El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

AGENDA

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

Monday, December 4th, 2017, **5:30 p.m.**
El Camino Hospital | Conference Room A & B
2500 Grant Road, Mountain View, CA 94040

Melora Simon will be participating via teleconference from 107 Crescent Ave, Portola Valley, CA 94028

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**	Dave Reeder, Quality Committee Chair		**5:30 – 5:31pm**
2.	**ROLL CALL**	Dave Reeder, Quality Committee Chair		**5:31 – 5:32**
3.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**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.*	Dave Reeder, Quality Committee Chair	*public comment*	**Motion Required** **5:33 – 5:36**
	Approval a. Minutes of the Open Session of the Quality Committee Meeting (October 2, 2017) b. Minutes of the Open Session of the Quality Committee Meeting (October 30, 2017) ***Information*** c. Research Article d. Patient Story e. FY18 Pacing Plan f. Progress Against FY 2018 Committee Goals			
5.	**REPORT ON BOARD ACTIONS** **ATTACHMENT 5**	Dave Reeder, Quality Committee Chair		**Discussion** **5:36 – 5:39**
6.	**QUALITY PROGRAM UPDATE: UROLOGY** **ATTACHMENT 6**	David King, MD, Co-Medical Director, Urology Services Frank Lai, MD Medical Director, Urology Services		**Discussion** **5:39 – 5:59**
7.	**COMMITTEE MEMBER RECRUITMENT** **ATTACHMENT 7**	Dave Reeder, Quality Committee Chair		**Discussion** **5:59 – 6:04**
8.	**FY18 QUALITY DASHBOARD** **ATTACHMENT 8**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion** **6:04 – 6:19**
9.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE**	Ashlee Fontenot, Manager of Patient Experience		**Discussion** **6:19 – 6:24**

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
	ATTACHMENT 9			
10.	**PT. EXPERIENCE (HCAHPS)** **ATTACHMENT 10**	Michelle Gabriel, Director of Performance Improvement		**Discussion** **6:24 – 6:39**
11.	**ED PATIENT SATISFACTION (PRESS GANEY)** **ATTACHMENT 11**	Michelle Gabriel, Director of Performance Improvement		**Discussion** **6:39 – 6:54**
12.	**CMO REPORT** **ATTACHMENT 12**	William Faber, MD, Chief Medical Officer		**Discussion** **6:54 – 6:59**
13.	**PUBLIC COMMUNICATION**	Dave Reeder, Quality Committee Chair		**Information** **6:59 – 7:02**
14.	**ADJOURN TO CLOSED SESSION**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:02– 7:03**
15.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Dave Reeder, Quality Committee Chair		**7:03 – 7:04**
16.	**CONSENT CALENDAR** *Any Committee Member may pull an item for discussion before a motion is made.*	Dave Reeder, Quality Committee Chair		**Motion Required** **7:04 – 7:07**
	Approval *Gov't Code Section 54957.2.* a. Minutes of the Closed Session of the Quality Committee Meeting (October 2, 2017) b. Minutes of the Closed Session of the Quality Committee Meeting (October 30, 2017 ***Information*** c. Quality Council Minutes (October 4, 2017)			
17.	*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** **7:07 – 7:17**
18.	**ADJOURN TO OPEN SESSION**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:17 – 7:18**
19.	**RECONVENE OPEN SESSION/REPORT OUT**	Dave Reeder, Quality Committee Chair		**7:18 – 7:19**
	To report any required disclosures regarding permissible actions taken during Closed Session.			
20.	**ADJOURNMENT**	Dave Reeder, Quality Committee Chair		**Motion Required** **7:19 – 7:20pm**

Upcoming FY18 Meetings

- February 5, 2018
- March 5, 2018
- April 2, 2018
- April 30, 2018
- June 4, 2018

Upcoming Board & Educational Committee Gatherings

- April 25, 2018

a. Minutes of the Open Session of the Quality Committee Meeting (October 2, 2017)

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, October 2, 2017
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder, Jeffrey Davis, MD; Katie Anderson, Ina Bauman, Mikele Bunce, Wendy Ron, and Melora Simon	Nancy Carragee Peter Fung, MD	

**Melora Simon joined the meeting at 5:36pm*
**Mikele Bunce left the meeting at 7:05pm*
**Ina Bauman left the meeting at 7:25pm*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 2nd of October, 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 Chair Dave Reeder at 5:33 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Nancy Carragee and Dr. Peter Fung were absent. Melora Simon joined the meeting at 5:36pm and all other committee members were present during roll call. Chair Reeder welcomed Dan Woods, CEO, and a roundtable of introductions ensued.	***None***
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.	***None***
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 the Quality Committee Meeting (August 28, 2017) **Movant**: Ron **Second:** Davis **Ayes:** Anderson, Bauman, Bunce, Davis, Reeder, Ron, Simon **Noes:** None	***The Open Session Minutes of the August 28, 2017 meeting were approved.***

Agenda Item	Comments/Discussion	Approvals/Action
	Abstentions: None **Absent:** Carragee, Fung **Excused:** None **Recused:** None	
5. REPORT ON BOARD ACTIONS	Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee and briefly highlighted the following: • Appointment of new Board Member Neysa Fligor to the Executive Compensation Committee, the Corporate Compliance/Privacy and Internal Audit Committee, and elected to the El Camino Hospital Board of Directors.	***None***
6. QUALITY PROGRAM UPDATE: ROBOTICS	Alpert Pisani, MD, Co-Medical Director of Gyn/Robotics Surgery, updated the Committee on the Gynecologic Oncology Robotic surgery at ECH and reported that this program is the busiest in Northern California, with more than 6,500 cases done here yearly. He further highlighted that the Gyn mortality rate is recorded at 0 with one exception in August 2016; while SSI Rate is recorded at 1 at MV campus and 0 at LG campus and no CAUTIs are identified from July 2016 to Jan 2017. He also noted Gyn/Gyn Oncology 30 day procedure readmission is relatively low. Dr. Pisani explained that ECH is one of only two hospitals from the Bay area to offer bariatric robotic surgery. He described the advantages of Robotic-Assisted Operative Laparoscopy which 33% of patients are less likely to be readmitted, 64% are less likely to experience complications, and financially economical when compared to open direct cost. Dr. Pisani further updated the Committee of the FY17 goals of decrease TPN usage and the goal for FY 18: decrease post-operative opioid use after ERAS (Enhanced Recovery After Surgery) protocol and utilizing order set in iCare. Dr. Pisani asked for feedback and questions from the Committee and a brief discussion ensued.	***None***
7. COMMITTEE MEMBER RECRUITMENT	Chair Reeder informed the Committee of vacant positions available on the committee but not necessary to be filled and of two potential candidates: Dr. Carol Somersille (independent physician) and Julie Kriger (program director). A brief discussion ensued regarding the type of expertise and competencies needed for the Committee. The Committee asked to revisit the topic at the next meeting.	***Agenda item to be added for next meeting on October 30th, 2017***

Agenda Item	Comments/Discussion	Approvals/Action
8. FY18 QUALITY DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, reviewed the FY18 Quality Dashboard with the Committee. Ms. Carson discussed that the trend is near or at goal for falls in Jan 2017 and this data will be shared with the Falls team. A standardized infection rate from NSHN will be reported quarterly or every 6 months for CAUTI, CLABSI, CDI and SIR. No CLABSI were reported in July and 1 C.Diff infection was reported at the MV campus. Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population is now part of daily huddle. Sepsis Core Measure is based off Early Management Bundle: 1) Sepsis 3-hour window - initial lactate, antibiotic, and blood cultures, 2) Sepsis 6-hour window – repeat lactate, 3) Septic Shock 3-hour window – crystalloid fluids, and 4) Septic Shock 6 hour window – septic shock assessment. She further reported that the ED Physicians are more consistent in ordering fluid resuscitation for Sepsis patients. The Mortality Rate FY18 goal is based on the July 2016 to May 2017 top docile performers, the comparison is not yet available by Premier, and the rate is risk adjusted. The Rate the Hospital HCHAPS score for August exceeds maximum, maintaining that level will be the challenge. Due to the quarterly nature of the Infection metric, this last metric is not reported. Ms. Carson reported that through August, ECH has had 4 occurrences of CAUTI, 0 occurrences of CLABSI, and 4 occurrences of C-Diff. **Items of Note: Catherine Carson will reset Falls Goal to CALNOC top 10% docile and readjust chart to view one year data. Next meeting to provide all Falls data and all Falls data with Harm to the Committee and provide an overview of Medicare's criteria and coverage.*	
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Michelle Gabriel, Director of Performance Improvement, informed the committee on the status of hiring the Patient Experience Manager of which 17 applicants have applied with 3 potential candidates. She explained that the patient experience governance committee had their first meeting in September and is currently reviewing patient experience data to identify opportunities for improvements and piloting a dashboard. She asked the Committee members for feedback and a brief discussion ensued.	***None***
10. FY 17 ORGANIZATIONAL GOAL ACHIEVEMENT	Mick Zdeblick, Chief Operating Officer, shared the final outcomes of FY 17 Organizational Goals. Pain Reassessment has done very well at 89%, Pain Patient Satisfaction reached maximum goal at 76%, and LOS did	***None***

Agenda Item	Comments/Discussion	Approvals/Action
UPDATE	improve and didn't affect negatively on readmission. While Smart Growth was on target at 96.5%.	
11. READMISSION DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, shared the new format for FY 2018 Medicare 30 Day All-Cause, Unplanned Readmission Dashboard with the committee. She explained how Hospital Readmission Reduction Program will reduce reimbursement for 2,573 hospitals for fiscal year 2018 by Medicare according to CMS data. The latest penalties are based on readmission between July 2013 and June 2016 which affects Medicare payments that CMS makes to hospitals between October 1, 2017 and September 30, 2018. Ms. Carson further reported that CMS withholds up to 3% of regular reimbursement if a hospital has a higher-than-expected number of readmission within 30 days of discharge for 6 conditions: Chronic Lung Disease, Coronary Artery Bypass Graft Surgery, Heart Attacks, Heart Failure, Hips and Knee Replacements, and Pneumonia. The penalties which most affect ECH are for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG), and Total joints.	***None***
12. PSI-90 ST SAFETY INDICATORS	Catherine Carson, Sr. Director/Chief Quality Officer, explained that the PSI-90 Total Inpatient report is pulled from July 2016 to May 2017. The facility composite value was 0.668412 which is lower than the Premier PSI-90 score at 0.80 but ECH still has room for improvement to meet Premier PSI-90 top decile score of 0.57. She noted 3 out of 8 Patient Safety Indicators had an uptick: Perioperative PE or DVT, Postop Sepsis, and Accidental Puncture or Laceration. The Sepsis Committee reviewed each case for further details, and found a contributing factor due to lack of information from physician notation in medical records cause the uptick for accidental puncture or laceration scores and no trends were noted on Perioperative PE or DVT cases. **The committee noted that PSI-90 Composite graph's data value was not correct, Catherine will recalculate to generate accurate graph.*	***None***
13. CULTURE OF SAFETY SURVEY RESULTS	William Faber, MD, Chief Medical Officer, updated the Committee on the Press Ganey Culture of Safety questions and results. The employee and medical staff's scores were tabulated separately and both aggregate scores were slightly below the national average but showed multiple areas of improvement. Dr. Faber asked the Committee for feedback on specific areas of concern to include: • When a mistake is reported, the focus is on solving the problem, not writing up the person.	

Agenda Item	Comments/Discussion	Approvals/Action
	• My work unit works well together. • My work unit is adequately staffed. • Senior management provides a work climate that promotes patient safety. • I feel free to raise workplace safety concerns. • I can report patient safety mistakes without fear of punishment. The committee's feedback included providing a breakdown of the results by physician to the department chair in order to improve scores through working together with unit management.	
14. PUBLIC COMMUNICATION	None.	***None***
15. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:05 p.m. **Movant:** Davis **Second:** Simon **Ayes:** Anderson, Bauman, Bunce, Davis, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Carragee, Fung **Excused:** None **Recused:** None	***Adjourned to closed session at 7:05 p.m.***
16. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:26 pm. *Agenda Items 16 – 20 were addressed in closed session.*	
17. AGENDA ITEM 22: ADJOURNMENT	The meeting was adjourned at 7:26 pm. **Motion:** To adjourn at 7:26 p.m. **Movant:** Anderson **Second:** Ron **Ayes:** Anderson, Davis, Reeder, Ron, Simon **Noes:** None **Abstentions:** None **Absent:** Bauman, Bunce, Carragee, Fung **Excused:** None **Recused:** None	***Meeting adjourned at 7:26 pm***

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

b. Minutes of the Open Session of the Quality Committee Meeting (October 30, 2017)

Minutes of the Open Session of the
Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, October 2, 2017
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

Members Present	Members Absent	Members Excused
Dave Reeder, Jeffrey Davis, MD; Katie Anderson, Ina Bauman, And Nancy Carragee	Peter Fung, MD, Mikele Bunce, Wendy Ron, and Melora Simon	

**Jeffrey Davis, MD joined the meeting at 5:35pm via teleconference*

A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 30th of October, 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 Chair Dave Reeder at 5:36 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Peter Fung, MD, Mikele Bunce, Wendy Ron, and Melora Simon were absent. Jeffrey Davis, MD joined the meeting via teleconference.	***None***
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.	***None***
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 (October 2, 2017). **Movant:** Anderson **Second:** Carragee **Ayes:** Anderson, Bauman, Carragee, Davis, Reeder **Noes:** None **Abstentions:** None **Absent:** Bunce, Fung, Ron, Simon **Excused:** None **Recused:** None	***A vote was taken to approve the Open Session Minutes of the October 2, 2017 meeting, but will be presented for approval again at the next meeting due to lack of a quorum within the geographic boundaries of the El Camino Healthcare District.***

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.	***None***
6. QUALITY PROGRAM UPDATE: ELECTROPHYSIOLOGY	Shaun Cho, MD, Co-Medical Director for Electrophysiology, provided an overview of El Camino's Electrophysiological ("EP") Services. These services address, both diagnostically and therapeutically, the increasingly prevalent problems of atrial fibrillation and other electrical conduction diseases of the heart. Volume for EP services has increased 173% since 2013 with over 340 procedures now done at ECH per year, with excellent outcomes reported on several registries. Dr. Cho explained that as the outpatient procedures increase, the contribution margin and net income continue to increase as well; therefore, obtaining excellent reimbursement. Dr. Cho reported that ECH is part of ACC/NCDR registries for the in-patient setting. In addition, ECH has joined the EP Registry Suite along with 69 other hospitals that submitted their quarterly discharge data. Dr. Cho further updated the Committee on the new innovations, left atrial appendage closure and leadless pacemakers currently used in their procedures. Dr. Cho asked for feedback and questions from the Committee and a brief discussion ensued.	***None***
7. COMMITTEE MEMBER RECRUITMENT	Chair Reeder asked the Committee to revisit this topic at the next committee meeting scheduled for December 4, 2017. He asked the committee members to consider the type of expertise and competencies needed for potential Committee recruits.	
8. FY18 QUALITY DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, reviewed the new quality dashboard with the committee and there were no negative trends. With regards to Hospital Acquired Infections (HAIs), our area of intense organizational focus, we have had no CLABSIs during the first quarter of FY18 but are running slightly above target on CAUTIs, and slightly below target for C. difficile. Ms. Carson also shared ECH's performance on Core Measures from CMS Hospital Compare. Ms. Carson further detailed that the new goal from CALNOC is at 0.74 (top decile) and a trial for new toilet seat sensor alarm will begin to help address bathroom related falls. There were 2 CAUTIs in August and 2 in September were reported; therefore, HAI A3 actions are nurse-driven protocol for foley removal; competency for new	

Agenda Item	Comments/Discussion	Approvals/Action
	foley insertion tray and procedure for ED, Critical Care, and OR; and emphasis on daily bath and frequent peri-care for patients with foley catheters. The 2 C.Diff infections noted in September related to long or multiple antibiotic usage. The geometric LOS Expected for Medicare Population has improved from 4.08 to 4.19 in September and Arithmetic Observed LOS Average also improved to 4.63 which improved our ratio to below target goal. She further explained that Sepsis Core Measure compliance increased to 67% whereas other core measure hospitals are at 50%. IVF Bolus compliance is at 80% for ordering bolus received within 2 hours of TOP. CDI has increased the reported Expected Mortality rate due to more co-morbid conditions being documented. The data for August was preliminary for HCAHPS and the nursing team will be addressing nurse communication results.	
9. PEER REVIEW PROCESS CHANGES IMPLEMENTATION UPDATE	Catherine Carson, Sr. Director/Chief Quality Officer, updated the committee on the OPPE process which will be much more robust in November than ever before due to the implementation of new data extraction software and staffing to create metrics, with ongoing evaluations within the organization. She further explained that the profiles for all providers will include: Mortality Data , Review of outcome data: Clinical Complications/AHRQ Patient Safety Indicators, 30 Day Readmissions , Length of Stay Patterns, Pattern of Medication Usage, Antibiotic Usage compared to Peer Group, Pattern of Blood Usage, Documentation Metric, Behavioral Trends, Number of Peer Review Cases, and Custom Profiles for Specialties. She informed the committee of the future state of the Peer Review Process to contain 2 Peer Review Coordinators (RNs) to support all 13 Peer Review meetings and Peer Review committees, and a New Peer Review Manager software module will be implemented to support the new process.	
10. CDI DASHBOARD	Jessica Hatala, Interim Manager of Clinical Documentation Improvement, shared significant advances in our clinical documentation program over the past year, with the addition of three concurrent clinical reviewers. This has resulted in millions of dollars of added revenue to the hospital, but just as importantly, our mortality index and expected length of stay have improved because the severity of patient conditions is being captured more completely and accurately.	

Agenda Item	Comments/Discussion	Approvals/Action
11. CORE MEASURE	Catherine Carson, Sr. Director/Chief Quality Officer, explained CMS Core Measure results CMS for quarter 1 and quarter 2 required for inpatient and outpatient as further detailed in the submitted materials. Ms. Carson further explained that the goal for most measures is 100% and the color coding shows any measure below 90% as Red. The PC-IMM result for Q2 is not applicable because it is only collected in Flu Season: Oct. 1- March 31st.	
12. UPDATE ON CULTURE OF SAFETY RESULTS	Catherine Carson, Sr. Director/Chief Quality Officer, updated the Committee on the engagement survey results. She reported that a key driver for both employees and physicians to be: The Organization makes every effort to provide safe, error-free care to patients. This statement was selected as the enterprise-wide action which created action items under consideration and in process to address this statement: • Analysis of specific department behavior regarding reporting events • Patient Safety Newsletter – quarterly • Patient safety staff and Quality Medical Directors are providing direct feedback to submitters of QRRs • Crucial Conversation training for senior leaders, directors and managers. This will also include key staff leaders in 2018 • Re-starting Executive Rounding • Patient Safety Committee: consider splitting apart the enterprise Quality Improvement/Patient Safety Committee as it is focused on quality reporting and not safety reporting • Nurse Communication (as measured in HCAHPS) is a nursing goal • Addressing nursing concerns regarding staffing • Use of a nurse driven protocol regarding appropriateness of telemetry and facilitating discontinuation when the patient no longer clinically qualifies • Addressing Nurse to Physician Communication	
13. UPDATE ON PATIENT AND FAMILY CENTERED CARE	Cheryl Reinking, RN, Chief Nursing Officer, informed the committee on the Patient Centeredness Tactics which are: bedside handoff report, patient centered discharged rounds, empathy building exercises, expansion of the getting to know you program, and improved discharge instruction methodology. Ms. Reinking asked the Committee members for feedback and a brief discussion ensued.	***None***

Agenda Item	Comments/Discussion	Approvals/Action
14. PUBLIC COMMUNICATION	None.	***None***
15. ADJOURN TO CLOSED SESSION	**Motion:** To adjourn to closed session at 7:16 p.m. **Movant:** Carragee **Second:** Anderson **Ayes:** Anderson, Bauman, Carragee, Davis, Reeder **Noes:** None **Abstentions:** None **Absent:** Bunce, Fung, Ron, Simon **Excused:** None **Recused:** None	***Adjourned to closed session at 7:16 p.m.***
16. AGENDA ITEM 21: RECONVENE OPEN SESSION/ REPORT OUT	Open Session was reconvened at 7:29 pm. *Agenda Items 15 – 19 were addressed in closed session.*	
17. AGENDA ITEM 22: ADJOURNMENT	The meeting was adjourned at 7:29 pm. **Motion:** To adjourn at 7:29 p.m. **Movant:** Carragee **Second:** Anderson **Ayes:** Anderson, Bauman, Carragee, Davis, Reeder **Noes:** None **Abstentions:** None **Absent:** Bunce, Fung, Ron, Simon **Excused:** None **Recused:** None	***Meeting adjourned at 7:29 pm***

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

Research Article

"Blue light" cystoscopy for detection and treatment of non-muscle invasive bladder cancer

J. Ryan Mark, MD, Francisco Gelpi-Hammerschmidt, MD,
Edouard J. Trabulsi, MD, Leonard G. Gomella, MD
Department of Urology, Kimmel Cancer Center, Thomas Jefferson University, Philadelphia, Pennsylvania, USA

MARK JR, GELPI-HAMMERSCHMIDT F, TRABULSI EJ, GOMELLA LG. "Blue light" cystoscopy for detection and treatment of non-muscle invasive bladder cancer. The Canadian Journal of Urology. 2012;19(2):6227-6231.

In patients with non-muscle invasive bladder cancer, fluorescence cystoscopy can improve the detection and ablation of bladder tumors. In this paper we describe the technique and practical aspects of hexaminolevulinate (HAL) fluorescence cystoscopy, also known as "blue light cystoscopy".

Key Words: superficial bladder cancer, non-muscle invasive bladder cancer, fluorescence cystoscopy, hexaminolevulinate, blue light cystoscopy

Introduction

An estimated 73,510 patients will be diagnosed with bladder cancer in the United States in 2012.[1] Initial treatment of these tumors involves transurethral resection, however as many as 60%-70% of superficial urothelial carcinomas will recur.[2] This may partly be due to the inability to detect some small papillary tumors and transitional carcinoma in situ (CIS) under standard white light cystoscopic conditions. A new technique to improve the visualization of tumors, combining an intravesical agent with a specific blue light cystoscopic system, was approved by the FDA in 2010.

Hexaminolevulinate HCl (HAL) is available in the United States as Cysview (Photocure US, Princeton, NJ, USA). In Europe it has been available for several years under the brand name of Hexvix. The product is designed to enhance the detection of non-muscle invasive bladder cancer (NMIBC). When instilled intravesically, it improves the visualization of bladder tumors through fluorescence cystoscopy with abnormal areas of the bladder fluorescing under blue light examination, hence the common name of "blue light" cystoscopy.

Accepted for publication March 2012

Address correspondence to Dr. Leonard G. Gomella, Department of Urology, Thomas Jefferson University, 1025 Walnut Street, Suite 1112, Philadelphia, PA 19107

The intravesically administered compound is hexaminolevulinic acid, an ester that when applied topically will bypass cellular regulation mechanisms for heme synthesis and drive the accumulation of protoporphyrin IX (PpIX). PpIX fluoresces red with blue light and because PpIX accumulation preferentially occurs in malignant cells can be used to identify malignant tissue using HAL fluorescence cystoscopy (HAL-FC), Figure 1.[3]

Method and Technique

Equipment

To incorporate HAL-FC into your clinical care for bladder cancer you will need "blue light" compatible cystoscopic instruments as well as facility Pharmacy committee approval for the Cysview. Currently the FDA has only approved the Karl Storz D-Light C Photodynamic Diagnostic (PDD) system (Karl Storz, Endoscopy-America, Inc. El Segundo, CA, USA). Our experience has been with using D-Light C light source in conjunction with the Tricam SL II and PDD camera head. The Storz AIDA HD connect system captures video and still images and images with this article were captured using this system, Figure 2a. The D-Light C light source contains a 300 Watt xenon arc lamp with a band pass filter capable of producing white and blue light (wavelength 360 nm-450 nm) which is carried to the telescope using a

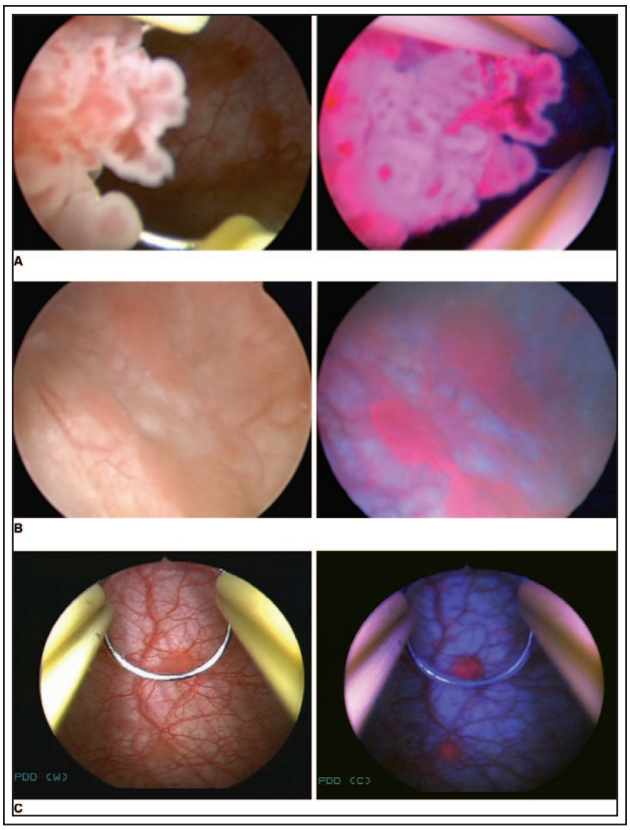

Figure 1. Bladder lesions under white and blue light with Cysview. **a)** Low grade Ta. **b)** Carcinoma in situ. **c)** High grade T1 (2 lesions identified).

Storz fluid light cable. Specific Storz PDD telescopes are required (available with 0, 12, 30, and 70 degree viewing angles) that contain a filter that is necessary to detect fluorescence. They are 30 cm in length and are compatible with current Storz rigid cystoscopy sets, Figure 2b. Compatible flexible instruments are not available at this time.

The PDD camera has a blue and silver buttons that allow the operator to switch between blue and white light in addition to controlling gain, shutter speed, and white balancing. Understanding these controls can be useful to the surgeon to optimize image quality. Pressing the blue button for 1 sec will switch in between blue and white light while pressing the blue button for > 3 sec will white balance the camera. The silver button will control shutter speed in either blue or white light mode. Default shutter speed is 1/15 second and can be changed by holding the silver button > 3 sec. While using blue light a shutter speed of 1/15 or 1/30 second is recommended. A 1 sec press of the silver button will allow the operator to cycle through gain settings to adjust lamp brightness during use.[4]

Patient selection

Cysview is approved for one-time use in patients with known or suspected non-muscle invasive bladder cancer and only for use with the Karl Storz D-Light C Photodynamic Diagnostic (PDD) system. It is contraindicated in patients with porphyria, gross hematuria, BCG treatment within 90 days, or known hypersensitivity to Cysview or other 5-ALA derivative.[5]

We have found clinical utility in HAL-FC consistent with recommendations recently published by a European panel of experts. HAL-FC is useful at primary cystoscopy and resection of bladder tumors, during restaging in patients not previously evaluated with Cysview, patients with positive urine cytology and negative white light cystoscopy, and for surveillance cystoscopy after treatment of CIS.[6] In practice the majority of our Cysview use has been incorporated in our treatment of CIS, typically in patients with positive cytology after treatment with BCG. Recently, we have incorporated this into our initial biopsy and resection of patients with newly diagnosed bladder cancer. This is not for repetitive use and is not a replacement for random bladder biopsies or other techniques used in the detection of bladder cancer.

Cysview reconstitution and patient preparation

Cysview is packaged in a kit containing 100 mg hexaminolevulinate HCL powder in a 10 mL glass vial, 50 mL of diluent (phosphate buffered saline), and a luer lock catheter adaptor, Figure 2c. Reconstitution is accomplished by aspirating the Cysview diluent using a 60 mL syringe with an 18 G blunt tipped needle. Ten milliliters of diluent is then injected into the glass vial containing Cysview powder. Without withdrawing the needle, the vial and syringe are gently rocked until all powder is visibly dissolved. The dissolved solution is then withdrawn into the 60 mL syringe containing the other 40 mL of diluent. Cysview is immediately ready for intravesical use, however if patient is not ready for treatment it may be stored for 2 hours at 2°-8°C. Prior to reconstitution, the Cysview kit may be stored at 20°-25°C.[5]

Reconstitution at our hospital is performed by the pharmacy after the patient has been admitted and assessed by our preoperative nurses. Once prepared, the Cysview is delivered by pharmacy and the patient is straight catheterized with a 16 Fr catheter using sterile technique and their bladder emptied of urine. All 50 mL of Cysview is slowly injected into the catheter and left to dwell in the bladder for between 1 and 3 hours. If left for longer than this time normal

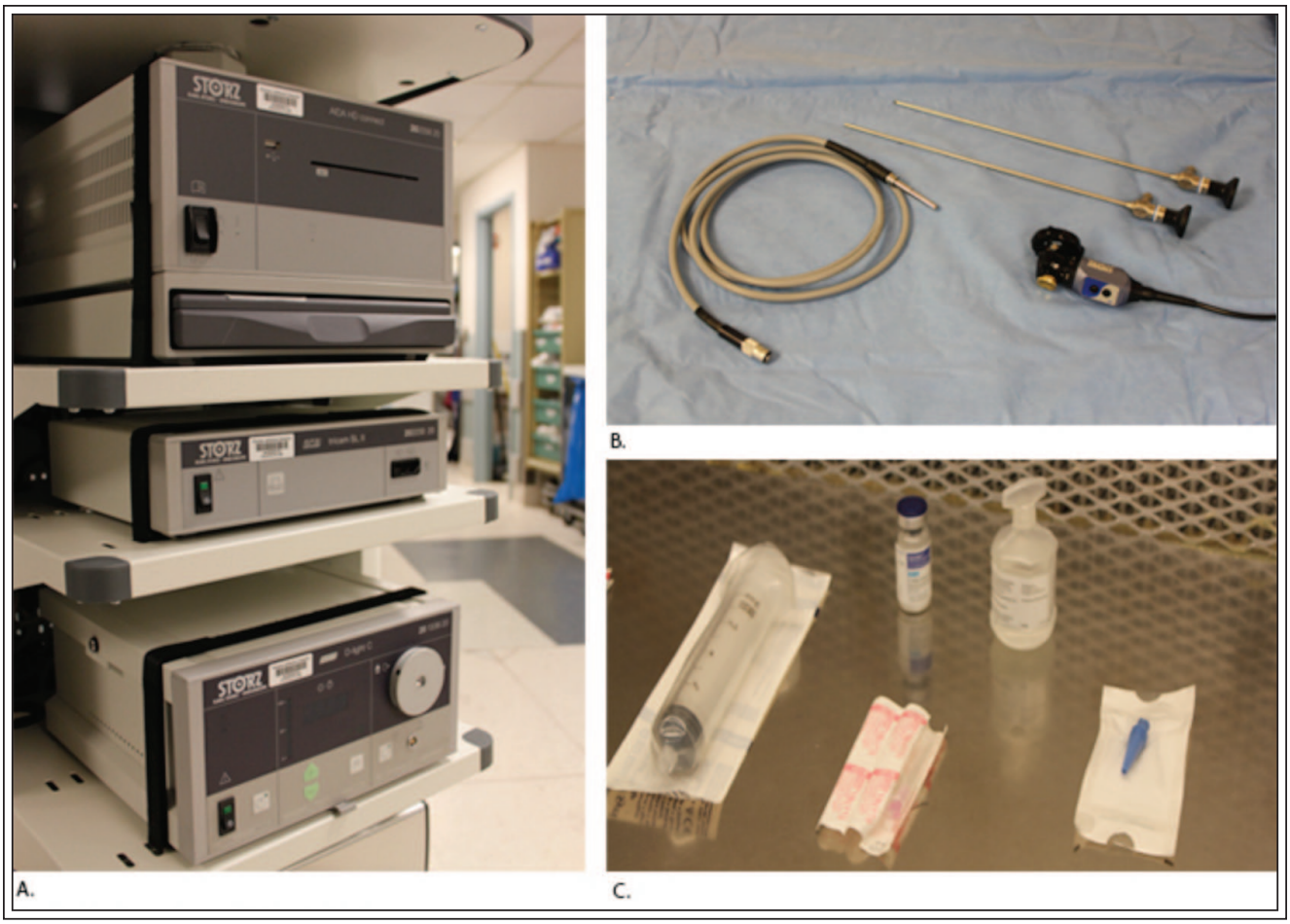

Figure 2. Equipment needed for hexaminolevulinate fluorescence cystoscopy (HAL-FC). **a)** Karl Storz PDD tower. **b)** Karl Storz PDD telescopes, light cord and camera. **c)** Contents of Cysview kit and items required for preparation.

bladder mucosa begins to respond to the Cysview solution and lesions become difficult to distinguish, causing excessive false positive results and lowering the specificity. Cysview is not approved for use with silver-coated catheters.

Procedure

After the Cysview has dwelled for approximately 1 hour the patient is taken to the operating room and prepared for rigid cystoscopy in the standard fashion. The utility of this technique is to direct biopsy and therefore these procedures are conducted in the operating room under adequate anesthesia. Rigid cystoscopy using the PDD system is performed using white light in a systematic manner identifying bladder anatomy and possible lesions requiring resection or biopsy. The blue button is then pressed for 1 sec and blue light cystoscopy is initiated. Before examining the bladder the scope is positioned at the bladder neck where a reddish/pink fluorescence is identified from a tangential effect confirming that Cysview has been applied properly. Systematic cystoscopy using blue light is then performed with 30 and 70 degree telescopes. When using blue light we have found that tangential artifact from the bladder wall can be minimized by directing the scope close and perpendicular to the bladder wall. Doing so makes lesions easily identifiable due to their bright red fluorescence. When lesions are identified we prefer to biopsy using white light as we feel the darker blue light illumination impedes depth perception. After initial fulguration of lesions, inspection using blue light should follow to identify any inadequately treated tumor left at the periphery. Fulguration under blue light has been safe in our hands, however resection should always be performed using white light due to decreased perception of depth and a perceivable strobe effect seen with quick movements. After resection blue light should be used to determine completeness

of resection as a rim of fluorescence is often visible possibly identifying residual malignant urothelium.

Visibility within the bladder using blue light can be improved with basic troubleshooting already routine to the urologist during endoscopic procedures. Clear optics rely on proper cleaning and handling of equipment, adjusting camera focus and ensuring all devices are connected appropriately. Blood in the bladder significantly obscures vision to a greater degree than white light cystoscopy. Urine fluoresces green under blue light and therefore should be routinely drained from the bladder to improve visualization. Using a non-PDD telescope will result in a dark blue image. Poor patient selection can also result in poor visualization of bladder tumors using blue light as patients with inflammation from UTI, recent BCG therapy, or recent resection show diffuse pink fluorescence that limits the utility of HAL-FC and increases the incidence of false positive results.

After the procedure postoperative care is routine. Patients with visible tumor receive intravesical mitomycin therapy followed by void trial or discharge with a foley catheter depending on patient history. We have not experienced any recognizable adverse reactions from using Cysview, however local symptoms such as bladder spasm, dysuria, and hematuria were reported in clinical trials and were not significantly different than controls. The compound has been used extensively in thousands of patients in Europe for several years and is generally considered to be very safe. One case of anaphylactic shock has been reported in the literature that was possibly due to the compound.[3]

Discussion

The treatment of superficial bladder cancer is often associated with a high rate of recurrence. "Blue light" cystoscopy offers a new tool in the management and treatment of NMIBC that may increase the detection of lesions not well seen under white light examination. We have incorporated it into our practice and have experience in almost 100 patients including those on clinical trials and in over 40 patients in routine care. Special points to consider during blue light cystoscopy are summarized in Table 1. A limitation is the fact that benign lesions such as cystitis cystica and other inflammatory lesions may fluoresce using this technique. In our experience the ability to increase the detection of sites of intravesical CIS is one of the most appealing aspects of blue light cystoscopy.

Our initial experience with this technology was as participants in a phase III, multicenter clinical trial. During this study 196 patients with either bladder lesions, positive urine cytology, or recurrent bladder tumor after treatment received white light cystoscopy with mapping of all detectable lesions followed by HAL-FC. Flat lesions were biopsied and fulgurated and papillary tumors were resected. Notably, of the 113 CIS lesions identified, 104 were seen with blue light and only 77 with white light. HAL-FC was determined to give additional information by the surgeon in 55% of cases and caused a change in planned treatment in 14% of patients.[7] Other investigators have shown as many as 32% of their patients diagnosed with CIS by HAL-FC were missed by traditional cystoscopy with white light.[8]

TABLE 1. **Helpful tips for 'blue light" cystoscopy**

1. Make sure you are using blue light compatible telescope lens with the Storz PDD system.
2. Look for fluorescence at the bladder neck to verify that Cysview has been given appropriately.
3. Perform standard cystoscopy with white light first and then inspect the bladder with blue light. Keep the scope close to the bladder wall and move slowly when using blue light.
4. Fluorescence can fade during very long cases.
5. Urine fluoresces green and can obscure vision of tumors during blue light cystoscopy.
6. Perform retrograde pyelograms after blue light cystoscopy as contrast will obscure vision of tumors under blue light.
7. False positive fluorescence can be seen with: erythema, inflammation, scope or catheter trauma, or scar tissue from previous resection or biopsy from a previous cystoscopic examination. Blue light is not useful after recent UTI or BCG treatment within 90 days.
8. It is not useful for restaging TURBT within 90 days.
9. TURBT should be performed with white light as depth is difficult to perceive with blue light.
10. Cysview is not indicated for repetitive use and is not a replacement for random bladder biopsies.

Improved detection of superficial bladder tumors has proven beneficial by allowing for a more complete initial resection. Hermann et al recently performed a study where patients with suspected Ta or T1 bladder cancer were randomized to a control group receiving traditional TURBT with white light cystoscopy and an experimental group which received TURBT with white light followed by HAL-FC. Forty-five percent of patients with Ta and 43% of patients with T1 had residual tumor found by HAL-FC and the experimental group had a 35.5% relative reduction in tumor recurrence after 12 months.[9] This is comparable to recent data published on 5 year and 8 year follow up showing that HAL-FC has a roughly 30% higher tumor recurrent free survival rate.[3] The reduction in recurrence has lead to the European Association of Urology giving a grade B recommendation for fluorescence cystoscopy in patients who are thought to harbor high grade bladder tumors.[10]

Conclusion

HAL-FC using Cysview can improve detection of bladder tumors and long term experience in Europe with this technique has demonstrated its potential to decrease recurrence of bladder tumors. Now that "blue light" cystoscopy system is approved for use in the United States it adds a useful tool in the management of non-muscle invasive bladder cancer.

Disclosure

The authors report no conflict of interest associated with the publication of this paper. □

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Patient Story

Rec'd 10/24/17

Jeriann Fleres

1723 Gum Street
San Mateo, CA 94402
650-465-7382
coachezwife@aol.com

Dan Woods
Administration for El Camino Rehabilitation Center
2500 Grant Road
Mountain View, CA 94040

October 7, 2017

Dear Mr. Woods
I was filling out the patient survey and I realized that it could not possibly convey the way I felt about my stay at El Camino Rehabilitation Center from September 28 – October 7, 2017.

I have Syringomyelia in my cervical spinal cord, and had surgery at Stanford Hospital on Sept 25th. This was my third surgery for this disease as well as having three other lumbar surgeries. Therefore, it is fair to say that I have had a good amount of personal experience with surgeries and hospitals.

El Camino should be held as the standard that all patient care should strive to achieve. Coming into El Camino I was greeted as if I were an honoured guest that they had been waiting for. Anything I could have needed or wanted was provided. And all with a loving, caring, smiling face. Your staff made me feel safe, and comfortable at a time when I was in raging pain and scared to death. However, each in their own turn slowly convinced me that things will get better and that they were there for me.

One by one, your angels came to my room to evaluate my needs. Caseworker, nurses, psychological evaluation, speech evaluations, occupational therapist, physical therapist, and even spiritual people. Your physical and occupational therapists gently pushed me to my full potential, and in doing so gave me back my confidence. Nurse's aids who gently washed my back and said soothing things to me to calm my fears. Even the custodian staff who cleaned my room each day spotlessly and greeted me as if I were someone so special. Especially the doctors who never once talked down at me or make me feel like they were hurried to move on to the next patient. They came and explained my medication, the tests they were ordering, and why. Their tone was always warm and caring. They allowed all my questions and helped me feel that I was part of the team.

I will not specifically name one person because the magic of your staff is that they work as a team in complete support of each other for the good of the patient. You should be so proud that they are your team and I fully suspect that it is a reflection of your leadership that they are so special.

I would be honoured to discuss this with you further or answer any questions you may have. Please thank your entire staff for me from the bottom of my heart. I have been blessed for the experience and am confident that my wonderful recovery is because of the care I received at El Camino Rehabilitation Center.

God Bless you and the staff of El Camino Rehabilitation Center.

Jeriann Fleres

FY18 Pacing Plan

QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE
FY 18 Pacing Plan

FY2018 Q1		
JULY 2017	**AUGUST 7, 2017**	**August 28, 2017 (for September's meeting)**
No Board or Committee Meetings Routine Consent Calendar Items: ▪ Approval of Minutes ▪ Progress Against FY 2018 Committee Goals (Oct 30, March 5, June 4) ▪ FY18 Pacing Plan ▪ Med Staff Quality Council ▪ Patient Story ▪ Research Article	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. FY 17 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 17 Quality Dashboard 4. Clinical Program Update 5. Serious Safety/Red Alert Event as needed 6. CMO Report Special Agenda items: 1. Annual Patient Safety Report 2. Pt. Experience (HCAHPS) 3. ED Pt. Satisfaction (Press Ganey) 4. ECH Strategic Framework
FY2018 Q2		
OCTOBER 2, 2017	**OCTOBER 30, 2017 (for November's meeting)**	**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 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Culture of Safety Survey Results 6. Committee member recruitment (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 4. CDI Dashboard 5. Core Measures 6. Update on Patient and Family Centered Care 7. Update on Culture of Safety Results 8. Committee member recruitment	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~~ 3. Pt. Experience (HCAHPS) 4. ED Pt. Satisfaction (Press Ganey) 5. Committee member recruitment

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 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators	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 3. CDI Dashboard 4. Core Measures 5. Update on Patient and Family Centered Care
FY2018 Q4		
APRIL 2, 2018	**APRIL 30, 2018 (for May's meeting)**	**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 6. Leapfrog Survey Results 7. Value Base Purchasing Report (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 5. Pt. Experience (HCAHPS) 6. ED Pt. Satisfaction (Press Ganey) 7. Update on Patient and Family Centered Care 8. Credentialing Process Report	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 3. Readmission Dashboard 4. PSI-90 Pt. Safety Indicators 5. Update on Patient and Family Centered Care

Progress Against FY 2018 Committee Goals

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. • The Board has approved the FY18 goals and the Committee is monitoring LOS, HCHAPS, GMLOS, and Standardized Infection Ratios.
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. • FY18 Quality Dashboard is completed and supplemented by 2 additional Quality Metrics reports which are being review at every meeting • 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 • 1st quarter reviewed quality dashboard including standardized infection ratios

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

ATTACHMENT 5

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality Committee Meeting Date: December 4, 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 a verbal report by the Chair of the Committee.	
	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 November 2017 Board Actions. There were no ECHD meetings in November.	

November 2017 ECH Board Actions*

1. November 8, 2017
    a. Approved the FY18 Board, Board Chair, and Committee Self-Assessment Tools. The Biennial Committee Assessment will launch in November or early December 2017 and we expect to have results in February. The Annual Board and Board Chair Assessment will launch in the Spring of 2018.
    b. Approved the Annual Safety Report for the Environment of Care.

*This list is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.

ATTACHMENT 6

El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Urology/Men's Health
Quality Committee Board

David King, Co-Medical Director
Frank Lai, Co-Medical Director
Bido Baines, Executive Director
Date 12-4-17

Urology

The medical and surgical specialty focusing on the evaluation and treatment of diseases of the male and female urinary tract and the male reproductive organs.

Urology/Men's Health Service Line

Mission: To provide the highest quality of urology care to our patients.

Vision: To deliver excellence in urology care by providing state of the art center which incorporates technological innovation and compassionate care by our health care team for our patients.

Urology SERVICE LINE STRATEGY STATEMENT

To Deliver High Touch Personalized Care to Physicians

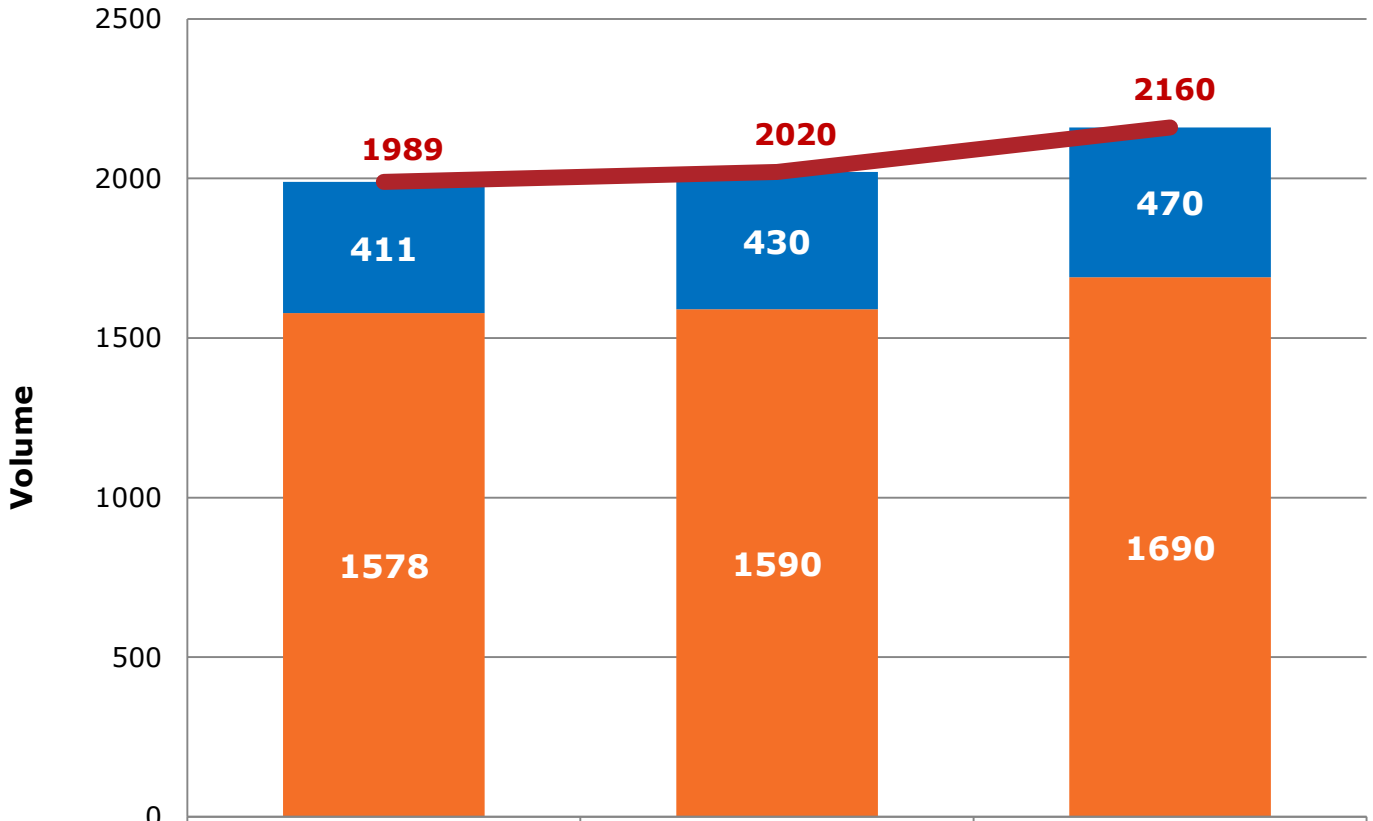
UROLOGY STRATEGY	TACTICS	GOALS
▪ Physician Satisfaction ▪ High Touch ▪ High level of interaction with MD	▪ 24 hour access to scheduling ▪ 7 days a week dedicated procedure room ▪ Fast track stone program for ER patients ▪ Staff expertise/Dedicated staff to assist.	▪ Time from when MD calls to case scheduled 15 minutes Actual: 5 minutes or less ▪ Zero MD complaints concerning scheduling time request and equipment. Actual: 100% of time equipment available and time to schedule case. ▪ All patients presenting in ER with a stone are fast tracked with immediate bedding as well as initiating care with IV and pain meds. ▪ Maintain specialized technicians to assist on every case and dedicated coordinator to improve access, scheduling and operations for patients and physicians.

Urology/Men's Health Service Line: **Value**

- Strong history of Urological Care at Los Gatos Campus beginning with original HM3 Lithotripter (stones) in 1984.
- Acknowledged Center of Urology Excellence within the medical community of the South Bay Area
- 31 urologists on Medical Staff from Atherton to Fremont to Morgan Hill to Santa Cruz to Mt. View.
- Dedicated Urology Administrator and staff including full time urology specialty technicians, and coordinator to improve access, scheduling, and operations for patients and physicians.

VOLUME

Urology - IP AND OP SURGICAL VOLUME



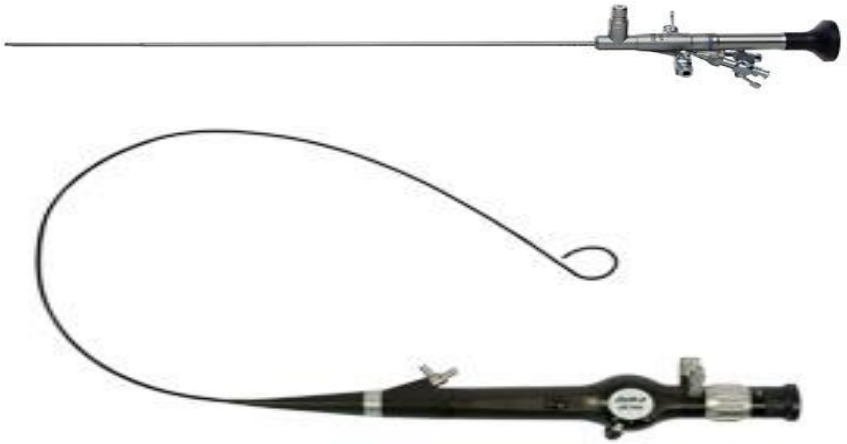
	FY2015	FY2016	FY2017
MV	411	430	470
LG	1578	1590	1690
Enterprise	1989	2020	2160

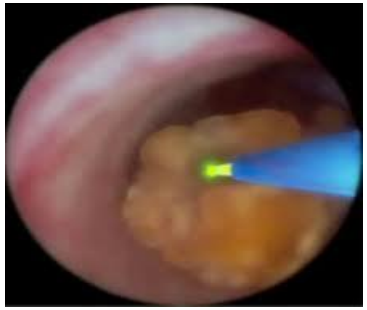
Urology - Inpatient and Outpatient surgical volume increased year over year

Stone Treatment Options

Extracorporeal Shock Wave Lithotripsy (ESWL)

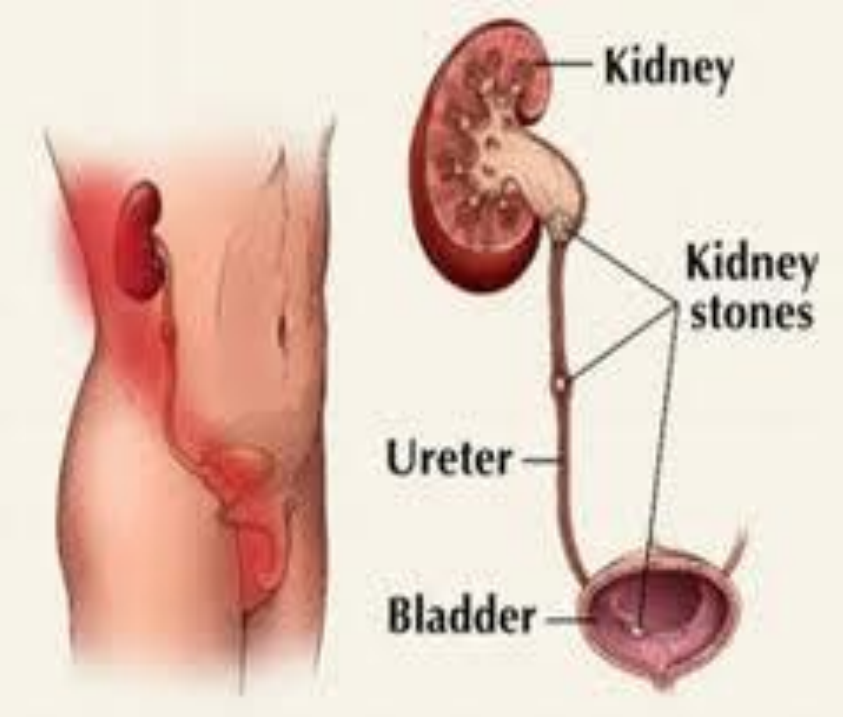
Intracorporeal Laser Lithotripsy (ISWL)



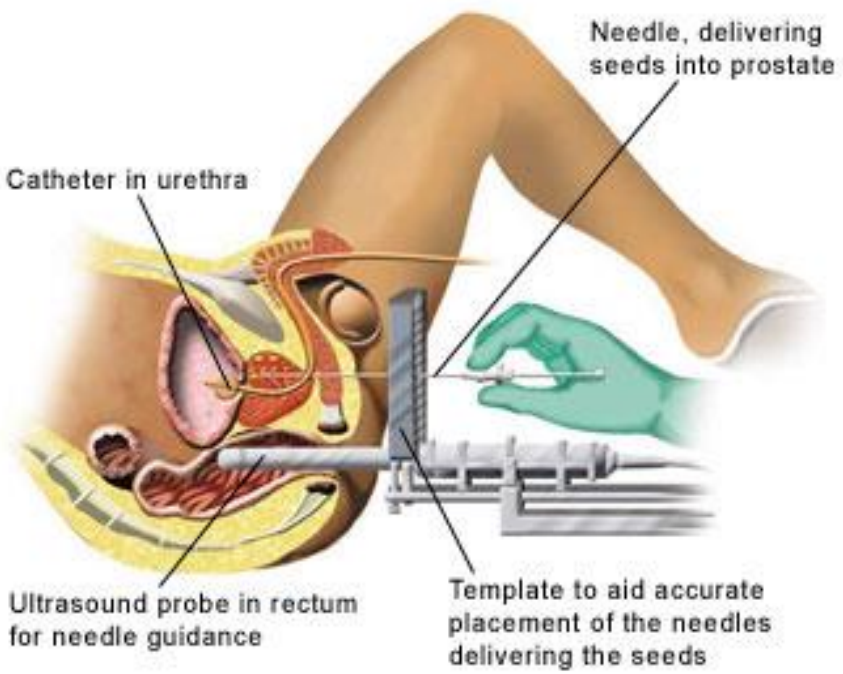


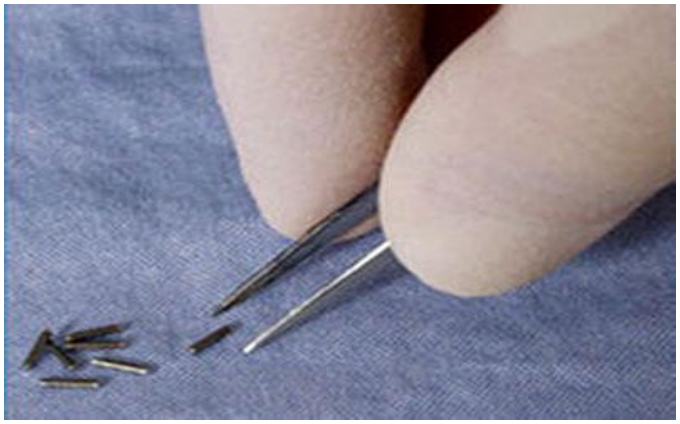
Kidney, Ureter and Bladder Stones

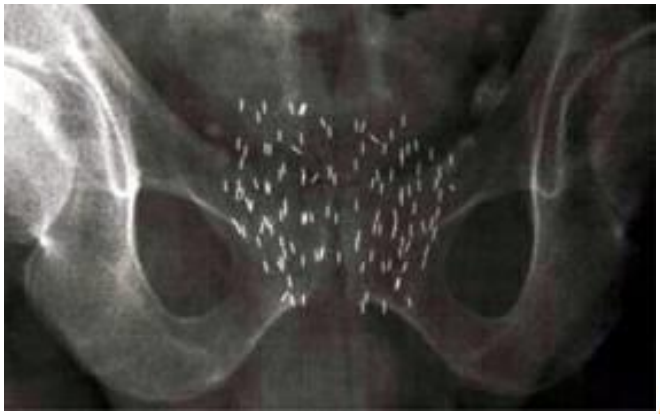
- ECHLG treats on average 750 stone patients per year
- We have a Fast Track stone program. Coordination of E.R., Radiology, Urology, and Hospitalist.



Prostate Brachytherapy – **Radioactive Seed Implant**







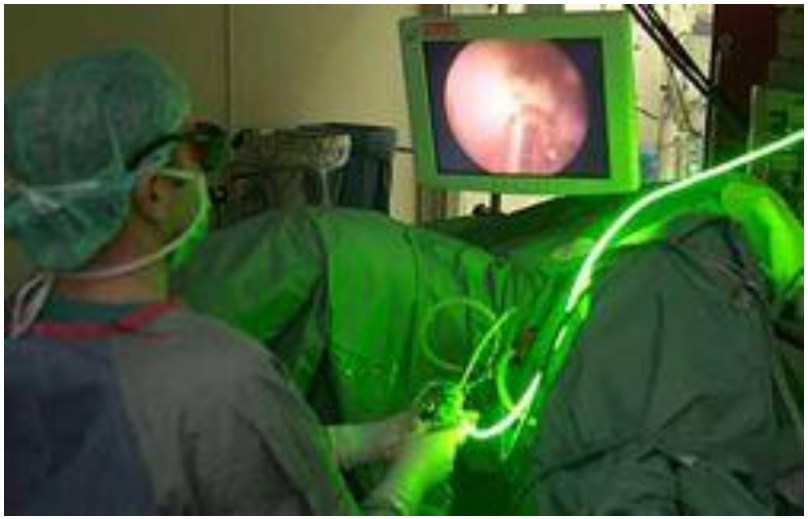
Male BPH, Incontinence and ED

BPH

TURP, Standard and Gyrus

Greenlight Laser

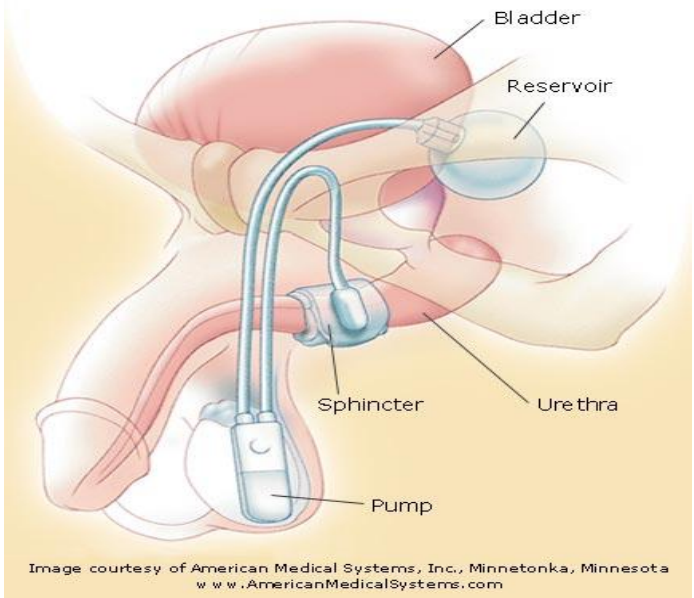
PlasmaButton, UroLift



Male Incontinence and ED

Artificial Urinary Sphincter

Male Urethral Sling



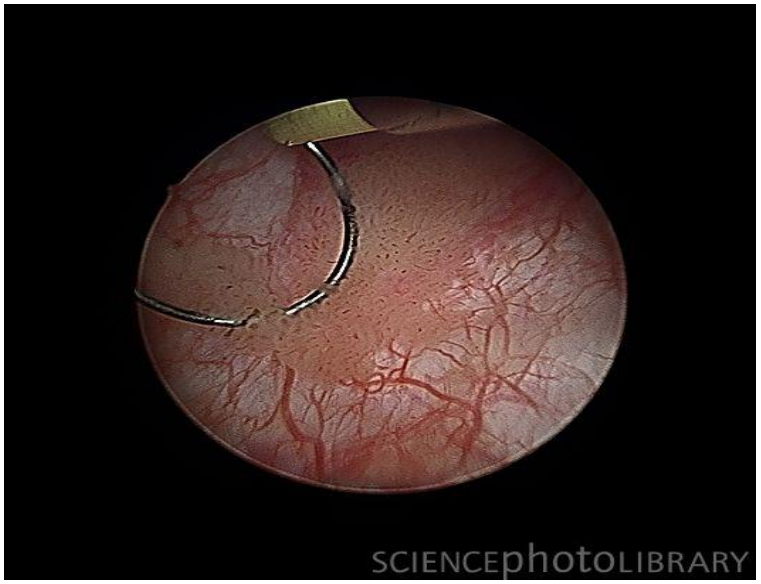
Urology Services: **Oncology**

Prostate, Kidney, Testicular, cancers.

Both open and minimally invasive surgery.

Bladder and Ureteral **Cancers**

Open and Minimally Invasive Endoscopic Methods of Treatment

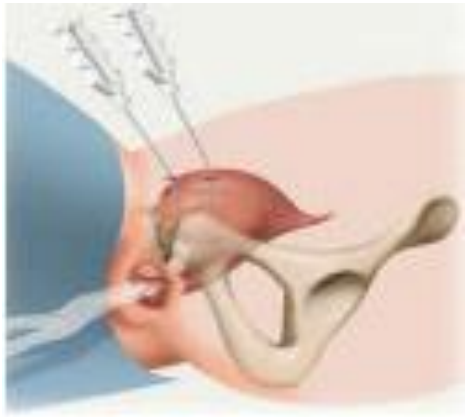


Female Urology

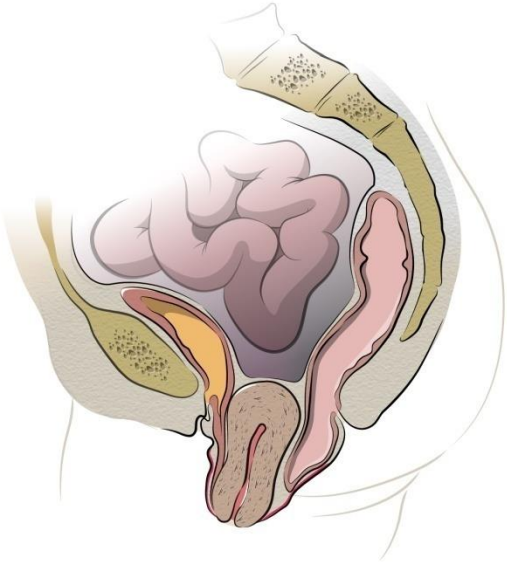
Incontinence

Urethral Sling Surgery

Peri-urethral Bulking Agent



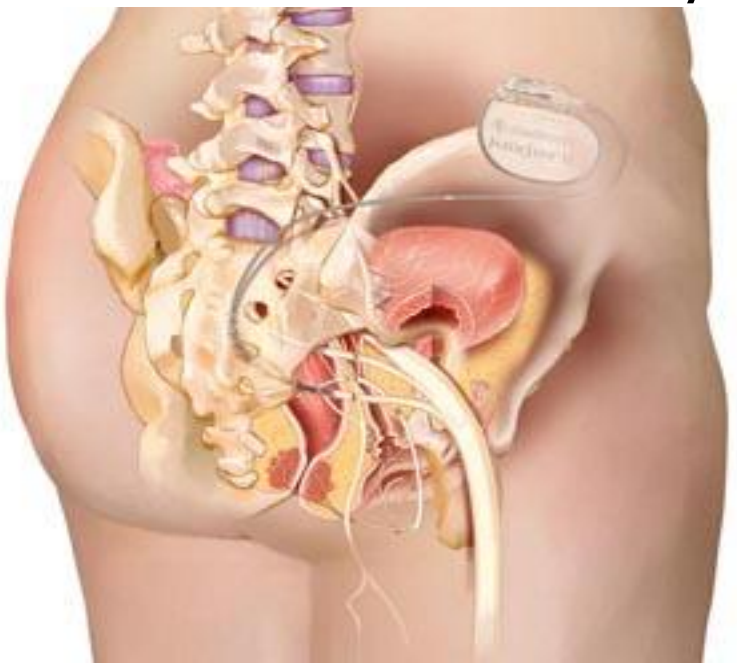
Pelvic Floor Prolapse



Neuro-Urology

Sacral Nerve Stimulation; Interstim Implant

- For female and male urinary frequency, urgency, urgency incontinence and non-obstructive urinary retention.



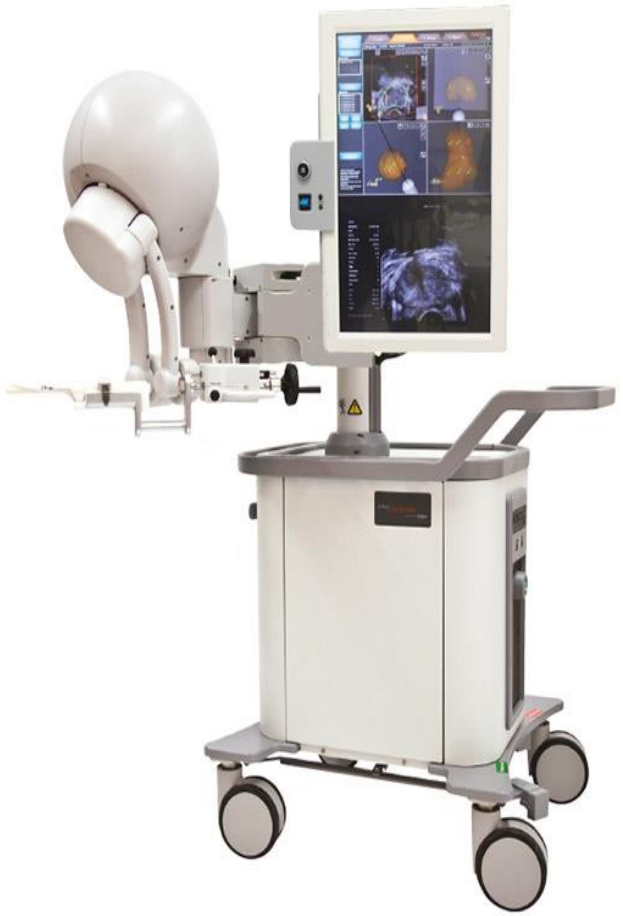
New Technology to Detect Prostate Cancer

ARTEMIS PROSTATE BIOPSY

Increase detection of significant prostate cancer and reduce biopsies

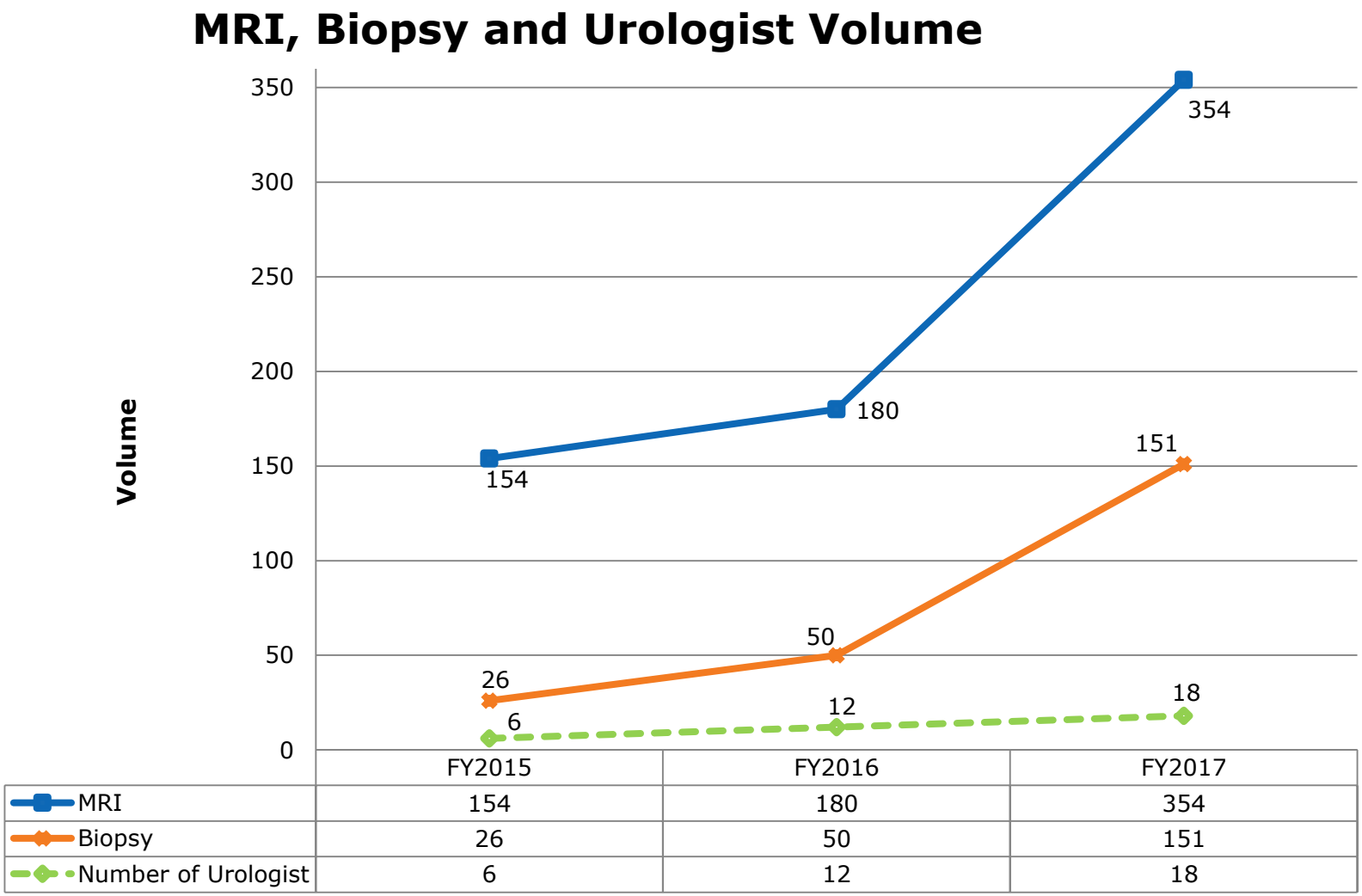
Prostate MRI used to detect suspicious lesions

Real time prostate ultrasound image fused to MRI to allow for precise targeted biopsy



Prostate MRI & Artemis

FY2015, FY2016, FY2017



	FY2015	FY2016	FY2017
MRI	154	180	354
Biopsy	26	50	151
Number of Urologist	6	12	18

Prostate MRI & PI-RADS Scoring

PI-RADS 1 – Very low

(presence of clinically significant cancer highly unlikely)

PI-RADS 2 – Low

(presence of clinically significant cancer unlikely)

PI-RADS 3 – Intermediate

(presence of clinically significant cancer is equivocal)

PI-RADS 4 – High

(presence of clinically significant cancer is likely)

PI-RADS 5 – Very high

(presence of clinically significant cancer is highly likely)

Cancer Detection Rate
August 2014- June 2017

PI-RADS 3

- Overall Cancer Detection Rate: 12/20 = 60 %
  - Percent cancer >= Gleason 7 : 5/12 = 42%
  - Percent biopsy >= Gleason 7 : 5/20 =25%

PI-RADS 4

- Overall Cancer Detection Rate: 110/175 = 62 %
  - Percent cancer >= Gleason 7 : 63/110 = 57 %
  - Percent biopsy >= Gleason 7 : 63/175 =36 %

PI-RADS 5

- Overall Cancer Detection Rate: 24/31= 77 %
  - Percent cancer >= Gleason 7 : 20/24 = 83 %
  - Percent biopsy >= Gleason 7 : 20/31 =65%

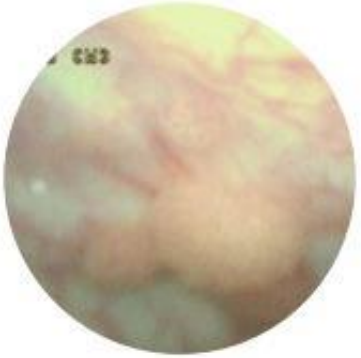
Artemis MRI/US Prostate Biopsy

- Has increased yield of significant cancer on biopsy
- Increase in PIRADS score correlates with cancer detection when cancers missed by MRI
- Majority low risk cancer but still can miss significant cancers
- PIRADS 5 lesions especially significant
- Potentially need to biopsy more PIRADS 3 lesions
  Especially men on active surveillance

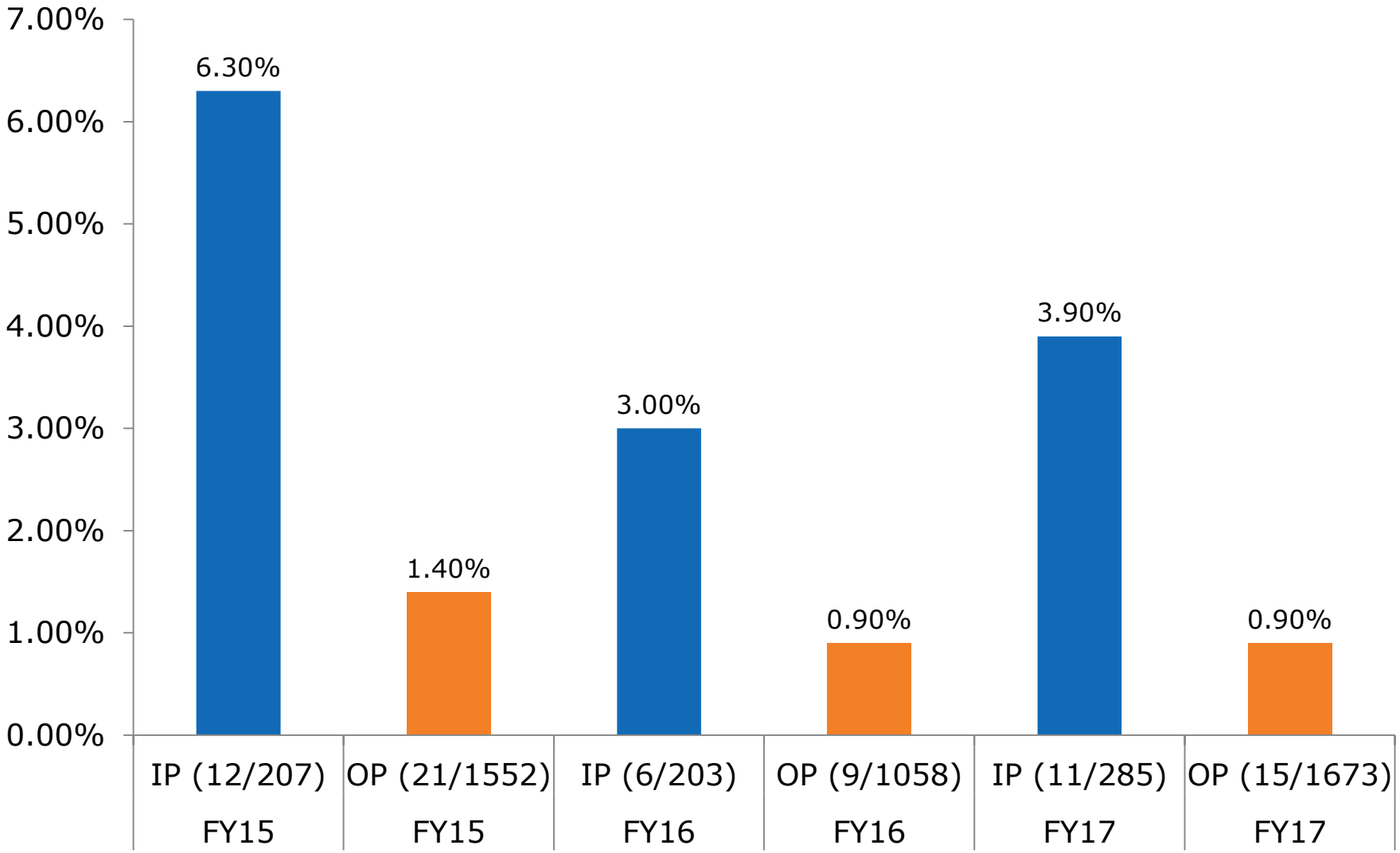
New Technology for Bladder Tumors
Blue Light Cystoscopy

Blue Light Technology Can Improve Bladder Cancer Detection

Blue light cystoscopy is performed in two parts, first with conventional white light and then followed with blue light. This agent makes detection easier even under conventional white light, and under blue light, it causes tumors to show up as bright pink, making them much easier to see and enabling more complete resection.

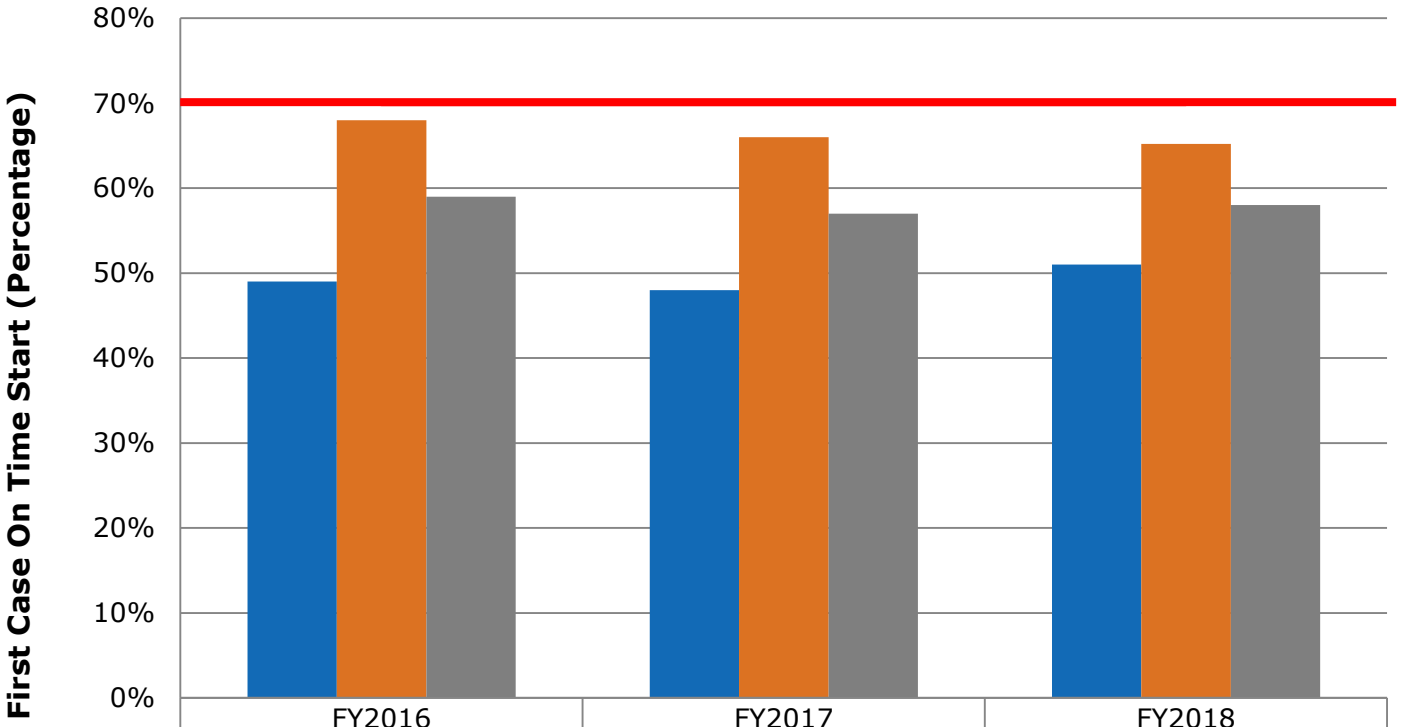


30 Day Readmission Rate
FY15- FY17



EFFICIENCY
FIRST CASE START TIME WITHIN 5 MINS
GOAL 70%

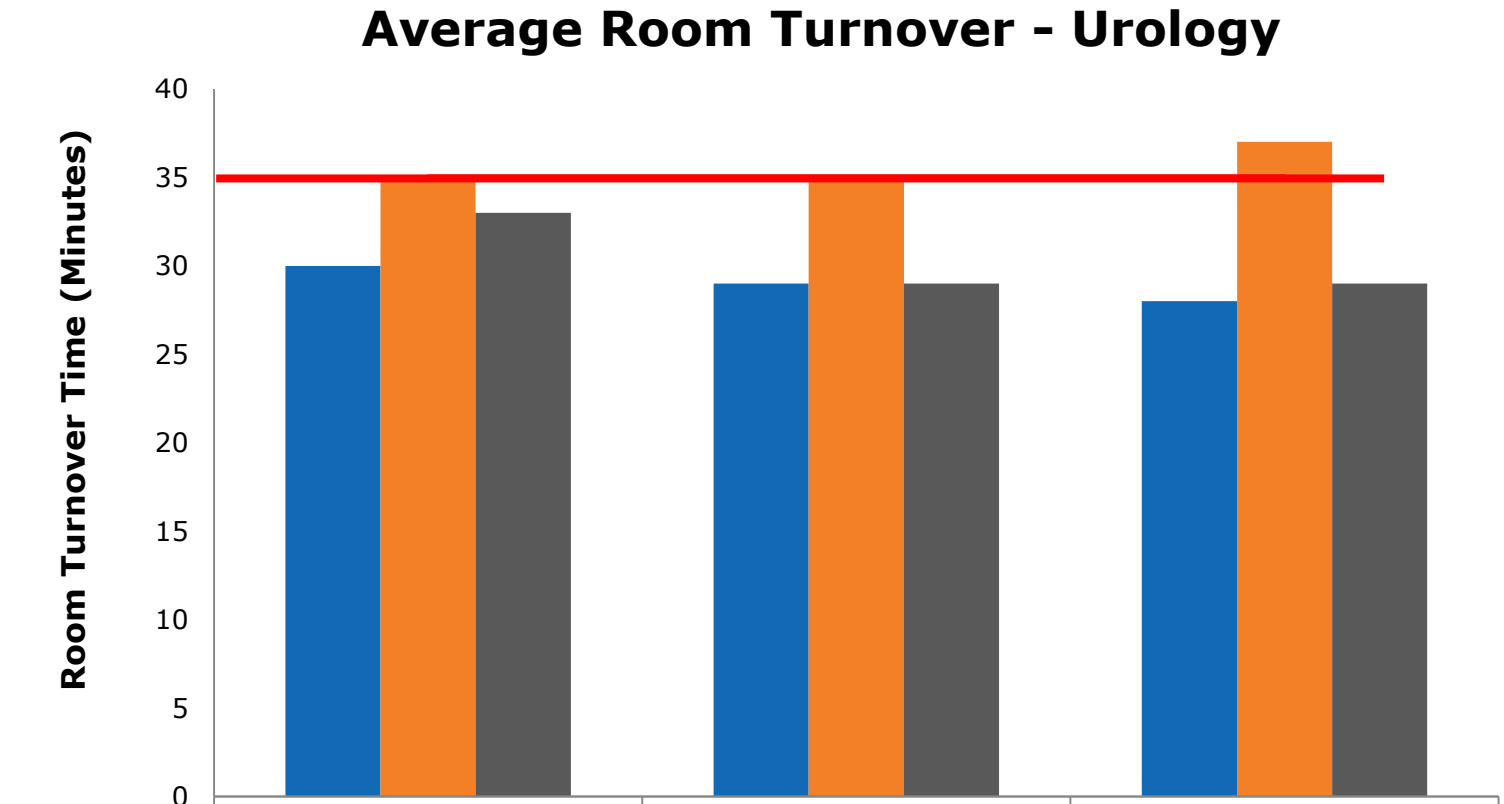
First Case On Time* Start -Urology



	FY2016	FY2017	FY2018
LG	49%	48%	51%
MV	68%	66%	65%
Enterprise	59%	57%	58%
Goal	70%	70%	70%

* On time start is defined as case start within 5 minutes of the scheduled time.

Average Turnover Time: Goal 35 Minutes or Less



	FY2016	FY2017	FY2018
LG	30	29	28
MV	35	35	37
Enterprise	33	29	29
Goal	35	35	35

Urology/Men's Health: **ACCOMPLISHMENTS**

- Busiest Center in Northern California for treating kidney and urinary stones
- Highest volume for prostate radioactive seed implant (brachytherapy) cases (outside Kaiser)
- Leading hospital for men's health surgery
- First successful Comprehensive Men's Health program in California.
- Proctorship Center for prostate laser surgery
- Only medical facility in the Bay Area to have a dedicated minimally invasive room in the operating room 7 days a week, 24 hours a day.

ATTACHMENT 7

Quality, Patient Care and Patient Experience Committee Charter

Purpose

The purpose of the Quality, Patient Care and Patient Experience ("Quality Committee") committee is to advise and assist the El Camino Hospital Board of directors in constantly enhancing and enabling a culture of quality and safety at ECH. The committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the El Camino strategic plan related to delivering high quality healthcare to the patients that we serve. High quality care is defined as care that is:

- Culture of safety that mitigates risk and utilizes best practice risk prevention strategies
- Patient-centered
- Delivered in an efficient and effective manner
- Timely
- Delivered in an equitable, unbiased manner

The organization will measure the degree to which we have achieved high quality healthcare using the CMS value based purchasing program among other measures.

Authority

All governing authority for ECH resides with the Hospital Board except that which may be lawfully delegated to a specific Board committee. The Committee will report to the full Board at the next scheduled meeting any action or recommendation taken within the Committee's authority. In addition, the Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management and quality improvement.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

The Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Membership

- The Quality Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Quality Committee may also include (A) no more than nine (9) external (non-director) members who possess knowledge and expertise in assessing quality indicators, quality processes (e.g., LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management, alignment of goals and incentives, or medical staff matters, and members who have previously held executive positions in other hospital institutions (e.g., CNO, CMO, HR); and (B) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine external members are recommended to serve on this committee.
- All Committee members shall be appointed by the Board Chair, subject to approval by the Board, for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice-Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board member, the Vice-Chair of the Committee shall be a Hospital Board member.

Staff Support and Participation

The CMO shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as senior members of the ECH staff may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. These may include the Chiefs/Vice Chiefs of the Medical Staff.

General Responsibilities

The Committee's primary role is to develop a deep understanding of the organizational strategic plan, the quality plan and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and

with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for:

- Ensuring that performance metrics meet the Board's expectations
- Align those metrics and associated process improvements to the strategic plan and organizational goals and quality plan
- Ensuring that communication to the board and external constituents is well executed.

Specific Duties

The specific duties of the Quality Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT) to benchmark progress using a dashboard
- Oversee management's development of Hospital's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services
- Review reports related to ECH-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
    a. ECH-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan
    b. ECH-wide patient safety goals and hospital performance relative to patient safety targets
    c. ECH-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports and risk management reports
    d. ECH-wide LEAN management activities and cultural transformation work
    e. ECH-wide patient satisfaction and patient experience surveys
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to include, but not be limited to, The Joint Commission (TJC), Department of Health and Human Services, and Office of Civil Rights
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements
- Review sentinel events and red alerts as per the hospital and board policy
- Oversee organizational performance improvement for both hospital and medical staff activities and ensure that tactics and plans, including large-scale IT projects that target clinical needs, are appropriate and move the organization forward with respect to objectives described in the strategic plan
- Ensure that ECH scope of service and community activities and resources are responsive to community need.

Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and Hospital's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans. Annually, the committee should do a self-evaluation to determine the degree to which we have achieved our specific objectives related to quality of care.

Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for review and approval.

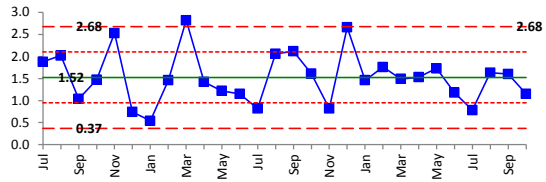
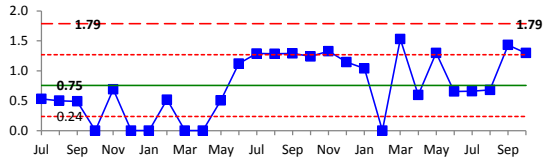
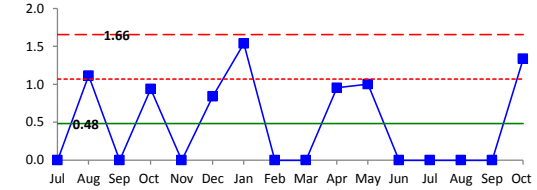
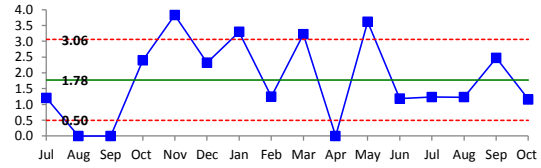
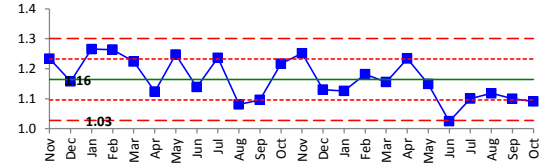
Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board and the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24 hour notice.

Approved as Revised: 11/12/14; 4/8/15

ATTACHMENT 8

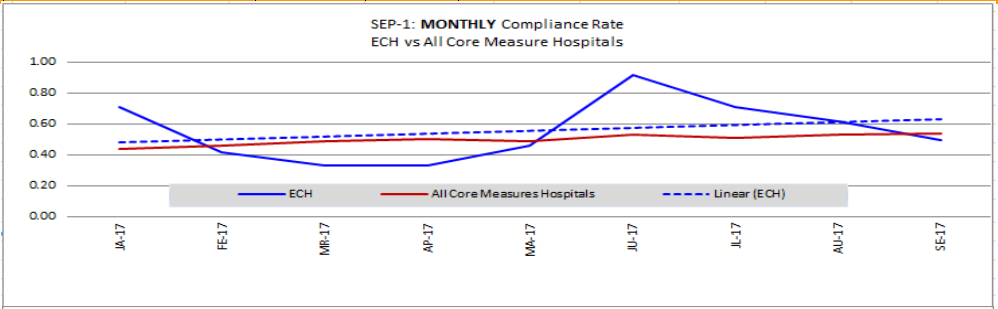
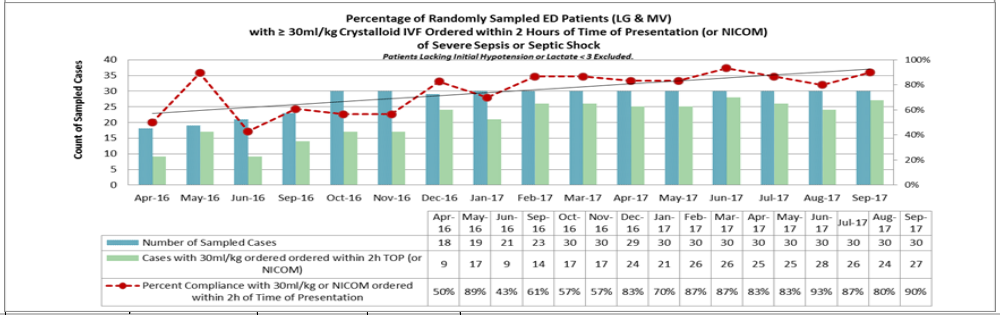
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

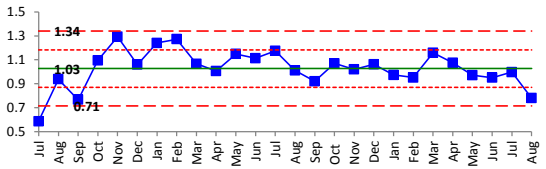
Quality and Safety Dashboard (Monthly)

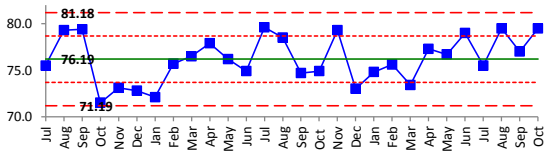
Reports run: 11/20/17			Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS	Performance Month	Performance FYTD	FY2017 Actual	FY2018 Goal		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt Days* *Date Period: Oct 2017*	1.60 (6/5,210)	1.29 (26/20200)	1.49	0.74 (Top decile CALNOC)		Review of 1st qtr. Fall data: equal # of falls on Day/Evening Shift, less than 1/2 on night shift. 55% of falls related to toileting. Team reviewing TJC recommended fall assessment tool, data showed 11% of pts who fell did not have a fall risk assessment. Issues with bed alarm settings continue, to be addressed with education at unit huddles.
2 *Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Oct 2017* *SIR Goal: <= 0.75*	1.30 (2/1,544)	1.01 (6/5,928)	1.09	SIR Goal: <= 0.75		1st Qtr 2018: 4 CAUTI (3 MV - 1 LG) 2nd Qtr. 2018: 4 CAUTI (4 MV - 0 LG) New P&P requiring daily bath/linen change implemented, All RN's receiving education on new Bard Sure-Step Foley insertion kit, Nsg. Mgrs now have access to EPIC daily foley/central line lists. Education on reducing catheter re-insertions.
3 *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Oct 2017* *SIR Goal: <= 0.50*	1.34 (1/748)	0.28 (1/3,633)	0.56	SIR Goal: <= 0.50		1 new CLABSI: 29 yr old pregnant pt w/ hyperemesis, PICC line for TPN. Blood stream infection - common skin flora. Daily bathing not done, implement Central line standard of daily CHG bath to all central lines, not just critical care.
4 *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Oct 2017* *SIR Goal: <= 0.70*	1.16 (1/8,624)	1.52 (5/32,941)	1.89	SIR Goal: <= 0.70		1st Qtr 2018: 4 C.Diff infections (4 MV - 0 LG) 2nd Qtr. 2018 1 in MV. New infection with long term ABX use and PPI use after ICU. ABX Stewardship reviewed and discussed with physicians re: PPI use.
Efficiency	Performance Month	Performance FYTD	FY17 Actual	FY 2018 Goal		
5 ★Organizational Goal **Arthimetric Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: Oct 2017*	1.09	1.10	1.16	1.11		Use of individual GMIOS from CDI reported daily and on EPIC banner for nursing/ care coordination to view and use to prioritize, has helped lower ALOS, while CDI continues to improve GMLOS through better documentation of co-morbidities. Result is better ratio.

Definitions and Additional Information

Measure Name	Definition Owner	Work Group	FY 2017 Definition	FY 2018 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		**QRR Reporting and Staff Validation**
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carso/Catherine Nalesnik		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIS were observed than predicated, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicated.		
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Catherine Carso/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)	Catherine Carso/Catherine Nalesnik				
Arithmetic Observed LOS Average over Geometric LOS Expected.	Cheryl Reinking Catherine Carson (Jessica Hatala)		ALOS (Average Length of Stay) for Medicare FFS inpatients age 65 and older Include: 1) Medicare FFS Primary Payor - 010001, 010003, or 074001; 2) Discharge Nurse Stations - LG ICU, LG Medical, LG Ortho-Spine, LG Surgical, MV CCU, MV MS Oncology, MV Medical, MV PCU, MV Surg-Peds, MV Telemetry, MV Telemetry - Stroke; Age ≥ 65; and 3) DRG specified (coded) *Exclude: 1) Discharge: Expired or left against medical advice; 2) Null Charges Flag is equal to N (patients with zero charge are excluded)*		

Reports run: 9/20/17		Baseline	FY18 Goal	Trend	Comments
6	**Sepsis Core Measure** SEP-1 100% or 0% *Date Period: Sep 2017*				Sept-1 compliance rate of 58% represents 6 failures: 2 related to Lactate, 1 late ABX, 2 related to Crystalloid fluids, 1 to septic shock focused exam.
7	**IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded) *Date Period: Sep 2017*				Ordering and giving adequate Crystalloids and the 3 hour bundle have a positive effect on the Sepsis mortality rate. Crystalloid ordering up to 90% in October, then Sepsis mortality rate down to 9.3% for 1st Qtr. 2018 and at 6.35 in October.

Mortality		Performance Month	Performance FYTD	FY 2017	FY 2018	Trend	Comments
8	**Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Aug 2017*	0.78 (1.12%/1.43%)	0.89 (1.34%/1.50%)	1.02 (1.88%/1.83%)	0.62		The work of CDI to improve clinical documentation affects the observed/expected mortality rate with improved documentation on the risk of death for each pt. The result is an O/E mortality rate of 0.89 and approaching our goal of the top decile of westeren US hospitals.

SERVICE		Performance Month	Performance FYTD	FY 2017 Actual	FY 2018 Goal	Trend	Comments
9	«Organizational Goal **HCAHPS Rate Hosptal 0-10 Top Box Rating 9 and 10** *Date Period: Oct 2017*	79.5 (186/234)	77.9 (746/958)	76.30	78.0%		The October Top Box Rating has improved to 79.5% above the Target goal of 78.

Measure Name	Definition Owner	Work Group	FY 2017 Definition	Source
Sepsis Core Measure- SEP-1: MONTHLY Compliance Rate ECH vs All Core Measure Hospitals	Catherine Carson/Kelly Nguyen	Sepsis Steering Committee	New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate > 2 or evidence of organ dysfunction, Hospital must meet ALL 4 measures in order to be compliant with this core measure, Patients with septic shock require an assessment of volume status and tissue perfusion within 6 hours of presentation, Patients NOT included are those transferred from another facility or those placed on comfort cares.	**EPIC Chart Review**
IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock (Patients lacking initial hypotension or lactate <3 excluded)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**
Mortality Rate (Observed/Expected)	Catherine Carson			**Premier Quality Advisor**
HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10	Michelle Gabriel; Cheryl Reinking	Patient Experience Committee	"'9' or '10' (high)" for the Overall Hospital Rating item	**Press Ganey Tool**

ATTACHMENT 9

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Patient and Family Centered Care Update

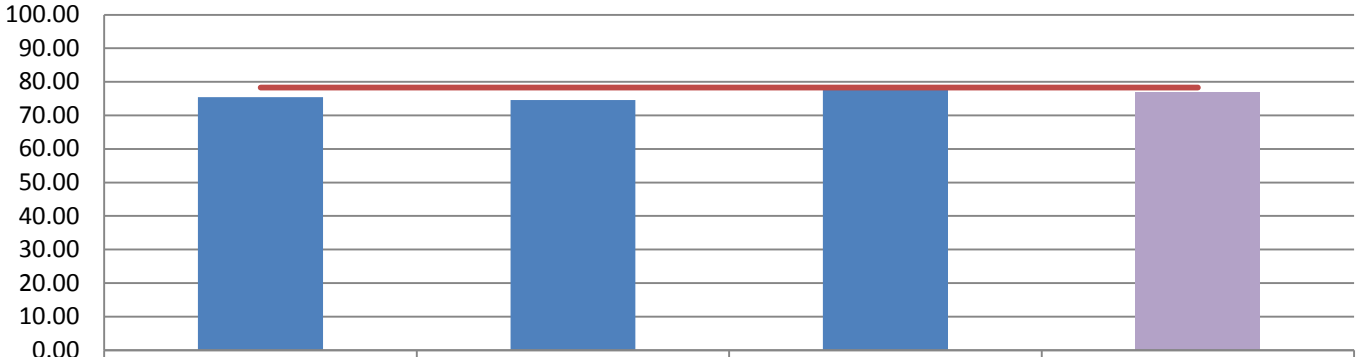
Ashlee Fontenot, Manager of Patient Experience
December 4th, 2017

Patient and Family-Centered Care Update

- Patient Experience Manager
- Improving Patient Experience
  - Nurse Communication Workgroup
    - Exploring bedside hand-off initiatives
    - Updating of whiteboards
    - Leader rounding
    - Enhanced data visualization
    - Unit recognition
  - Onsite assessment by DTA
- PFAC update

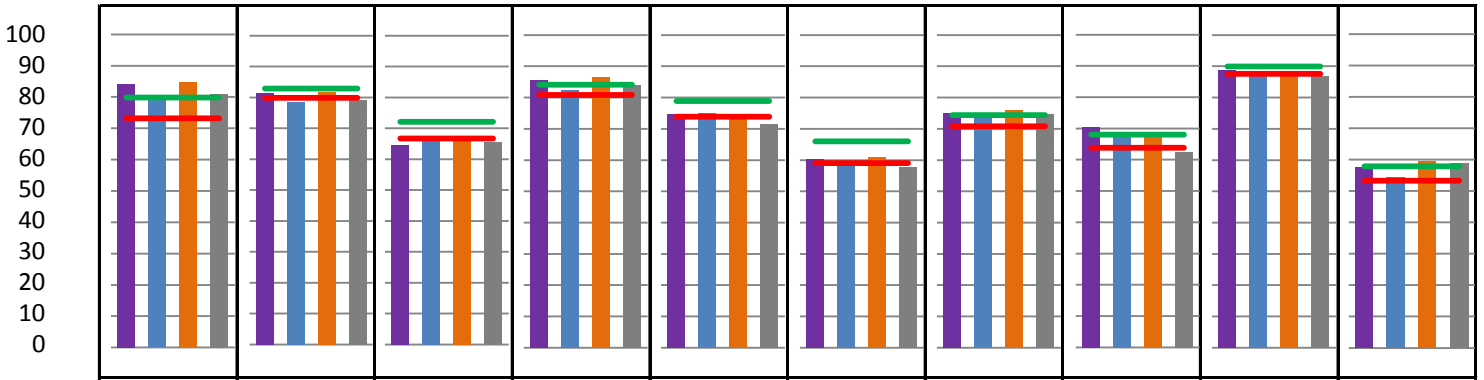
ATTACHMENT 10

ECH Enterprise HCAHPS Rate Hospital 0-10



	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	Jul - Sep 2017
Rate Hospital 0-10	75.40	74.60	77.80	76.8
Goal	78.30	78.30	78.30	78.3

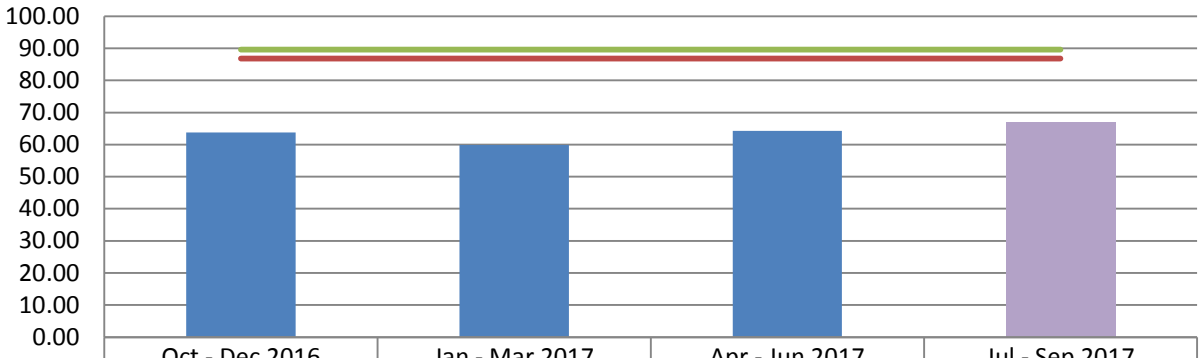
ECH Enterprise HCAHPS Individual Question



	Recomm the Hosp.	Comm w/Nurses	Resp. of Hosp Staff	Comm w/Doc	Cleaniness of Hosp Env.	Quietness of Hosp Env.	Pain Mgnt	Comm about Med.	Discharge Info	Care Transition
Oct - Dec 2016	84	81.4	64.6	85.6	74.6	60.4	75	70.5	88.7	57.6
Jan - Mar 2017	80.1	78.5	66.7	82.4	75	58.8	74.9	68.2	87.1	54.3
Apr - Jun 2017	84.6	81.7	66.4	86.5	73.7	61	75.9	67.6	87.8	59.4
Jul - Sep 2017	81	79	65.7	83.8	71.6	57.6	74.8	62.5	87	58.9
50% PG	73.2	79.9	66.7	80.8	73.9	59	70.8	63.8	87.6	53.3
75% PG	79.8	82.9	72.1	84.1	78.9	66	74.4	68	89.9	57.9

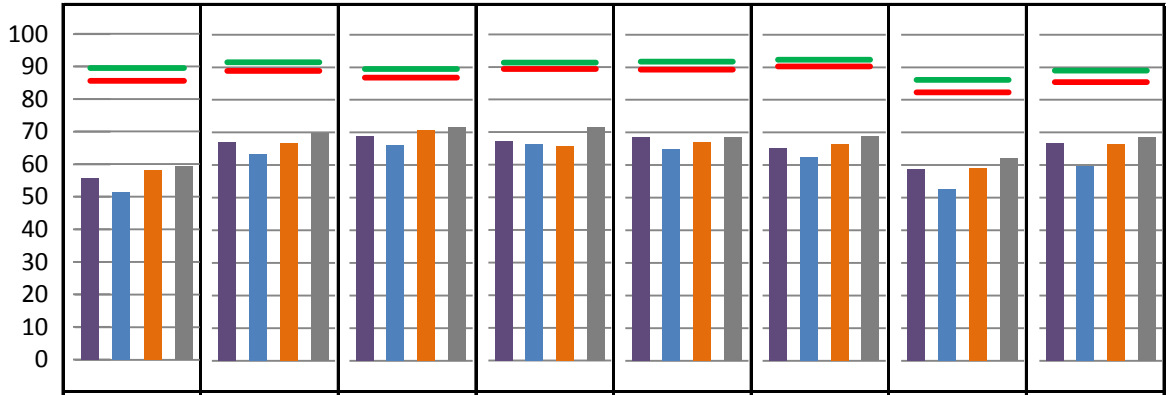
ATTACHMENT 11

ED Entertirse Overall



	Oct - Dec 2016	Jan - Mar 2017	Apr - Jun 2017	Jul - Sep 2017
Overall	63.80	59.90	64.30	66.90
50% PG	86.80	86.80	86.80	86.80
75% PG	89.60	89.60	89.60	89.60

ED Enterprise Individual Question



	Arrival	Nurses	Doctors	Tests	Family or Friends	Personal / Ins Info	Personal Issues	Overall Assessment
Oct - Dec 2016	55.70	67.00	68.90	67.30	68.50	65.20	58.80	66.60
Jan - Mar 2017	51.20	63.30	66.00	66.40	64.80	62.50	52.70	59.70
Apr - Jun 2017	58.20	66.60	70.50	65.60	67.10	66.50	59.10	66.40
Jul - Sep 2017	59.40	69.80	71.60	71.60	68.70	68.80	62.20	68.40
50% PG	85.50	88.90	86.80	89.40	89.30	90.30	82.30	85.40
75% PG	89.50	91.50	89.50	91.30	91.70	92.30	86.10	89.00

ED Question

Overall

- Arrival
  - Waiting time before noticed arrival
  - Helpfulness of first person
  - Comfort of waiting area
  - Waiting time to treatment area
  - Waiting time to see doctor
- Nurses
  - Nurses courtesy
  - Nurses took time to listen
  - Nurses attention to your needs
  - Nurses information regarding treatments
  - Nurses concern for Privacy
- Doctors
  - Doctors Courtesy
  - Doctor took time to listen
  - Doctor informative regarding treatment
  - Doctors concern for comfort
- Tests
  - Courtesy of person who took blood
  - Concern blood draw comfort
  - Waiting time for radiology test
  - Courtesy of radiology staff
  - Concern for comfort radiology test
- Family or Friends
  - Courtesy shown family/friends
  - Adequacy of info to family/friends
  - Let family/friend be with you
- Personal/Insurance info
  - Courtesy during personal/Insurance Info
  - Privacy during personal/insurance Info
  - Ease giving personal/Insurance Info
- Personal Issues
  - Informed about delays
  - Staff cared about you as person
  - How well pain was controlled
  - Information about home care
  - Safe/secure felt in ER/ED
- Overall Assessment
  - Overall rating ER care
  - Likelihood of recommending

ATTACHMENT 12

CMO Report

- David Clark has started as our new Interim Chief Operating Officer.
- Winchester opened on November 13th with Dr. Ornelas. Dr. Squarer will start on December 1st, Dr. Dudyala has signed to start in 2018.
- Construction is progressing on-time all over campus with structural steel up for the new Behavioral Health Facility.
- Volumes and revenues are up significantly from this time last year.
- The Medical Staff Office has been stabilized with three temporary workers and we have two strong prospects for the Director position.
- ECH was one of only a few bay-area hospitals to recently receive an A rating from Leapfrog.
- The American Heart and Stroke Association commended ECH in October for top performance in its Get with the Guidelines program.