explained our newly expanding Wound Care Services program as an important community resource. Dr. Singh asked for feedback and questions from the Committee and a brief discussion ensued.	
7. FY17 QUALITY DASHBOARD	Catherine Carson, RN, Sr. Director of Quality Improvement and Patient Safety reviewed the newly annotated FY17 quality dashboard with the committee. Ms. Carson discussed the ongoing challenge of falls prevention and highlighted a new initiative to provide patients with pajamas that have cuffs to prevent tripping. Cheryl Reinking, RN, CNO, explained that nursing staff is receiving ongoing education around remaining with patients at high risk for falls while toileting. Ms. Carson reported that pain reassessment scores are improving and an enterprise-wide pain management pharmacist will be added to the staff this summer. Other Metrics: med errors are well under baseline; length of stay is below benchmark and has stayed under control for the last 3-4 months; the readmission rate is the lowest in the community; we are above goal for the sepsis metric due to operationalization of a new ED protocol. The Committee had a lengthy discussion about surgical site infections and asked the team to bring back comparator groups to provide some context for developing a reasonable goal. Ms. Carson also reported that HCHAPS scores are better for February (communication with nurses = 80.9; staff responsiveness = 73.6; pain management = 79.2; and communication about medication = 77.1) than the January scores reflected in the version of the	

Agenda Item	Comments/Discussion	Approvals/Action
	dashboard presented. Dr. Faber advised the committee he plans to start looking at longer trend lines in an effort to evaluate the long-term sustainability of corrective initiatives.	
8. PROPOSED FY18 QUALITY COMMITTEE DATES	The Committee discussed the proposed FY18 Committee Dates including the new dates of August 7, 2017, October 30, 2017, and April 30, 2018. Chair Reeder explained the changes are due to the time frame with the corresponding Hospital Board Meetings. **Motion:** To recommend that the Board approve the FY18 Quality Committee Meeting Dates. **Movant:** Fung **Second:** Simon **Ayes:** Anderson, Bunce, Carragee, Davis, Fung, Simon, Reeder, Ron, Russell **Noes:** None **Abstentions:** None **Absent:** Tsao, Pinsker **Excused:** None **Recused:** None	***Proposed FY18 Quality Committee Dates approved***
9. DRAFT FY18 ORGANIZATIONAL GOALS	Mick Zdeblick, COO, reviewed the Proposed FY18 Organizational Goals to include: 1. Arithmetic Observed LOS Average/Geometric LOS expected for Medicare population (ALOS / GMLOS) 2. HCAHPS Service metric: Rate the Hospital 3. Culture of Safety: Percent improvement in staff perception of culture of safety Mr. Zdeblick reviewed the proposed FY18 organizational goals which follow ECH's standard format - the first is performance to budget, the next three are modeled on the Triple Aim. For affordability/cost effectiveness, a new goal of improving inpatient utilization for Medicare patients of average length of stay over predicted length of stay (GMLOS) was proposed. This goal captures improvements in both length of stay and accuracy of clinical documentation and received the committee's support. The proposed patient service goal is improvement of HCAHPS performance on "rate the hospital." The committee also supported this goal in concept, at least in part because it brings in all departments, but asked management to bring back further information about actual measurement. The proposed quality goal would measure an improvement in the Culture of Safety, based on AHRQ survey results that will be available on May 9th. A customized methodology to measure improvement was discussed and there are technical issues to be worked out. Staff will come back with a revised goal, pending analysis of AHRQ survey results.	***FY18 Organizational Goals recommended for approval***

Agenda Item	Comments/Discussion	Approvals/Action
10. COMMITTEE MEMBERSHIP	Chair Reeder asked if the Committee members wished to continue to serve on the Committee in FY18. Diana Russell is declining to serve on the committee for FY18 due to other commitments. All other members expressed that they would like to serve. The Committee is hoping to recruit 2 "patient representative" members.	***Committee list to be provided to the Board Chair***
11. PUBLIC COMMUNICATION	None.	
12. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:19 p.m. **Movant:** Carragee **Second:** Anderson **Ayes:** Anderson, Carragee, Davis, Fung, Reeder, Ron, Russell, Simon **Noes:** None **Abstentions:** None **Absent:** Bunce, Pinsker and Tsao **Excused:** None **Recused:** None	***Adjourned to closed session at 7:19pm.***
13. AGENDA ITEM 16: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:26 pm. *Agenda Items 13 – 15 were addressed in closed session.* Chair Reeder reported that the Closed Session Minutes of the April 3, 2017 Quality Committee Meeting were approved.	
14. AGENDA ITEM 17 ADJOURNMENT	The meeting was adjourned at 7:28pm. **Motion:** To adjourn at 7:28 p.m. **Movant:** Fung **Second:** Davis **Ayes:** Anderson, Carragee, Davis, Fung, Reeder, Ron, Russell, Simon **Noes:** None **Abstentions:** None **Absent:** Bunce, Pinsker and Tsao **Excused:** None **Recused:** None	***Meeting adjourned 7:28pm***

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

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

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, June 5, 2017
El Camino Hospital, Conference Rooms E&F
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Jeffrey Davis, MD; Nancy Carragee, Alex Tsao and Melora Simon	Katie Anderson, Mikele Bunce, Peter Fung, MD; Robert Pinsker, MD; Dave Reeder, Wendy Ron, and Diana Russell, RN	

A quorum was not present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 6th of June, 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 Vice Chair Jeffrey Davis, MD at 5:33 p.m.	
2. ROLL CALL	Vice Chair Davis asked Michele Lee to take a silent roll call. Katie Anderson, Mikele Bunce, Peter Fung, MD; Robert Pinsker, MD; Dave Reeder, Wendy Ron, and Diana Russell, RN were absent. All other Committee Members were present.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Vice Chair Davis asked if any Committee member may have a conflict of interest with any of the items on the agenda. No conflict of interest was reported.	
4. CONSENT CALENDAR ITEMS	Vice Chair Davis asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed. Since a quorum was not present approval of the Minutes of the May 1, 2017 meeting was deferred to the August 7, 2017 meeting.	
5. REPORT ON BOARD ACTIONS	Vice Chair Davis briefly reviewed the Board Report as further detailed in the packet with the Committee and highlighted the Board's current priorities to include: • Expanded Hospital Board membership to add 2 additional appointed/subject matter experts. Also voted to change CEO to a non-voting member of the Board. • The District Board appointed Robert Rebitzer to the El Camino Hospital Board of Directors • Biennial Board Officer Election (for a two year term, effective July 1, 2017): ○ Hospital Board Chair – Lanhee Chen	

Agenda Item	Comments/Discussion	Approvals/Action
	○ Hospital Board Vice Chair – John Zoglin ○ Hospital Board Secretary/Treasurer – Julia Miller • Committee structure will remain the same	
6. QUALITY PROGRAM UPDATE: NICU	Dharsi Sivakumar, MD, Medical Director, NICU, updated the Committee on the accomplishments of the Level III NICU program. Dr. Sivakumar reported that El Camino Hospital provides high tech respiratory technology in the NICU: Inhaled Nitric Oxide, Drager Baby Log Ventilators, Vapotherm and SiPAP. She highlighted that the program's safety on Central Line Associated Blood Stream Infections. She explained the future goals of the NICU program with various research and quality improvement projects, subspeciality services, implementing delayed cord clamping, neurological monitoring, and designing a new 31 bed hybrid NICU with private rooms. Dr. Sivakumar asked for feedback and questions from the Committee and a brief discussion ensued.	
7. FY17 QUALITY DASHBOARD	Catherine Carson, RN, Sr. Director of Quality Improvement and Patient Safety reviewed the newly annotated FY17 quality dashboard with the committee. Ms. Carson reported that the numbers of falls has stabilized right around the goal. She is looking more into data surrounding falls related to bed exit and toileting. She also reported that pain reassessment scores continue to improve, med errors are up, near misses are down, sepsis is above goal and there were zero SSI's for March enterprise-wide. Meanwhile, Average Length of Stay (LOS) trended upwards in April due to 3 long stay patients. But the overall Readmission rate remains below goal. Ms. Carson also reported that some HCHAPS scores are trending upward in March.	
8. PATIENT AND FAMILY ADVISORY COUNCIL UPDATE	Cheryl Reinking, RN, Chief Nursing Officer briefly went over the Patient and Family Advisory Council background: currently has 8 members of patients and deciding about rotating membership of two year engagement. Ms. Reinking informed the committee about the 3 meetings the PFAC held since January 2017 and the topics that were on the agendas. In the January meeting, infection control and hygiene were discussed. In the March meeting, standardized uniform for hospital staff and lost patient belongings process were topics and valuable feedback was obtained. In the May meeting, emergency department redesign process and MOON notice feedback was conversed.	
9. PROPOSED FY18 PACING PLAN	Vice Chair Davis discussed the proposed FY18 Pacing Plan with the committee members. The Committee members participating in the meeting reviewed the recommendation and no objections were stated	
10. UPDATE ON FY18 QUALITY	The Committee briefly discussed the updated FY18 Committee Goals. William Faber, MD, Chief Medical	

Agenda Item	Comments/Discussion	Approvals/Action
COMMITTEE GOALS	Officer explained the minor changes are due to adding metrics for the goals.	
11. DRAFT FY18 ORGANIZATIONAL GOALS	Mick Zdeblick, COO, explained the proposal to change the measurement for the threshold goal to 95% of budgeted operating margin proposed for FY18 per the Finance Committee recommendation, and the Executive Compensation Committee's recommendation to decrease the delta between target and maximum. The Committee discussed the newly proposed quality goal to reduce Hospital Acquired infections. A robust discussion around using the SIR (standardized infection rate) to statistically normalize measurement, specifically whether the SIR may be too volatile to use as a fair and reliable measure of achievement, but ultimately the committee supported the staff recommendation. The Committee discussed the relationship between a length of stay goal and affordability to the patient. Staff will come back next year with information that may lead to a different efficiency goal in FY19 around total cost of care. The Committee members participating in the meeting reviewed the three specific quality, service, and affordability goals and no objections were stated.	
12. PUBLIC COMMUNICATION	None.	
13. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 6:56 p.m. **Movant:** Simon **Second:** Tsao **Ayes:** Carragee and Davis **Noes:** None **Abstentions:** None **Absent:** Anderson, Bunce, Fung, Pinsker, Reeder, Ron, Russell **Excused:** None **Recused:** None	***Adjourned to closed session at 6:56 p.m.***
14. AGENDA ITEM 19: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:21 pm. *Agenda Items 14 – 18 were addressed in closed session.*	
15. AGENDA ITEM 17 ADJOURNMENT	The meeting was adjourned at 7:22pm. **Motion:** To adjourn at 7:22 p.m. **Movant:** Carragee, **Second:** Tsao **Ayes:** Davis and Simon **Noes:** None **Abstentions:** None **Absent:** Anderson, Bunce, Fung, Pinsker, Reeder, Ron, Russell **Excused:** None	***Meeting adjourned 7:22pm***

Agenda Item	Comments/Discussion	Approvals/Action
	Recused: None	

Attest as to the approval of the foregoing minutes by the Quality Committee of El Camino Hospital:

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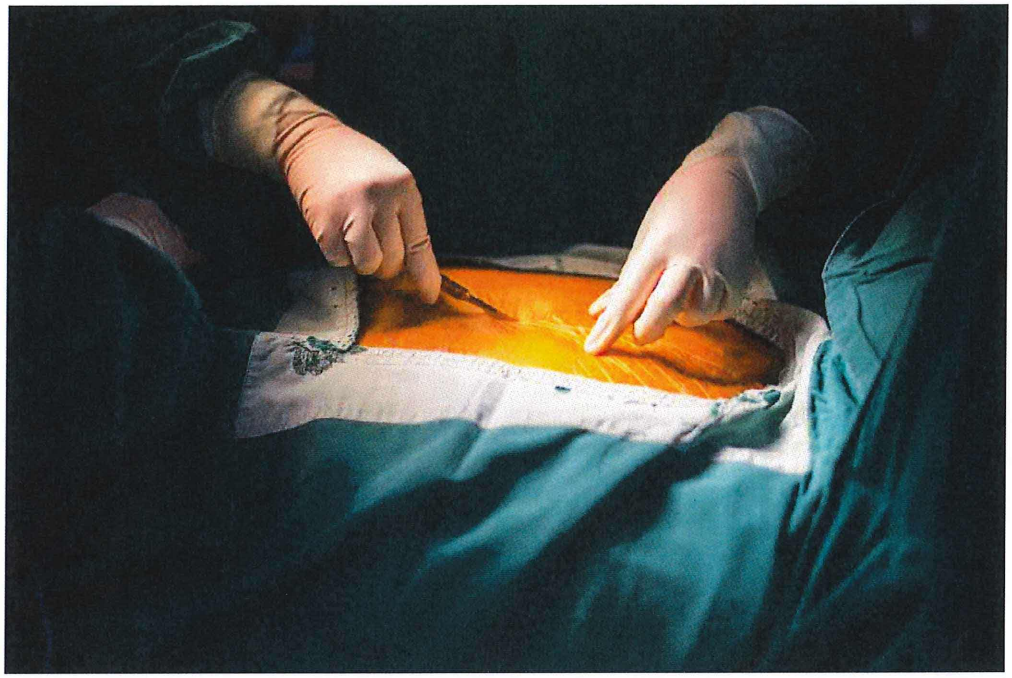
Dave Reeder
Chair, ECH Quality, Patient Care and
Patient Experience Committee

Benefits and Risks of Coronary Bypass Surgery

1/12/2015



Coronary artery bypass graft surgery is one of several major advances in the effort to manage cardiovascular disease—the leading cause of death and disability in the United States. You may have heard this surgery referred to simply as "bypass surgery" or as CABG (pronounced "cabbage" and short for "coronary artery bypass graft").

Coronary bypass surgery is used to treat **heart attacks** or serious chest pain (**angina**) caused by blockages in the arteries that supply blood to the heart muscle. The surgeon attaches (**grafts**) a blood vessel taken from elsewhere in the body to the diseased heart artery, rerouting blood around the blockage in the same way a road detour re-routes traffic around road construction. A double, triple or quadruple bypass refers to the number of heart arteries that are bypassed.

The surgery carries many benefits, including some particularly for patients who have serious cardiovascular disease. The operation can save your life if you are having a heart attack or are at high risk of having one. If you have ongoing angina and shortness of breath from diseased heart arteries, elective coronary bypass surgery is highly effective at eliminating or reducing discomfort. Coronary bypass surgery can give you your life back.

Because coronary bypass surgery is an open-heart procedure requiring general anesthesia and in many cases that the heart is stopped during the operation, bypass carries risks. The good news is that recent decades have seen a steep drop in serious complications. Today, more than 95 percent of people who undergo coronary bypass surgery do not experience serious complications, and the risk of death immediately after the procedure is only 1–2 percent.

The risk of serious complications is higher for **emergency** coronary bypass surgeries, such as for patients who are having a heart attack, when compared to **elective** surgery for treatment of angina and other symptoms. Additionally, patients may be at higher risk if they are over 70 years old, are female or have already had heart surgery. Patients who have other serious conditions, such as **diabetes**, **peripheral vascular disease**, kidney disease or lung disease, may also be at higher risk.

While complications from coronary bypass surgery are relatively rare today, your care team will make every effort to guard against them and to treat them if they do develop. They may include the following:

- **Risk of bleeding from site of attached graft and other sources**. About 30 percent of patients will require blood transfusions after the surgery. Very rarely, bleeding will be severe enough to require additional surgery.
- **Heart rhythm problems**. Atrial fibrillation (a condition in which the upper chambers of the **heart** quiver rather than beating properly) is a common complication of coronary bypass surgery and can contribute to blood clots that form in the heart and that can travel to other parts of the body. Other forms of heart rhythm problems are possible as well, though less common.
- **Blood clots**. If blood clots form, they can cause a heart attack, **stroke**, or lung problems.
- **Infection at the incision site where the chest was opened for surgery**. This complication is rare, occurring in only about 1 percent of coronary bypass patients.
- **"Post-pericardiotomy syndrome."** This condition occurs in about 30 percent of patients from a few days to 6 months after coronary bypass surgery. The symptoms are fever and chest pain.

- **Kidney, or renal, failure**. Coronary bypass surgery may damage the functioning of a patient's kidneys, though this is most often temporary.
- **Memory loss or difficulty thinking**. Many patients report difficulty thinking after coronary bypass surgery. This problem typically improves in 6 months to a year. Researchers are not sure what causes this, though one theory is that the use of a heart-lung machine to allow surgery on the heart dislodges tiny bits of fatty build-up in an artery that can travel to the brain. Studies have been inconclusive about whether surgeries on a beating heart and without the heart-lung machine reduce this complication.
- **Reactions to anesthesia**. As with any surgery performed while the patient is "asleep," patients may have reactions to the anesthesia, including difficulty breathing.
- **Death**. In-hospital death is very rare after coronary bypass surgery. It is typically caused by heart attack or stroke.

If you are considering coronary bypass surgery on an elective basis to treat your heart disease, please discuss any concerns you have about balancing the benefits and risks of the surgery with your **cardiac surgeon**. To help you start this conversation, consider downloading **Questions to Ask Your Doctor About Coronary Bypass Surgery**.

Learn More

If you'd like to learn more about cardiovascular conditions, follow the links below:

- **Coronary Artery Disease**. Blockages form in the heart arteries as a result of a progressive disease process. If you have had or are being recommended to have coronary bypass surgery, it is to treat your underlying coronary artery disease.
- **Angina/Chest Pain**. Coronary bypass surgery is one treatment option for non-heart-attack chest pain caused by a lack of blood flow through arteries leading to the heart muscle. This chest pain is called angina. Treatment can restore your ability to enjoy everyday activities.
- **Heart Attack**. Heart attack patients who have blockages in certain locations in heart arteries or who have blockages in multiple blood vessels and diabetes may be better candidates for coronary bypass surgery than less invasive **angioplasty and stenting**. Understanding the mechanisms behind a heart attack can help you understand how treatment works.
- **Diabetes & Your Heart**. Diabetes and cardiovascular disease, unfortunately, often go hand in hand. Coronary bypass surgery is the preferred treatment for patients who have diabetes and blockages in multiple heart arteries.

Dear Doctors Taylor, Havel, and Garner, and Tamara and Carmen,

I can't thank all of you enough for the care you provided me with over the last ten months.

It was a difficult time for me, but you never gave up on me; in fact, from the very beginning, you gave me hope when I had none. I remember sitting on my bed in 1-South, not able to see a way forward, and yet you took me on in a promise that things could get better, that life was still worth it. (And you were right!) Your kindness and compassion were always so appreciated.

I'm doing very well nowadays, in a large part due to the ECT. I am almost half-way done with EMT school, plus volunteering every week, active and doing well in my NA recovery, studying singing with the eventual goal of joining the Stanford choir, going on hikes, and playing with my pet rat.

Life is still tough at times, but I feel more able to cope with it all.

Thank you all again, so much,

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

FY 18 Pacing Plan

FY2018 Q1		
JULY 2017	**AUGUST 7, 2017**	**August 28, 2017**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ FY 2018 Committee Goal Completion Status ▪ FY18 Pacing Plan ▪ Quality Council Minutes ▪ Patient Story ▪ Research Article	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items 1. Committee Recruitment 2. Update on Patient and Family Centered Care 3. FY17 Organizational Goal Achievement Update 4. Review proposed new format for Quarterly Quality and Safety Review 5. BPCI program 6. Appoint Committee Vice Chair	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda items: 1. Committee Recruitment 2. FY 17 Organizational Goal Achievement Update/Approval 3. FY 18 Organizational Goal Metric Approval 4. Review proposed new format for quarterly Quality and Safety review
FY2018 Q2		
OCTOBER 2, 2017	**OCTOBER 30, 2017**	**DECEMBER 4, 2017**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. FY 17 Organizational Goal Achievement Update/Approval 3. Year-End Review of RCA (10/25 – Joint Board and Committee Session)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Peer Review Process Changes Implementation Update 2. Safety Report for the Environment of Care 3. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Credentialing Process Report

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

FY 18 Pacing Plan

FY2018 Q3		
JANUARY 2018	**FEBRUARY 5, 2018**	**MARCH 5, 2018**
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. iCare Update 2. Proposed FY19 Organizational Goals
FY2018 Q4		
APRIL 2, 2018	**APRIL 30, 2018**	**JUNE 4, 2018**
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient and Family Centered Care 2. Proposed FY 19 Committee Goals 3. Proposed FY 19 Committee Meeting Dates 4. Review Committee Charter 5. Proposed FY 19 Organizational Goals (4/25 – Joint Board and Committee Session)	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Proposed FY 19 Committee Goals 2. Proposed FY 19 Organizational Goals 3. Review Biennial Committee Self-Assessment Results 4. Quarterly Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY18 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda Items: 1. Update on Patient Centered Care 2. Approve FY19 Pacing Plan

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

FY18 COMMITTEE GOALS

Quality, Patient Care and Patient Experience Committee

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, 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 experiences 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: **William Faber, MD**, Chief Medical Officer

The CMO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives may participate in the meetings upon the recommendation of the CMO and at the discretion of the CEO and the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurse, and members from the community advisory councils or the community at-large. The CEO is an ex-officio member 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 FY18 – Goals • Q3 FY18 - Metrics	• Review, complete, and provide feedback given to management, the Governance Committee, and the Board.
2. Alternatively (every other year) review peer review process and medical staff credentialing process. Monitor and follow through on the recommendations made through the Greeley peer review process.	• Q2 FY18	• Receive update on implementation of peer review process changes • Review Medical Staff credentialing 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.	• Q1 – Q2 FY18 – Proposal • Q2 FY18 – Implementation • Month Q1 – Q4 FY18	• Receive a proposed format for quarterly Quality and Safety Review; make a recommendation to the Board and implement new format. • Monthly review of FY18 Quality Dashboard
4. Oversee the development of a plan with specific tactics and monitor the HCAHPs scores for Patient and Family Centered Care.	• Q2 FY18	• Review the plan and approve
5. Monitor the impact of interventions to reduce hospital-acquired infections.	• Quarterly	• Review process toward meeting quality (infection control) organizational goal

SUBMITTED BY:

David Reeder **Chair**, Quality Committee
William Faber, MD **Executive Sponsor**, Quality Committee

Approved by the ECH Board of Directors on June 14, 2017

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality, Patient Care and Patient Experience Committee Meeting Date: August 7, 2017
	Responsible party:	Cindy Murphy, Director of Governance Services
	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 ECH and ECHD June 2017 Board Actions	

June 2017 ECH Board Actions*

1. June 14, 2017
    a. Approved the FY17 Period 10 Financials
    b. Approved the FY18 Operating and Capital Budget
    c. Approved the FY 18 Community Benefit Plan awarding approximately $3.2 million in grants and sponsorships.
    d. Approved the FY18 CEO and Executive Salary Ranges
    e. Approved recommended revisions to the Executive Benefits Design Plan increasing Long-Term Disability Benefits
    f. Approved Funding for the Xi Da Vinci Robot, 828 Winchester Tenant Improvements, Los Gatos MRI Replacement, and Initial Development Steps for Patient Family Residence
    g. Approved FY18 Board Committee Appointments and Re-Appointments
    h. Approved FY18 Advisory Committee Goals
    i. Approved Recommended Revisions to the Physician Financial Arrangements Review and Approval Policy authorizing the CEO to execute certain agreements not to exceed $1 million.
    j. Approved the FY18 Organizational Goals
    k. Approved the Management of Serious Events and Red Alert Patient safety Policy
    l. Approved Employment of Dan Woods as El Camino Hospital's CEO.

2. June 28, 2017
    a. Approved the El Camino Hospital Strategic Framework.
    b. Adopted a Resolution acknowledging Neal Cohen's 5 years of service on the Hospital Board.

June 2017 ECHD Board Actions*

1. June 14, 2017
    a. Approved the Selection of Dan Woods as El Camino Hospital's CEO.

2. June 20, 2017
    a. Approved the FY18 El Camino Hospital Capital and Operating Budget
    b. Approved the FY18 Community Benefit program awarding approximately $7 million in grants and sponsorships
    c. Elected Board Officers:
        i. Chair – Peter C. Fung, MD
        ii. Vice Chair – Julia Miller
        iii. Secretary/Treasurer – John Zoglin
    d. Voted to fill the vacancy on the ECHD Board created by Dennis Chiu's resignation by appointment at a meeting scheduled for August 16, 2017.
    e. Elected John Zoglin and Dave Reeder to serve on an Ad hoc Committee that will make recommendations to the District Board regarding selection of ECH Board Members.

*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.

Christina Lai, a member of the Hospital's Governance Committee, will serve as Advisor to the Committee.

3. June 28, 2017
    a. Approved the El Camino Hospital Strategic Framework.
    b. Adopted a Resolution acknowledging Dennis Chiu's nearly 5 years of service on the District and Hospital Boards.
    c. Approved a revision to the El Camino Hospital Bylaws expanding the Board to 10 seats, but removing the CEO as a voting member of the Board.

*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.

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY
NORMA MELCHOR
HEART & VASCULAR INSTITUTE

Adult Cardiac Surgery
Quality Committee Meeting
Pei Tsau, MD
August 7, 2017

Agenda

- Cardiac Surgery Volumes

- STS Outcomes and benchmarking for Cardiac Surgery
    - IsoCABG – IsoAVR – AVR/CABG

- FY2017 Process improvement Projects
    - Peri-Operative Blood Utilization- continued
    - Cardiac Surgery Inpt Readmissions
    - 20mEq KCL IV Replacement / Telemetry Unit
    - Sodium BiCarb Shortage
    - RN Education

The Surgeons:

Vincent Gaudiani, MD
Tomomi Oka, MD
Pei Tsau, MD
Conrad Vial, MD

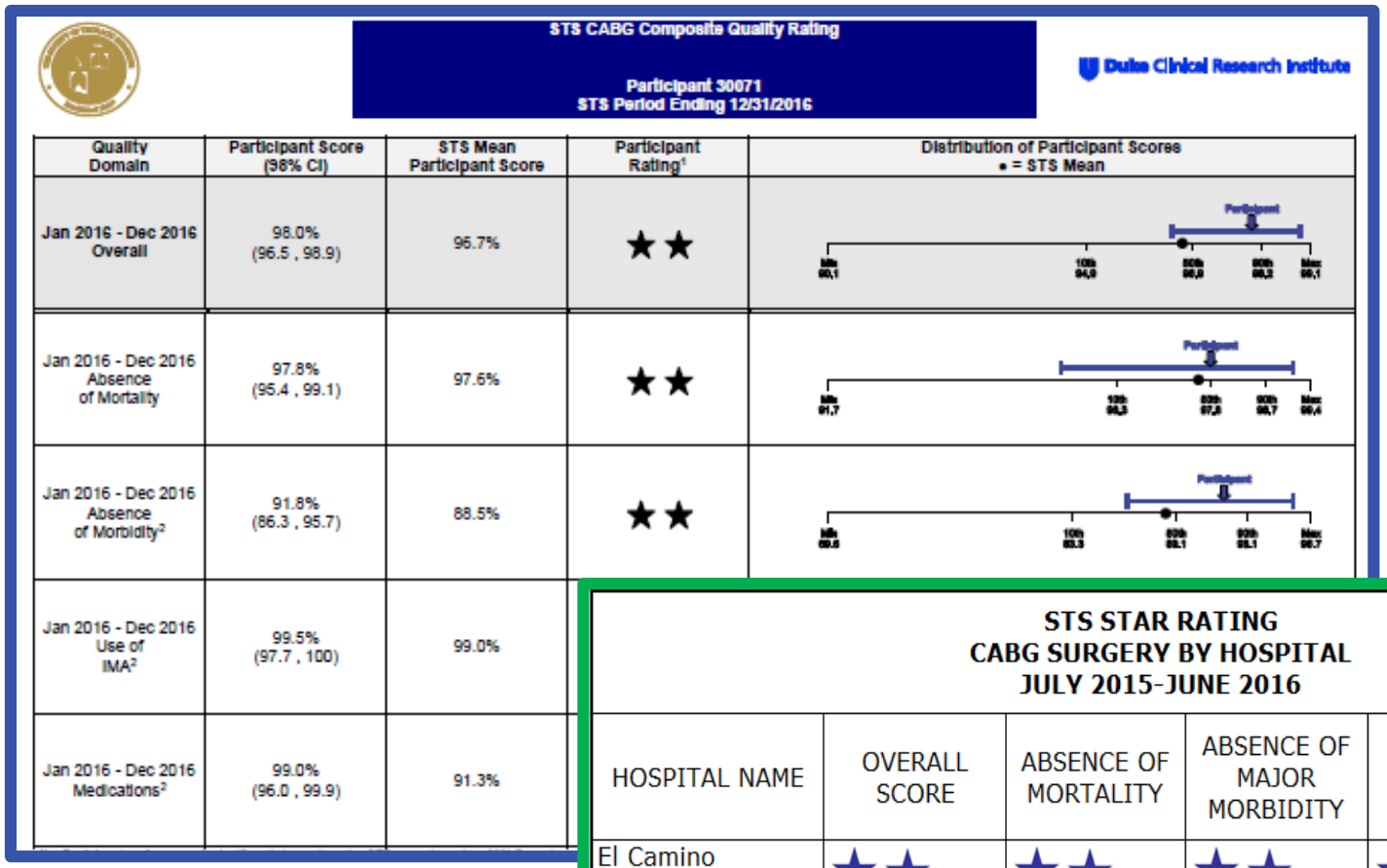
- STS National database established in 1989
  - Quality improvement
  - Patient Safety Initiative
- Houses over 5.5 million cardiac surgical records
- Provides Benchmarks & Practice Guidelines
- STS 3-Star rating represents the top 5% performance in the country

Cardiac Surgery Volumes

Procedure	2012	2013	2014	2015	2016
1 - Isolated CABG	51	71	80	86	89
2 - Isolated AVR	61	60	53	70	51
3 - Isolated MVR	6	3	12	11	10
4 - AVR + CAB	4	14	13	12	16
5 - MVR + CAB	0	2	1	0	0
6 - AVR + MVR	1	4	3	4	2
7 - MV Repair	24	17	23	33	31
8 - MV Repair + CAB	3	5	6	4	3
Other	93	60	65	92	82
ECH OHS Total Volume	**243**	**236**	**256**	**312**	**284**
TAVR (Includes Research)	26	40	64	54	74
MitraClip (Includes Research)	6	2	12	27	28
Total Structural Heart Volume	275	278	332	393	386

ECH Isolated CABG Quality Rating

1/1/16 – 12/31/16



STS CABG Composite Quality Rating

Participant 30071
STS Period Ending 12/31/2016

Duke Clinical Research Institute

Quality Domain	Participant Score (98% CI)	STS Mean Participant Score	Participant Rating[1]	Distribution of Participant Scores • = STS Mean
Jan 2016 - Dec 2016 Overall	98.0% (96.5 , 98.9)	96.7%	★★	
Jan 2016 - Dec 2016 Absence of Mortality	97.8% (95.4 , 99.1)	97.6%	★★	
Jan 2016 - Dec 2016 Absence of Morbidity[2]	91.8% (86.3 , 95.7)	88.5%	★★	
Jan 2016 - Dec 2016 Use of IMA[2]	99.5% (97.7 , 100)	99.0%		
Jan 2016 - Dec 2016 Medications[2]	99.0% (96.0 , 99.9)	91.3%		

CABG STAR RATING BY HOSPITAL

STS STAR RATING
CABG SURGERY BY HOSPITAL
JULY 2015-JUNE 2016

HOSPITAL NAME	OVERALL SCORE	ABSENCE OF MORTALITY	ABSENCE OF MAJOR MORBIDITY	USE OF INTERNAL MAMARY ARTERY	RECEIVED REQUIRED MEDICATIONS
El Camino Hospital	★★	★★	★★	★★	★★★
Good Samaritan Hospital	★★	★★	★★	★★	★★
Kaiser Santa Clara Hospital	★★	★★	★★	★★	★★
Mills Penisula Hospital	★★	★★	★★	★★	★
Stanford Hospital & Clinics	★★	★★	★★	★★	★★

Cardiac Surgery Dashboard – STS Data
IsoCABG

	Case Count , Outcomes and Process Measurements	2014 Jan-Dec	2015 Jan -Dec	2016 Jan-Dec	STS 2016 Benchmark 12/31/16	Variance
1	Number of Cases	80	86	**89**		
2	CP Bypass Time	68.6	78.3	**75.8**	**94.5**	-18.7 minutes
3	OR Time	290.9	291.4	**287.9**	**313.6**	-25.7 minutes
4	Total Blood Products	53.8	39.5	**46.1**	**42.4**	+3.7%
5	Ventilation Hours	6.4	7.7	**9.0**	**18.2**	-9.2 hours
6	CCU Hours	53.1	54.2	**52.2**	**71.9**	-19.7 hours
7	30D Risk Adj. Mortality	1.2	1.2	**1.8**	**2.2**	-0.4%
8	Any Reoperation	1.3	1.2	**2.2**	**3.6**	-1.4%
9	Stroke	0.0	2.3	**1.1**	**1.3**	-0.2%
10	Post Procedure LOS	5.6	6.2	**7.1**	**6.9**	+0.2
11	Readmission ≤ 30D	10.1	7.1	**13.6**	**10.0**	+3.6%

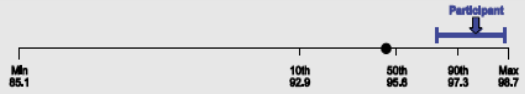
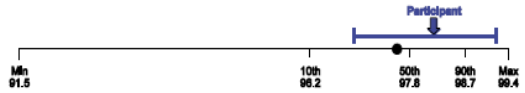
ECH Isolated AVR Quality Rating

1/1/2013 – 12/31/2016

STS AVR Composite Quality Rating

Participant 30071
STS Period Ending 12/31/2016

Duke Clinical Research Institute

Quality Domain	Participant Score (95% CI)	STS Mean Participant Score	Participant Rating[1]	Distribution of Participant Scores • = STS Mean
Jan 2014 - Dec 2016 Overall	97.8% (96.7 , 98.6)	95.3%	★★★	
Jan 2014 - Dec 2016 Absence of Mortality	98.2% (96.9 , 99.2)	97.6%	★★	
Jan 2014 - Dec 2016 Absence of Morbidity[2]	93.9% (91.0 , 96.1)	88.6%	★★★	

[1] = Participant performance is significantly lower than the STS mean based on 97.5% Bayesian probability

AVR STAR RATING BY HOSPITAL

STS STAR RATING
AVR SURGERY BY HOSPITAL
JULY 2013-JUNE 2016

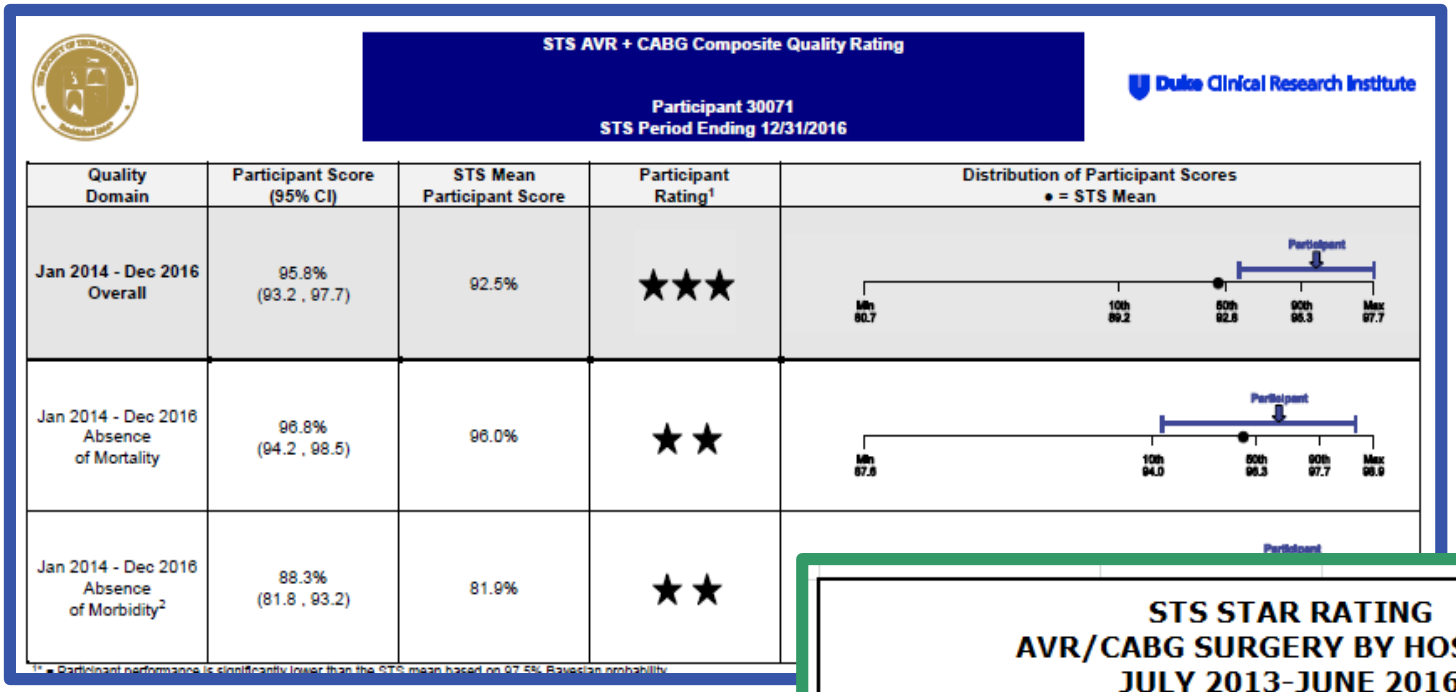
HOSPITAL NAME	OVERALL SCORE	ABSENCE OF MORTALITY	ABSENCE OF MAJOR MORBIDITY
El Camino Hospital	★★★	★★	★★★
Good Samaritan Hospital	★★	★★	★★
Kaiser Santa Clara Hospital	★★	★★	★★
Mills Penisula Hospital	★★	★★	★★
Stanford Hospital & Clinics	★★★	★★	★★★

Cardiac Surgery Dashboard – STS Data
IsoAVR Surgery

	Case Count , Outcomes & Process Measurements	2014 Jan-Dec	2015 Jan -Dec	2016 Jan-Dec	STS 2016 Benchmark 12/31/16	Variance
1	Number of Cases	53	70	**51**		
2	CP Bypass Time	71.6	70.3	**72.2**	**101.2**	-29.0 minutes
3	OR Time	243.5	241.7	**238.1**	**290.0**	-51.9 minutes
4	Total Blood Products	54.7	51.4	**41.2**	**43.7**	-2.5%
5	Ventilation Hours	9.1	6.3	**4.3**	**16.1**	-11.8 hours
6	CCU Hours	56.5	57.6	**52.7**	**67.6**	-14.9hours
7	30D Risk Adj. Mortality	1.8	0	**1.4**	**2.2**	-0.8 %
8	Any Reoperation	1.9	1.4	**0.0**	**4.8**	-4.8%
9	Stroke	0.0	1.4	**0.0**	**1.4**	-1.4%
10	Post Procedure LOS	5.8	6.7	**6.0**	**7.0**	-1.0 day
11	Readmission ≤ 30D	5.8	4.3	**4.0**	**9.8**	-5.8 %

ECH AVR/CABG Quality Rating

1/1/2013 – 12/31/2016



STS AVR + CABG Composite Quality Rating

Participant 30071
STS Period Ending 12/31/2016

Duke Clinical Research Institute

Quality Domain	Participant Score (95% CI)	STS Mean Participant Score	Participant Rating[1]	Distribution of Participant Scores • = STS Mean
Jan 2014 - Dec 2016 Overall	95.8% (93.2 , 97.7)	92.5%	★★★	Participant; Min 80.7, 10th 89.2, 50th 92.6, 90th 95.3, Max 97.7
Jan 2014 - Dec 2016 Absence of Mortality	96.8% (94.2 , 98.5)	96.0%	★★	Participant; Min 87.6, 10th 94.0, 50th 96.3, 90th 97.7, Max 98.9
Jan 2014 - Dec 2016 Absence of Morbidity[2]	88.3% (81.8 , 93.2)	81.9%	★★	Participant

1* = Participant performance is significantly lower than the STS mean based on 97.5% Bayesian probability

AVR / CABG STAR RATING BY HOSPITAL

STS STAR RATING
AVR/CABG SURGERY BY HOSPITAL
JULY 2013-JUNE 2016

HOSPITAL NAME	OVERALL SCORE	ABSENCE OF MORTALITY	ABSENCE OF MAJOR MORBIDITY
El Camino Hospital	★★★	★★	★★
Good Samaritan Hospital	★★	★★	★★
Kaiser Santa Clara Hospital	★★	★★	★★
Mills Penisula Hospital	★★	★★	★★
Stanford Hospital & Clinics	★★	★★	★★

Cardiac Surgery Dashboard – STS Data
AVR/CABG Surgery

	Case Count, Outcomes & Process Measurements	2014 Jan-Dec	2015 Jan -Dec	2016 Jan-Dec	STS 2016 Benchmark 12/31/16	Variance
1	Number of Cases	13	12	16		
2	CP Bypass Time	93.8	111.2	**100.4**	**141.6**	-41.2 minutes
3	OR Time	295.5	341.8	**302.8**	**367.0**	-64.2 minutes
4	Total Blood Products	76.9	58.3	**43.8**	**64.8**	-21.0 %
5	Ventilation Hours	6.5	5.0	**6.6**	**25.8**	-19.2 hours
6	CCU Hours	72.3	43.0	**60.7**	**90.0**	-29.3 hours
7	30D Risk Adj. Mortality	0	0	**0**	**3.3**	-3.3 %
8	Any Reoperation	0	0	**0**	**6.2**	-6.2%
9	Stroke	0	0	**0**	**2.2**	-2.2%
10	Post Procedure LOS	7.4	5.7	**7.3**	**8.4**	-1.1 days
11	Readmission ≤ 30D	0	8.3	**0**	**12.2**	-12.2 %

STS 3-STAR RATING:
2-PROGRAMS COMBINED: AVR & AVR/CABG

Participant Performance AVR vs. CABG + AVR Overall Composite Score:

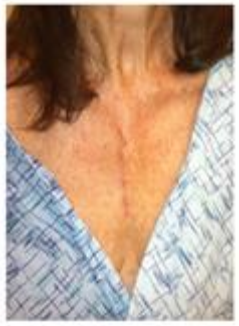
	AVR + CABG *No star rating*	AVR + CABG ★	AVR + CABG ★★	AVR + CABG ★★★	TOTAL
AVR *No star rating*	113	1	27	0	141
AVR ★	0	1	18	0	19
AVR ★★	75	15	674	27	791
AVR ★★★	2	0	44	20	66
TOTAL	190	17	763	47	1017

2016 Aortic Valve Replacement Surgery

109 Total AVR Surgeries

51 Isolated AVR (46.8%)

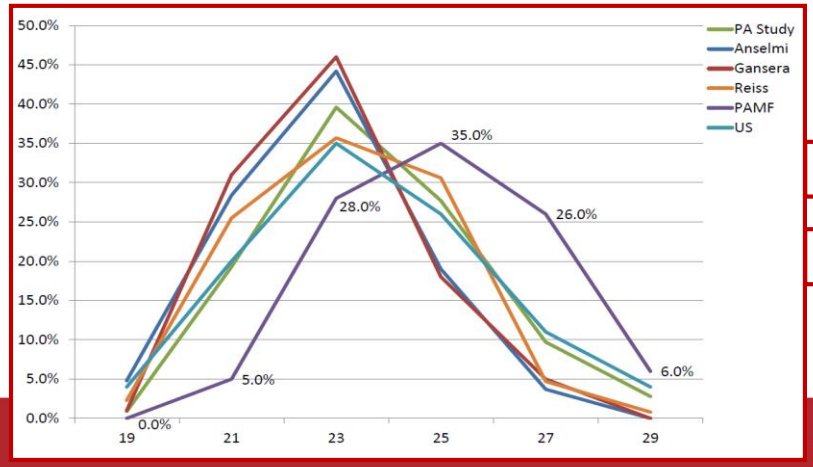
58 AVR Combined (53.2%)



Mini-Sternotomy

Full Sternotomy

- 68.6% of Isolated AVR had Mini-Sternotomy
- **39.2%** of Isolated AVR had LVOTE (STS 4.2%)



US = 23 mm

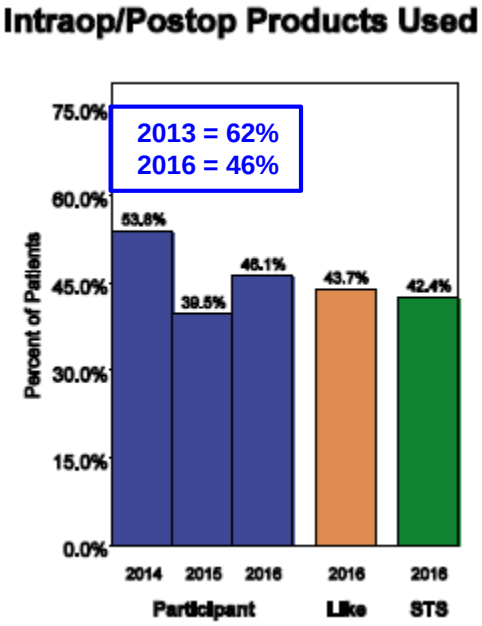
PAMF: 25 mm

FY2017 Process Improvement Projects

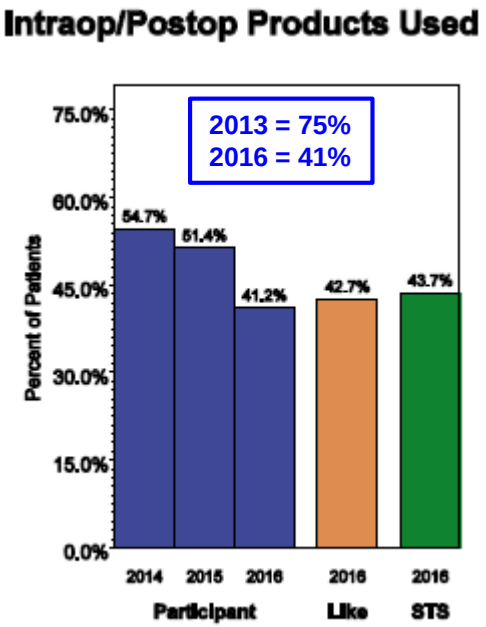
- Peri-Operative Blood Utilization – Continued
- Inpatient Cardiac Surgery Readmissions
- Sodium BiCarb Shortage
- 20mEq KCL IV Replacement Telemetry Unit
- RN Education
    - Cardiac Surgery classes
    - Mock code Blue Classes
    - Pericardial Pacing
    - Road to Home Checklist

Blood Utilization

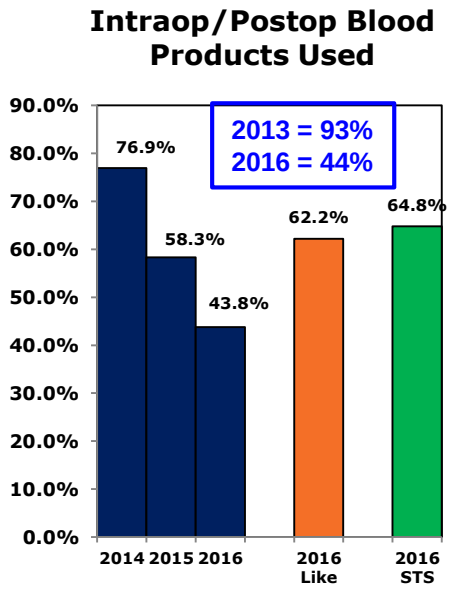
1/1/13 – 12/31/16



CABG Surgery



AVR Surgery



AVR/CABG

Cardiac Surgery ≤30D Readmission

STS RE-ADMIT BENCHMARKS	ECH CASES 2016	READMIT NO.	ECH 2016 readmit Percent	STS 2016 Benchmark
Isolated CABG	89	12	13.6	10.0
Isolated AVR	51	2	4.0	9.8
Isolated MVR	10	2	20.0	15.1
AVR / CABG	16		0	12.2
MVR / CABG	0		0	17
AVR/MVR	2		0	
Isolated MVV	31	1	3.2	8.8
MVV / CABG	3		0	13.7
Other	82	10		
CASE TOTAL	284	27	9.9	

ECH 2016 InPt. Readmissions

STS 2016 National Benchmarks

- Concern re: High CABG Surgery readmissions
- Multidisciplinary Team reviewed every 2016 readmit
- Discovered 11 Pulmonary/Pericardial Effusion in-Pt admits
- Practice change
- Jan – June 2017: 7 readmissions

  1 Pleural effusion

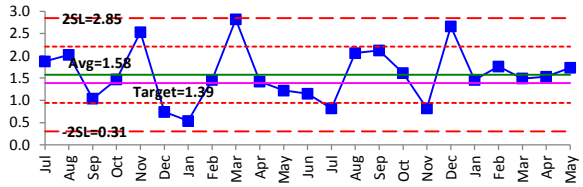
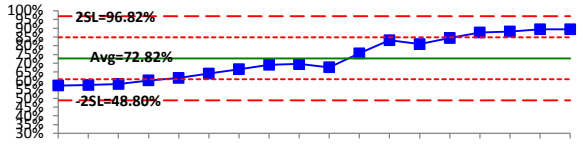
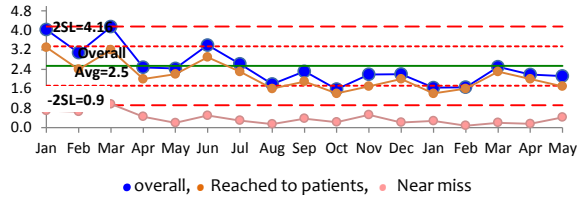
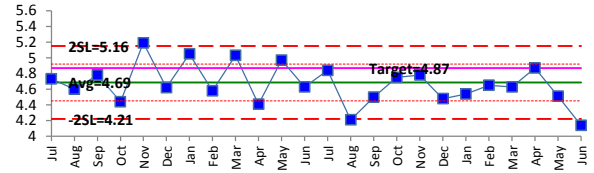
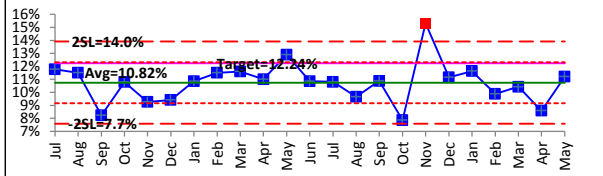
The Cardiac Surgery Team:

Anesthesiologists
Cardiologists
Clinical Nurse Specialist
Echo Techs
Nursing Staff
Occupational Therapy
Operating Room Staff
Perfusionists
Physical Therapy
Physician Assistant
Surgeon
Respiratory Therapy
and The Patient!

- Nurse Education:
  - 8-Hr Cardiac Surgery Boot Camp
  - Pericardial Pacemaker education/training
  - Open Chest Mock Codes
- 20 mEq IV KCL Replacement practice change
- Road to Home Cardiac surgery Check List

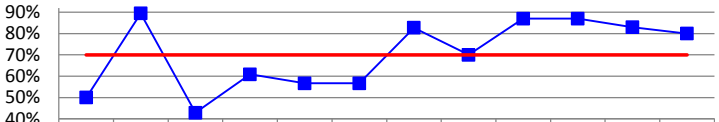
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

Date Reports Run: 7/11/2017			Baseline	FY17 Goal	Trend	Comments
SAFETY EVENTS	Performance		FY2016	FY2017 goal		
1	**Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: May 2017*	9/5198	1.73	1.51	1.39 (goal for FY 16)		After review of each fall, Team states that almost half are preventable by use of bed/chair alarms, and staying with the patient while toileting. 1/3 of falls in May were assisted, with no harm to patients from any fall. Focus is on use of bed/chair alarms, and staying w/pt. in BR.
2	★Organizational Goal **Pain reassessment within 60 mins after pain med administration** *Date Period: June 2017*	6987/7816	89.4%	59.8% (Jan-Jun 2016)	75% (min) 80% (mid) stretch goal=90%		Efforts by Nursing staff and managers resulted in continuous improvement over the last 17 months. Last data point for June 30, 2017 at 89.4, just 0.6 short of stretch goal. Periodic reporting suggested in FY 2018 to sustain these gains.
3	**Medication Errors (Overall: reached to patients and near miss)** *Errors / 1000 Adj Total Patient Days* *Date Period: May 2017*	30/14158	2.12	2.68	0.00		Near miss reporting up slightly and errors reaching the patient down. Significant errors addressed indivually with providers and staff, no trends noted.
EFFICIENCY	Performance		Jan-Jun 2016 (6-month avg)	FY 2017 goal		
4	★Organizational Goal **Average Length of Stay (days)** *(Medicare definition, MS-CC, ≥ 65, inpatient)* *Date Period: June 2017*	FYTD 5169 June 2017 405	FYTD 4.57 June 2017 4.14	4.78	4.87		LOS dropped precipitously over 3 months. Mgr attributes drop to daily Huddle and Vis Board that focuses all Care Coordinators on assisting one another to discharge difficut patient and address barriers to discharge.
5	★Organizational Goal **30-Day Readmission (Rate, LOS-Focused)** *(ALOS-Linked, All-Cause, Unplanned)* *Date Period: May 2017*	FYTD 515/47579 May 2017 49/437	FYTD 10.83 Mar 2017 8.58	11.53	At or below 12.24		Rate is remaining below goal.

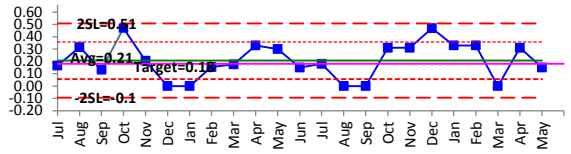
Definitions and Additional Information

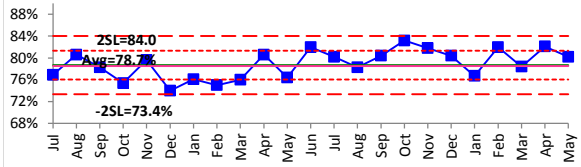
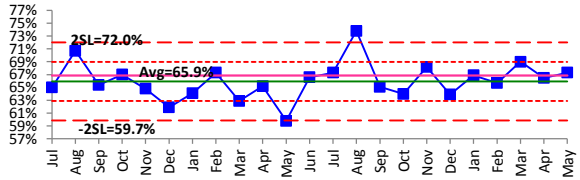
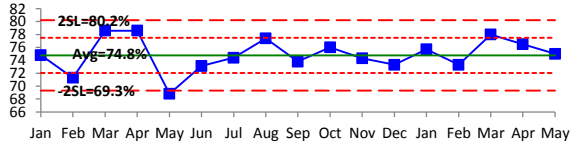
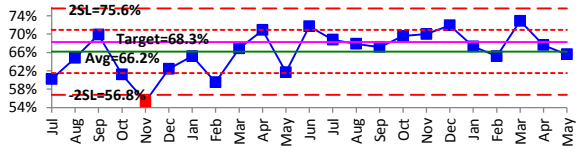
Measure Name	Definition Owner	Work Group	FY 2016 Definition	FY 2017 Definition	Source
Patient Falls	Sheetal Shah; Cheryl Reinking	Falls Committee	All Med/Surg/CC falls reported to CALNOC per 1,000 CALNOC (Med/Surg/CC) patient days CALNOC Fall Definition: The rate per 1,000 patient days at which patients 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: May 2017				The use of SMART phrases for bolus documentation increased from 43% to 63% in May, which supports meeting this metric. The compliance increased from 25 to 32 records, while the sample increased by 10 cases.

Goal: 70% (Min); 75%(Max); 80% (Stretch)

	Apr	May	Jun	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Number of Sampled Cases	18	19	21	23	30	30	29	30	30	30	30	40
Cases with 30ml/kg ordered or NICOM with 3 hours TOP	0	0	0	1	0	0	0	2	1	0	0	0
Cases with 30ml/kg ordered (or NICOM) ordered with 2 hours TOP	9	17	9	14	17	17	24	21	26	26	25	32
% Compliance with 30ml/kg ordered within 2 hours of TOP	50%	89%	43%	61%	57%	57%	83%	70%	87%	87%	83%	80%
Min Goal	70%	70%	70%	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: May 2017*	1/668	0.15	0.20	0.18 (goal for FY 16)		One SSI identified for MV, Total Hip Arthroplasty. MV to begin "nose to toes" initiative w/Total Joint cases: A 2015 study, in JAMA Surgery demonstrated a > 50% decrease in SSI rate in patients undergoing orthopedic implant surgery after implementation of a preop decontamination protocol w/chlorhexidine gluconate (CHG) cloths, intranasal povidone-iodine solution & oral rinse.

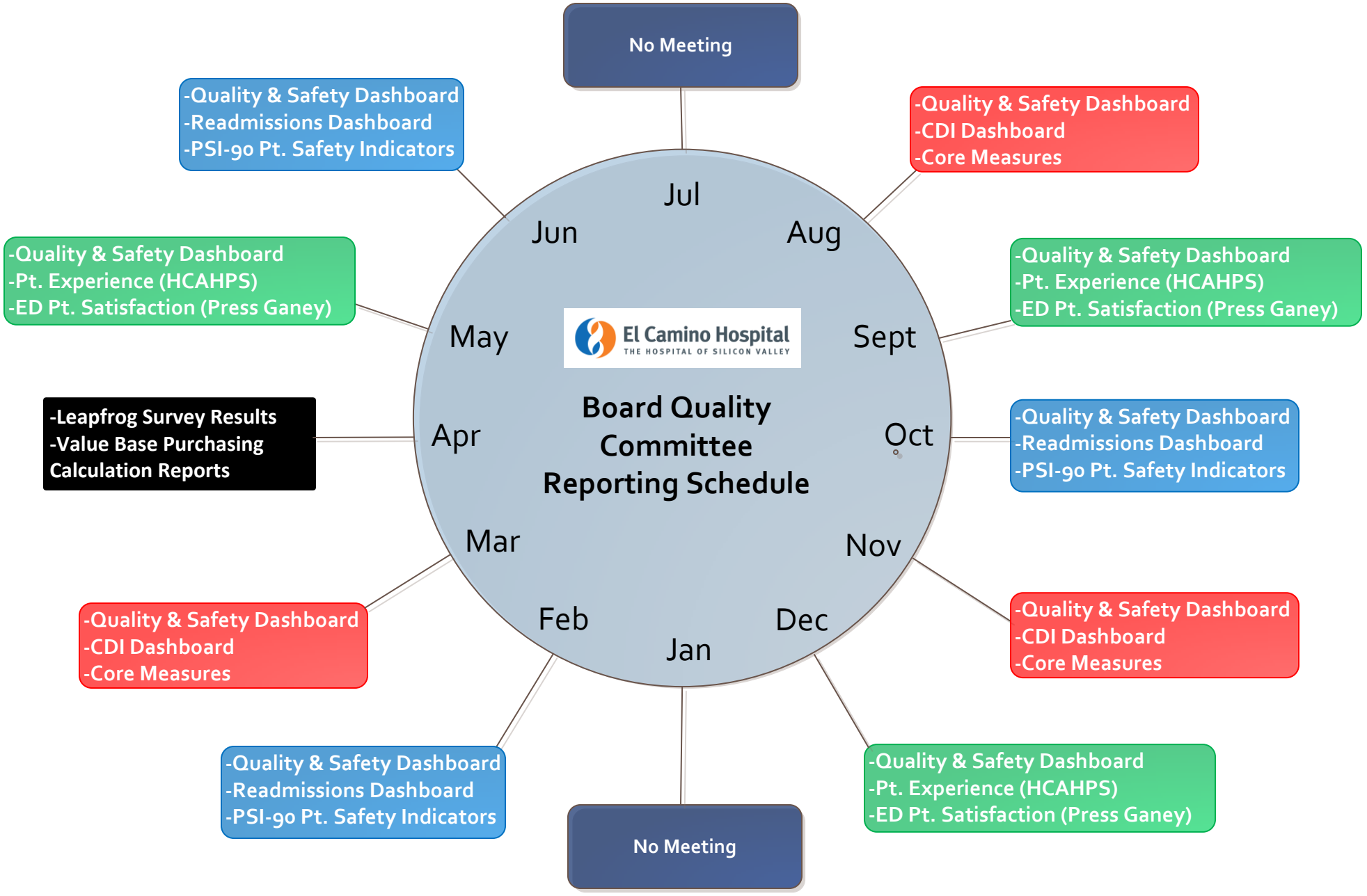
SERVICE		Performance		FY 2016	FY 2017 goal		
8	**Communication with Nurses** *(HCAHPS composite score, top box)* *Date Period: May 2017*	162/202	80.2%	78.0%	78.5%		
9	**Responsiveness of Hospital Staff** *(HCAHPS composite score, top box)* *Date Period: May 2017*	132/196	67.3%	64.9%	66.8%		
10	★Organizational Goal **Pain management** (HCAHPS composite score, top box) *Date Period: May 2017*	103/137	75.0%	72.5%	73% min 74% max 76% stretch		
11	**Communication About Medicines** *(HCAHPS composite score, top box)* *Date Period: May 2017*	90/137	65.6%	72.9%	68.3%		

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**

FY17 Organizational Goals

Prepared: 7/3/2017

Organizational Goals FY17		Benchmark	2016 ECH Baseline	Minimum	Target	Maximum	Weight	Performance Timeframe	FY17 through May	
Threshold Goals										
Budgeted Operating Margin		90% threshold *[Recommended by Exec Comp Consultant (FY16)]*	105% of Budgeted	90% of Budgeted			Threshold	FY 17		Met
Quality, Patient Safety & iCare										
Quality Pain Management	**Pain Reassessment** (% Pain Reassessment Documented within 60 min on RN Flowsheet)	Internal Improvement	56.3% *Nov 2015 (post iCare go-live) to Apr 2016 [6-month measurement]*	75%	80%	90%	34%	Q4 FY 2017		79%
	Pain Patient Satisfaction (CMS HCAPHS Pain Management % Scored Top Box- **2 month delay**)	Internal Improvement	72.9% *FY 2016 Q1 - Q3 [9-month measurement)*	73%	74%	76%				75%
LOS & Readmission	Achieve Medicare **Length of Stay** Reduction while Maintaining Current **Readmission Rates** for Same Population **(Readmission - 45 day delay)**	Internal Improvement	FY16 Max Goal 4.86 LOS Readmission Target 12.39%	4.81 .05 Day Reduction from FY16 Max, Readmission at or below FY16 Target	4.76 .10 Day Reduction from FY16 Max, Readmission at or below FY16 Target	4.66 .20 Day Reduction from FY16 Max, Readmission at or below FY16 Target	33%	FY17		LOS: 4.60 Readmission: 10.91% (515/4722)
Smart Growth										
Achieve budgeted inpatient growth (surgical and procedural cases plus Deliveries and NICU), and budgeted outpatient growth (surgical and procedural cases plus infusion).		Internal Documentation	94.26% of FY17 Budget	95% of Budgeted Volume	100% of budgeted Volume	110% of Budgeted Volume	33%	FY 17		96.7% of Budgeted Volume


El Camino Hospital
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Board Quality Committee Reporting Schedule
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
No Meeting
-Quality & Safety Dashboard
-CDI Dashboard
-Core Measures
-Quality & Safety Dashboard
-Pt. Experience (HCAHPS)
-ED Pt. Satisfaction (Press Ganey)
-Quality & Safety Dashboard
-Readmissions Dashboard
-PSI-90 Pt. Safety Indicators
-Leapfrog Survey Results
-Value Base Purchasing Calculation Reports
-Quality & Safety Dashboard
-Pt. Experience (HCAHPS)
-ED Pt. Satisfaction (Press Ganey)
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-PSI-90 Pt. Safety Indicators
-Quality & Safety Dashboard
-CDI Dashboard
-Core Measures

ECH Board Quality Committee

Rotating Quality Reports to Augment Quality & Safety Dashboard

Group	Date	Name of Report	Description of Report
1	**August November March**	**CDI Dashboard**	Clinical Documentation Improvement (CDI) report, The (CDI) program promotes clear, concise, complete, accurate and compliant documentation in the medical record. This is accomplished through *analysis and interpretation* of documentation to identify and rectify situations where documentation is insufficient to accurately support the patient's severity of illness and care, including specificity of principal diagnosis, associated comorbidities or complications, treatments and procedures. Supports Case Mix Index, Risk of Mortality, Severity of Illness, and GMLOS.
		Core Measures	Core measures are clinical metrics that are standardized nationally and reflect best practices to achieve the best clinical outcomes. These processes are designed to provide the right care at the right time for common conditions such as stroke. These data are required to be reported to CMS and TJC for payment and accreditation. Since 2003 hospitals have improved compliance with some measures to 99-100%, which were then retired, i.e. CHF, AMI, Pneumonia and SCIP. Other measures and outpatient measures have replaced retired measures.
2	**September December May**	**Patient Experience (HCAHPS)**	The HCAHPS (*Hospital Consumer Assessment of Healthcare Providers and Systems*) survey is a national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS is a standardized survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. While many hospitals have collected information on patient satisfaction for their own internal use, until HCAHPS there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally. This report will include all HCAHPS questions and domains.
		Patient Experience Emergency Department (Press Ganey)	This is a survey of Emergency Department patients through Press Ganey to assess their satisfaction with their experience. Questions include *Staff cared about you as person, Overall rating ER care, Likelihood of recommending, Informed about delays, Nurses informative re treatments, Adequacy of info to family/friends, How well pain was controlled, Information about home care, Safe/secure felt in ER/ED, Waiting time to see doctor.*

3	**October February June**	**Readmission Dashboard**	In 2012 CMS began reducing Medicare payments for IPPS hospitals with excess readmissions; defined as a readmission for any cause within 30 days of discharge. Excess readmissions are determined calculating the # of readmissions divided by the # of "expected" 30-day readmissions, the resulting ratio should be 1.000 or below. CMS applies a penalty of up to 3% of IPPS payments if any one of these six diagnoses/procedures is excessive: Acute MI, Heart Failure, Pneumonia, COPD, hip/knee replacement, and CABG. For FFY 2017, ECH has a 0.53% readmission penalty which equates to $436,000.00. This dashboard will include ECH Medicare All Cause 30 day readmission rate and the rates for the six penalty populations.
		Patient Safety Indicators (PSI-90)	The AHRQ Patient Safety Indicators (PSIs) are a set of measures of hospital complications and adverse events that occur following surgeries, procedures, and childbirth. They were developed after a comprehensive literature review, analysis of ICD-9-cm codes, review by a clinical panel, risk adjustment and empirical analysis. The PSI-90 Composite was included in Value Based Purchasing measures, and includes Pressure Ulcer, Iatrogenic Pneumothorax, CLASBI, Postop Hip Fracture, Periop PE or DVT, Postop Sepsis, Postop Wound Dehiscence, and Accidental Puncture or Laceration. These cases are part of OPPE and are reviewed for trends every 8 months, and some are referred to Peer Review. ECH PD-90 composite for VBP is a score of 10/10, very few occurrences.
4	**April**	**Leapfrog Report**	Leapfrog is an annual survey of hospital safety, quality, and efficiency based on national performance measures that are of specific interest to health care purchasers and consumers. The measures also provide hospitals with the opportunity to benchmark their progress in improving the care they deliver. Included in the assessment is a CPOE test that assesses the use of the EHR. Based on the Leapfrog Hospital Survey results, Leapfrog publishes a Hospital Grade (A-F) twice each year. ECH will complete the Survey by the end of 2017, and will receive a grade in April 2018.
		Value-Based Purchasing	Hospital Value-Based Purchasing (HVBP) is part of Medicare's payment system to reward providers for the quality of care they provide. This program adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS), based on the quality of care they deliver. The VBP Program is funded by reducing participating hospitals' base FY 2017 operating MS-DRG payments by 2%. Any leftover funds are redistributed to hospitals based on their Total Performance Scores (TPS). What hospitals earn depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY. It's possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that fiscal year. This year VBP includes HCAHPS scores (25%) Clinical Care (25% AMI, CHF, PN mortality), Safety (PSI-90 + PC-01 + HAIs), and Efficiency/Cost Reduction (25% Medicare spending per beneficiary).

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Patient and Family Centered Care Update

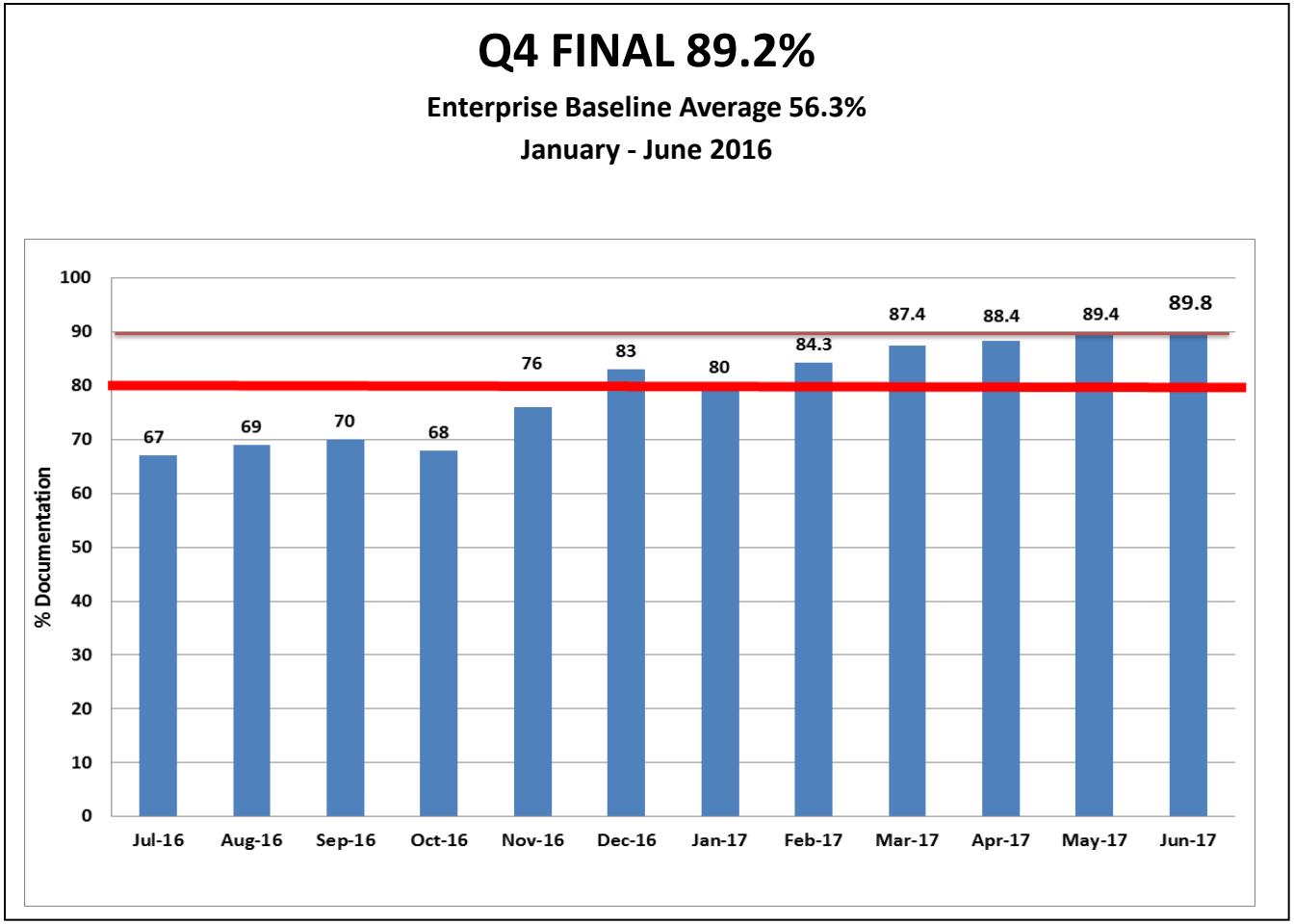
Perspectives from my first 90 days

- Staff is dedicated to providing quality care and excellent service
- Patient Experience team is valued as a resource
- Technology in use to support the patient experience
- Patient and family voices
- Habit of being reactive -> need to shift to proactive
- Many priorities -> what will we do and what won't we do?

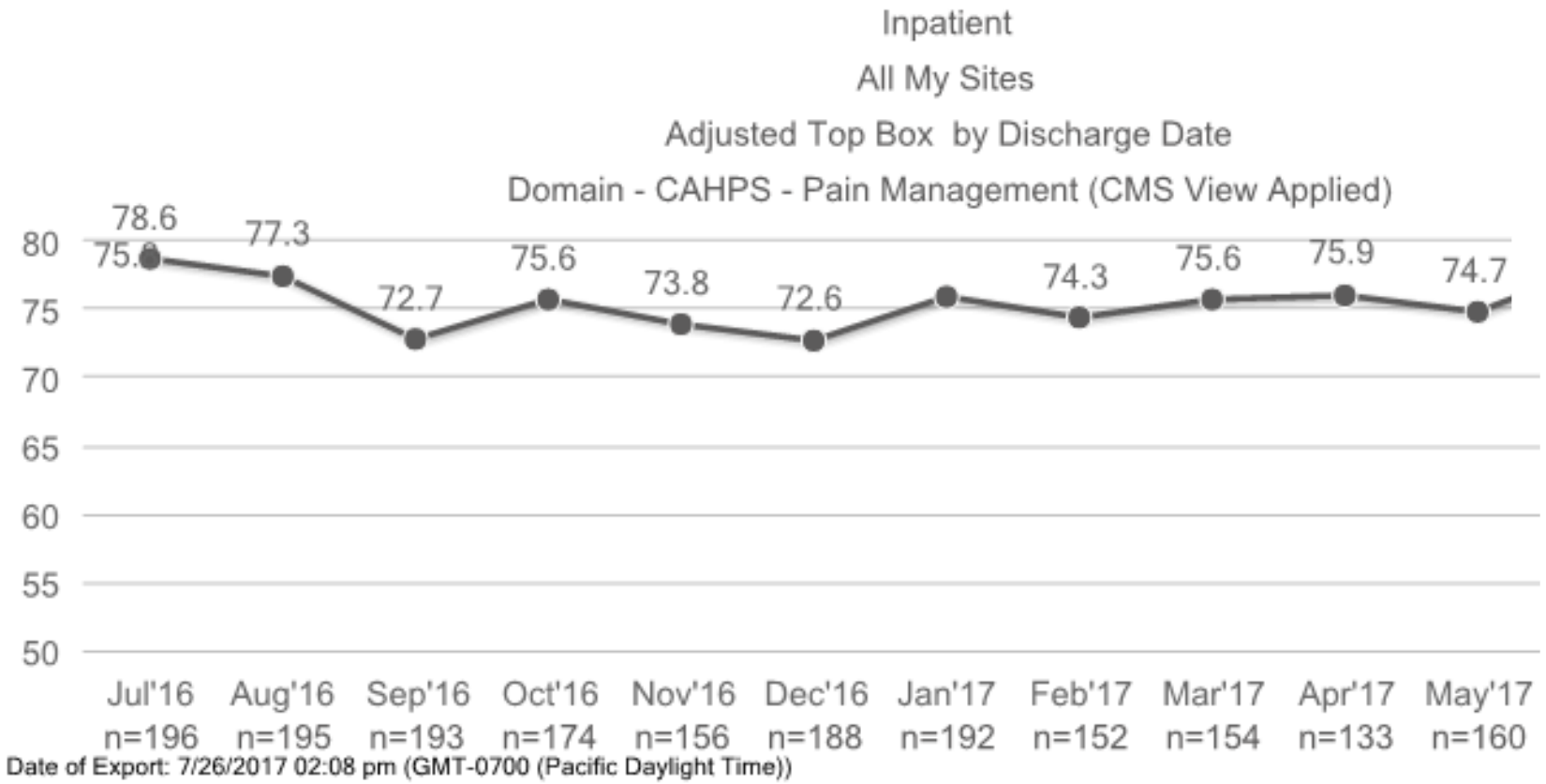
Current State of Patient Experience at ECH

- Foundational
  - Leadership commitment
  - Dedicated team to support and enhance the experience
    - Patient reps – 2.8 FTE
    - Healing arts (musicians, artists, massage)
    - Chaplaincy
      - Mon – Fri: 9am – 5pm and 10 hours covered at night
      - Sat – Sun: 3pm – 11:30pm
    - Auxiliary/volunteers – 620 in auxiliary, with others in various programs (e.g. spiritual care, South Asian Heart Center)
  - Including the patient and family voice
    - Patient and Family Advisory Council (meets 6 times a year)
    - Involvement of patients and families

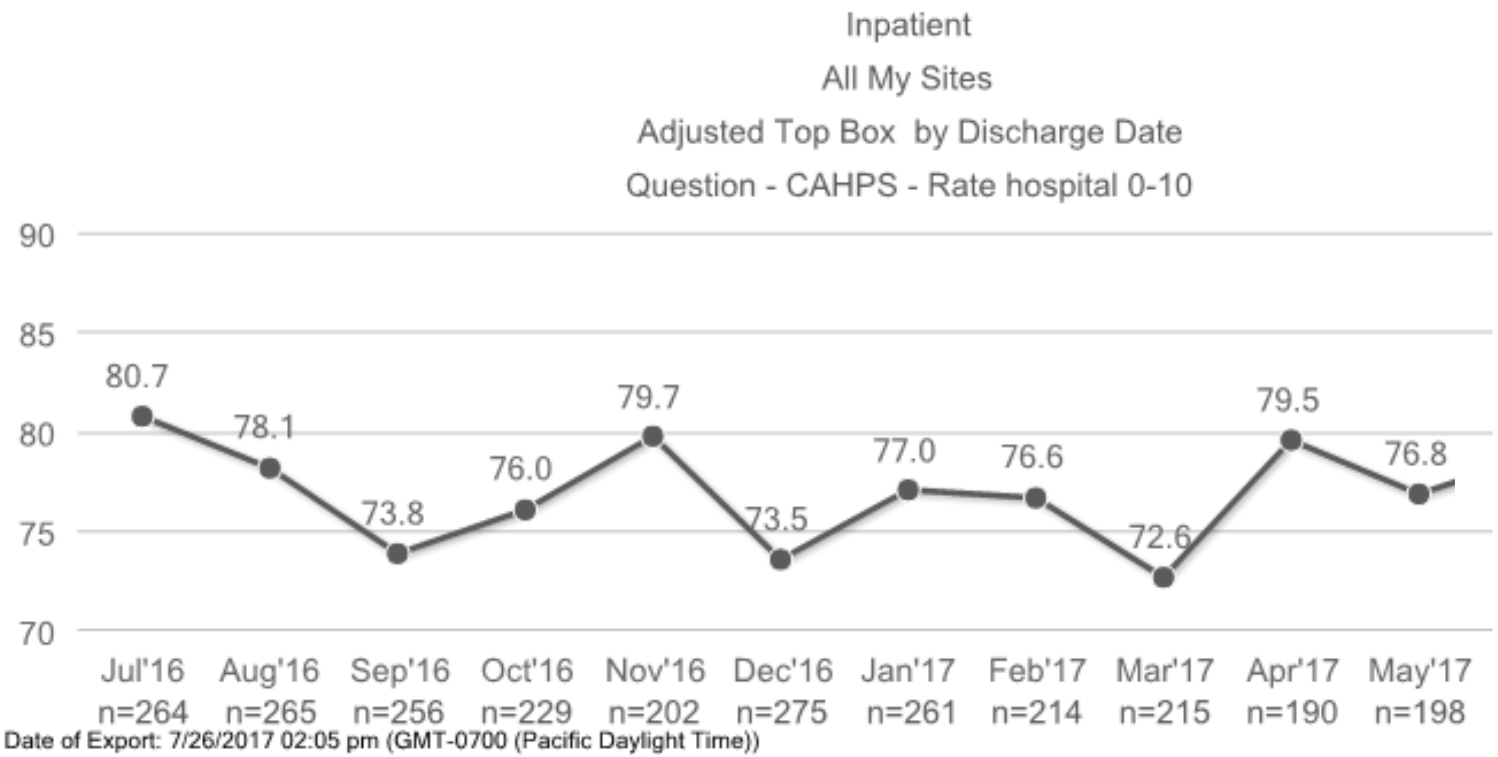
Pain Management



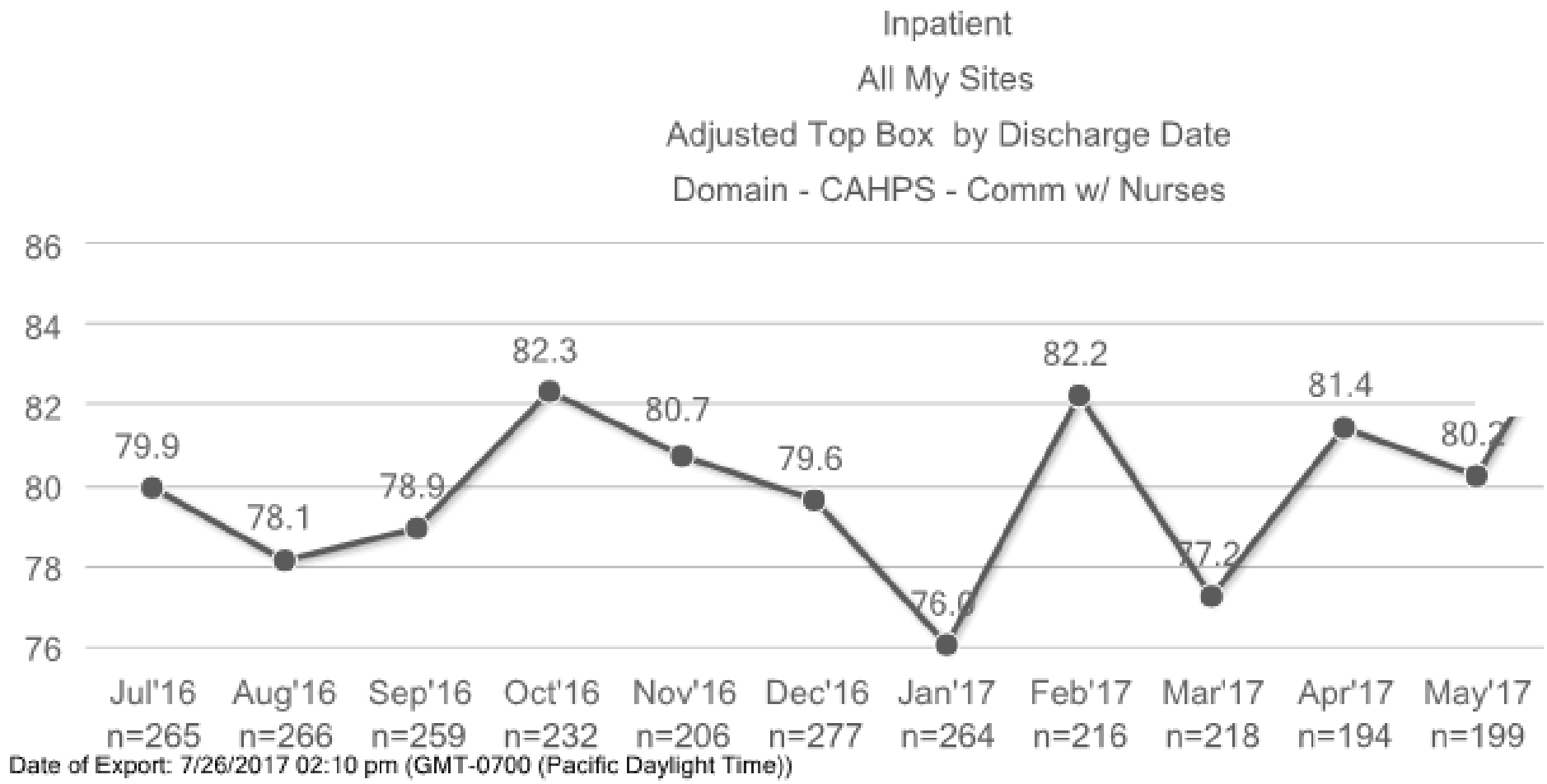
Pain Management



Rate the Hospital



Communication with Nurses



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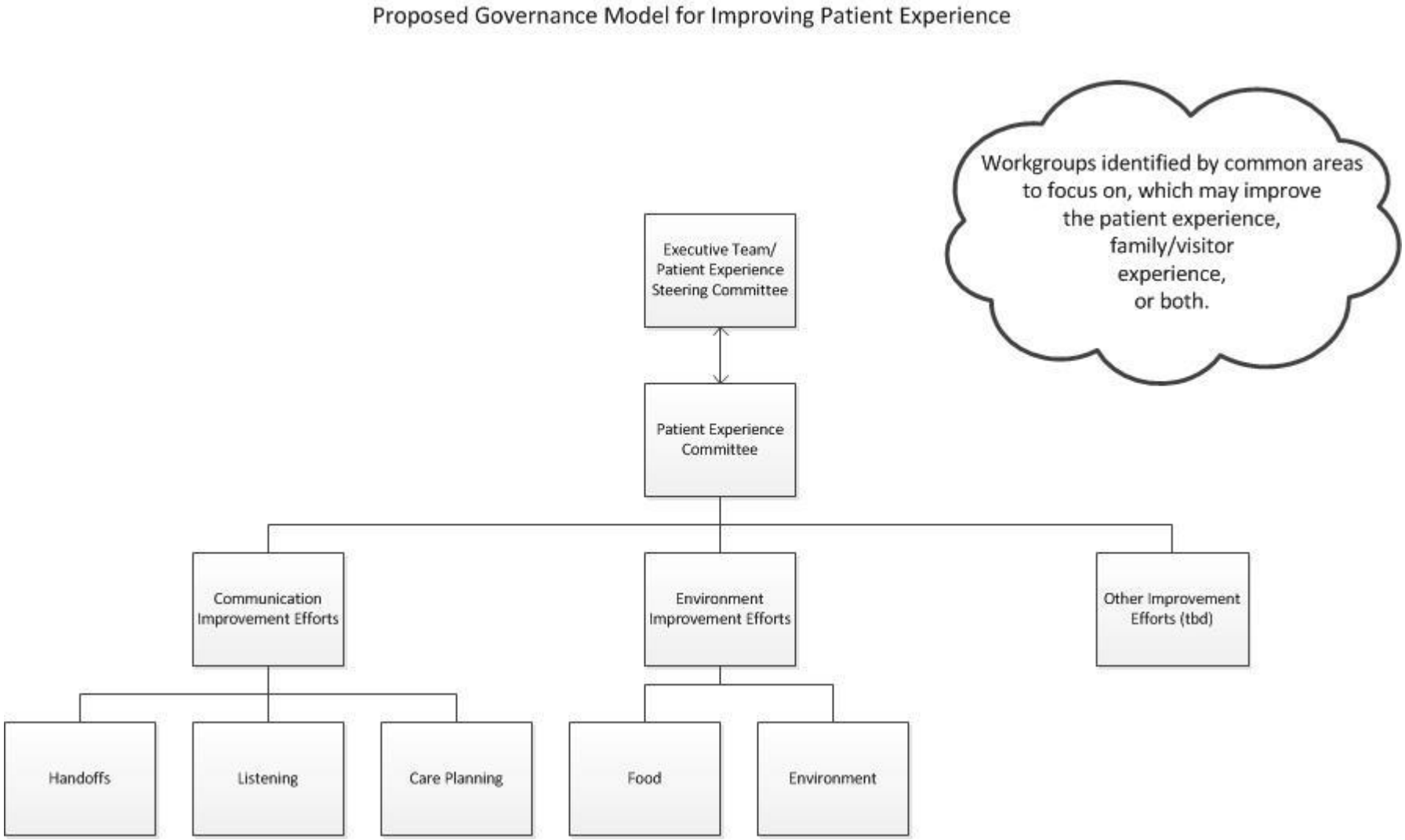
Next Steps:
Developing a Patient Experience Strategy

- Blending our reboot of PaCT (Lean) and our commitment to patient experience
- Using the organizational goal for Patient Satisfaction to keep focused on how we improve the experience
  - Goal alignment
  - Developing of systems to support improving the experience

Proposed Patient Experience Governance Structure



Patient Experience Manager

- Ideal candidate qualities and experience:
  - Passion
  - Strategy
  - Supervisory experience
  - Healthcare experience
- Process
  - Position posted
  - 16 applicants reviewed
  - 4 1st round interview panels