AGENDA

Quality, Patient Care and Patient Experience Committee Meeting of the
El Camino Hospital Board
Monday, February 5th, 2018, 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.

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>PRESENTED BY</th>
<th>ESTIMATED TIMES</th>
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<tbody>
<tr>
<td>1. CALL TO ORDER</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>5:30 – 5:31pm</td>
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<tr>
<td>2. ROLL CALL</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>5:31 – 5:32</td>
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<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>5:32 – 5:33</td>
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<td>4. CONSENT CALENDAR ITEMS: Any Committee Member or member of the public may pull an item for discussion before a motion is made.</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>public comment Motion Required 5:33 – 5:36</td>
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<tr>
<td>Approval</td>
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<tr>
<td>a. Minutes of the Open Session of the Quality Committee Meeting (December 4, 2017)</td>
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<tr>
<td>Information</td>
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<tr>
<td>b. Research Article</td>
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<tr>
<td>c. Patient Story</td>
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<tr>
<td>d. FY18 Pacing Plan</td>
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<tr>
<td>e. Progress Against FY 2018 Committee Goals</td>
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<tr>
<td>5. REPORT ON BOARD ACTIONS ATTACHMENT 5</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Discussion 5:36 – 5:39</td>
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<tr>
<td>7. WENDY RON’S STORY ATTACHMENT 7</td>
<td>Wendy Ron, Quality Committee Member</td>
<td>Discussion 5:59 – 6:09</td>
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<tr>
<td>8. UPDATE ON PATIENT AND FAMILY CENTERED CARE ATTACHMENT 8</td>
<td>Ashlee Fontenot, Manager of Patient Experience</td>
<td>Discussion 6:09 – 6:19</td>
</tr>
<tr>
<td>9. FY18 QUALITY DASHBOARD ATTACHMENT 9</td>
<td>Catherine Carson, Sr. Director of Quality Improvement and Patient Safety</td>
<td>Discussion 6:19 – 6:29</td>
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<tr>
<td>10. READMISSION DASHBOARD ATTACHMENT 10</td>
<td>Catherine Carson, Sr. Director of Quality Improvement and Patient Safety</td>
<td>Discussion 6:29 – 6:39</td>
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</table>

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.
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<th>AGENDA ITEM</th>
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<tbody>
<tr>
<td>11. PSI-90 PT. SAFETY INDICATORS</td>
<td>Catherine Carson, Sr. Director of Quality Improvement and Patient Safety</td>
<td>Discussion 6:39 – 6:49</td>
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<td>ATTACHMENT 11</td>
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<td>12. QUALITY RATINGS</td>
<td>Catherine Carson, Sr. Director of Quality Improvement and Patient Safety</td>
<td>Discussion 6:49 – 6:54</td>
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<td>ATTACHMENT 12</td>
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<td>13. OPIOIDS USAGE DISCUSSION</td>
<td>William Faber, MD, Chief Medical Officer</td>
<td>Discussion 6:54 – 7:09</td>
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<td>ATTACHMENT 13</td>
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<td>14. CMO REPORT</td>
<td>William Faber, MD, Chief Medical Officer</td>
<td>Discussion 7:09 – 7:14</td>
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<td>ATTACHMENT 14</td>
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<td>15. PUBLIC COMMUNICATION</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Information 7:14 – 7:17</td>
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<td>16. ADJOURN TO CLOSED SESSION</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:17 – 7:18</td>
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<tr>
<td>17. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>7:18 – 7:19</td>
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<tr>
<td>18. CONSENT CALENDAR</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:19 – 7:22</td>
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<tr>
<td>Any Committee Member may pull an item for discussion before a motion is made.</td>
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<td>Approval</td>
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<td>Gov’t Code Section 54957.2.</td>
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<tr>
<td>a. Minutes of the Closed Session of the Quality Committee Meeting (December 4, 2017)</td>
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<td>Information</td>
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<td>b. Quality Council Minutes (November 1, 2017)</td>
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<td>19. Health and Safety Code Section 32155, report related to Medical Staff quality assurance matters:</td>
<td>William Faber, MD, Chief Medical Officer</td>
<td>Discussion 7:22 – 7:27</td>
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<td>- Red/Orange Alert and RCA Updates</td>
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<td>20. ADJOURN TO OPEN SESSION</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:27 – 7:28</td>
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<td>21. RECONVENE OPEN SESSION/REPORT OUT</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>7:28 – 7:29</td>
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<td>To report any required disclosures regarding permissible actions taken during Closed Session.</td>
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<td>22. ADJOURNMENT</td>
<td>Dave Reeder, Quality Committee Chair</td>
<td>Motion Required 7:29 – 7:30pm</td>
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**Upcoming FY18 Meetings**
- March 5, 2018
- April 2, 2018
- April 30, 2018
- June 4, 2018

**Upcoming Board & Educational Committee Gatherings**
- April 25, 2018
Minutes of the Open Session of the Quality, Patient Care and Patient Experience Committee Meeting of the El Camino Hospital Board
Monday, December 4, 2017
El Camino Hospital, Conference Rooms A&B
2500 Grant Road, Mountain View, California

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

*Melora Simon joined the meeting via teleconference
A quorum was present at the El Camino Hospital Quality, Patient Care, and Patient Experience Committee on the 4th of December, 2017 meeting.

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<thead>
<tr>
<th>Agenda Item</th>
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<tbody>
<tr>
<td>1. CALL TO ORDER</td>
<td>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 5:35 p.m.</td>
<td>None</td>
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<td>2. ROLL CALL</td>
<td>Chair Reeder asked Michele Lee to take a silent roll call. Melora Simon joined the meeting via teleconference and Dr. Peter Fung was absence.</td>
<td>None</td>
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<tr>
<td>3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</td>
<td>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.</td>
<td>None</td>
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<td>4. CONSENT CALENDAR ITEMS</td>
<td>Chair Reeder asked if any Committee member wished to remove any items from the consent calendar for discussion. No items were removed.</td>
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Motion: To approve the consent calendar: Minutes of the Open Session of the Quality Committee Meetings (October 2, 2017 and October 30, 2017).
Movant: Davis
Second: Carragee
Ayes: Anderson, Bauman, Bunce, Carragee, Davis, Reeder, Ron, Simon
Noes: None
Abstentions: None
Absent: Fung
Excused: None
Recused: None
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<tr>
<td><strong>5. REPORT ON BOARD ACTIONS</strong></td>
<td>Chair Reeder briefly reviewed the Board Report as further detailed in the packet with the Committee.</td>
<td>None</td>
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<td><strong>6. QUALITY PROGRAM UPDATE: UROLOGY</strong></td>
<td>David King, MD, Co-Medical Director for Urology Services, provided an overview of El Camino’s Urology/Men’s Health Service Line. Urological Care has a strong history of at Los Gatos Campus beginning with original HM3 Lithotripter (stones) back in 1984. The service line is an Acknowledged Center of Urology Excellence within the medical community of the South Bay Area. Dr. King reported that the inpatient and outpatient urology surgical volume increased year over year. ECHLG treats on average 750 stone patients per year using two different stone treatment options: Extracorporeal Shock Wave Lithotripsy (ESWL) or Intracorporeal Laser Lithotripsy (ISWL). Also stating the high volume of a non-invasive radiation therapy called Radioactive seed implants for prostate cancer. Dr. King briefly reviewed about the new technology being utilized: Artemis Prostate Biopsy to detect prostate cancer and Blue Light Cystoscopy for bladder tumors. ECH is the first hospital in the Bay Area doing Blue Light Cystoscopy. Dr. King further updated the Committee on the accomplishments by stating ECH being the busiest Center for treating kidney and urinary stones in Northern California, having the highest volume (outside Kaiser) for prostate radioactive seed implant cases, being the leading hospital for men’s health surgery with the first successful Comprehensive Men’s Health program in California, the facility is a Proctorship Center for prostate laser surgery, and the 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. Dr. King asked for feedback and questions from the Committee and a brief discussion ensued.</td>
<td>None</td>
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<td><strong>7. COMMITTEE MEMBER RECRUITMENT</strong></td>
<td>Chair Reeder discussed the committee recruitment with the Committee. They reviewed the charter regarding the possibility of new member(s) from a different background aside from medical. The consensus is to not pursue the recruitment at this current time.</td>
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<td><strong>8. FY18 QUALITY DASHBOARD</strong></td>
<td>Catherine Carson, Sr. Director/Chief Quality Officer, reviewed the new quality dashboard with the committee.</td>
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<td>9. UPDATE ON PATIENT AND FAMILY CENTERED CARE</td>
<td>Ashlee Fontenot, RN, Manager of Patient Experience, updated the committee on the Patient and Family-Centered Care: Improving Patient experience through Nurse Communication Workgroups and Onsite Assessment by DTA. Ms. Fontenot asked the Committee members for feedback and a brief discussion ensued.</td>
<td>None</td>
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<tr>
<td>10. PT. EXPERIENCE (HCAHPS)</td>
<td>Michelle Gabriel, Director of Performance Improvement, shared the ECH Enterprise HCAHPS rate is at 76.8 for the quarter Jul-Sept 2017 with a slight decrease of last quarter rate of 77.8. Noting that we are still below our goal of 78.3. Michelle further explained that each individual question for HCAHPS all trended slightly downwards for this quarter.</td>
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<td>11. ED PATIENT SATISFACTION (PRESS GANEY)</td>
<td>Michelle Gabriel, Director of Performance Improvement, explained that the quarter of Jul-Sept 2017 for Patient Satisfaction in our ED Department has increased since</td>
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| 12. CMO REPORT | William Faber, MD, Chief Medical Officer, reviewed his CMO report with the Committee. Items of note for the month included:  
- New Interim Chief Operating Officer, David Clark has started at ECH.  
- November 13, Winchester property opened with Dr. Ornelas, Dr. Squarer stared on December 1 and Dr. Dudyala will start in 2018.  
- 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. | None |
| 13. PUBLIC COMMUNICATION | None. | None |
| 14. ADJOURN TO CLOSED SESSION | **Motion:** To adjourn to closed session at 7:00 p.m.  
**Movant:** Anderson  
**Second:** Bunce  
**Ayes:** Anderson, Bauman, Bunce, Carragee, Davis, Reeder, Ron, Simon  
**Noes:** None  
**Abstentions:** None  
**Absent:** Fung  
**Excused:** None  
**Recused:** None | **Adjourned to closed session at 7:00 p.m.** |
| 15. AGENDA ITEM 19: RECONVENE OPEN SESSION/REPORT OUT | Open Session was reconvened at 7:05 pm.  
Agenda Items 15 – 18 were addressed in closed session. |  |
| 16. AGENDA ITEM 20: ADJOURNMENT | The meeting was adjourned at 7:05 p.m.  
**Motion:** To adjourn at 7:05 p.m.  
**Movant:** Carragee  
**Second:** Anderson  
**Ayes:** Anderson, Bauman, Bunce, Carragee, Davis, Reeder, Ron, Simon  
**Noes:** None  
**Abstentions:** None  
**Absent:** Fung  
**Excused:** None  
**Recused:** None | **Meeting adjourned at 7:05 pm** |
Attest as to the approval of the foregoing minutes by the Quality Committee of El Camino Hospital

____________________________
Dave Reeder
Chair, ECH Quality, Patient Care and Patient Experience Committee
What is Interventional Radiology?

"Interventional Radiology" (IR) is a medical specialty which rely on the use of radiological image guidance (X-ray fluoroscopy, ultrasound, computed tomography or magnetic resonance imaging) to precisely target therapy. Most IR treatments are minimally invasive alternatives to open and laparoscopic (keyhole) surgery. Many IR procedures start with passing a needle through the skin to the target which is why it is called pinhole surgery.

The essential skills of an Interventional Radiologist are in diagnostic image interpretation and the manipulation of needles and the use of fine catheter tubes and wires to navigate around the body under imaging control. Interventional Radiologists are doctors who are trained in diagnostic radiology and interventional therapy. No other specialty possesses this unique combination of skills.

There is hardly any area of medicine where IR has not had some impact on patient management.

The range of conditions which can be treated by IR is vast and continually expanding. Well recognised advantages of these minimally invasive techniques include reduced risks, shorter hospital stays, lower costs, greater comfort, quicker recovery and return to work. The effectiveness of treatment is often better than with traditional treatments.

Blood vessel disease

Arteries (peripheral vascular disease)

Narrowing of arteries: leads to restricted blood flow (peripheral vascular disease): Interventional radiologists treat this by using balloons to stretch the vessel (balloon angioplasty, PTA) and sometimes metal springs called stents to hold them open. Sometimes arteries or bypass grafts block suddenly with a rapid loss of blood supply to the limb, which is a medical emergency. Unless the blood supply is restored quickly, this can lead to amputation. Interventional radiologists can help by infusing clot busting drugs directly into the artery via small catheters thus saving many limbs in a time critical environment.

Expanded arteries (aneurysms) at risk of rupture and bleeding. IR treats these by covering the blood vessel with a tube called a stent graft. At El Camino Hospital, we offer our patients the most advanced techniques for repairs of aneurysm, including special custom
made graft with special holes and branching limbs to maintain the perfusion of the normal organs, while excluding the aneurysm.

Fig1. Fenestrated endograft: it has special holes within the graft to maintain the blood flow to kidneys and intestine.

Bleeding: This is the most common vascular emergency treated by IR. Bleeding can come from almost anywhere such as from the gut, secondary to major injury or following birth. Bleeding can often permanently be stopped by blocking the vessel (embolization), relining the vessel with a stent graft or by blowing up a balloon in the vessel to stop the bleeding until emergency surgery can be performed. IR is also used to prevent bleeding during surgery such as during caesarean section in patients with a high risk of bleeding from an abnormal placenta (post partum bleeding).

fig2: Duodenal ulcer with active bleeding (arrow) and resolution of the bleeding with embolization.

Veins

Blood clots in the lung (pulmonary embolism): interventional radiologists can place a filter in the inferior vena cava to capture blood clots before they reach the lung preventing further PE. When there is a massive embolus causing collapse, IR may use small catheter tubes to break up the blood clot and restore blood flow.

Blocked veins: this can occur in the context of blood clot in the veins (venous thrombosis, DVT) which is sometimes treated by the injection of clot busters (thrombolysis) through a small catheter passed into the vein. Some patients develop blood clots as a result of a narrowing in a vein which could require placement of a stent

Dilated veins (varicose veins): these most commonly occur in the legs but can occur in the pelvis or scrotum, causing pain. These can be treated by blocking the vein by heat treatment (laser or microwave) or by the use of irritant drugs and embolization techniques.

Interventional Oncology

Interventional Oncology is a subspecialty where IR techniques are used to diagnose and treat tumors in patients with cancer.
Tumor targeted treatments are intended to shrink or destroy tumors at their primary site or metastasis. Targeted tumor treatment is an area of increasing advancement leading to longer patient survival and reduced morbidity.

**Biopsies:** the first step in management of any patient with cancer is to obtain an adequate diagnosis with a tissue biopsy. Today, is not enough to know the type of cancer (lung, colon…), but we need to know complete genetic components of the tumor, so the best treatments can be used.

**Tumor Embolization:** a small catheter is inserted through blood vessels using live x-rays. The catheter can travel all the way to a specific tumor. With the catheter in the correct position chemotherapy or radiation beads can be injected directly into the tumor, therefore minimizing side effects of the full body treatment.

**Tumor ablation (liver, kidney bone, lung):** IR uses destructive therapies usually involving heat (radiofrequency, laser, microwave, ultrasound) or cold damage (cryotherapy). The treatment is performed and monitored using imaging (ultrasound, computed tomography or magnetic resonance imaging). A small needle is precisely inserted into the tumor to destroy it.

**Fibroids and Prostate therapies**

**Uterine fibroids:** heavy menstrual bleeding and pain can be caused by benign tumors called fibroids. These can be treated by blocking blood vessels (uterine fibroid embolization, UFE) which leads to shrinkage of the fibroid and improvement of the symptoms.

**Prostate Embolization:** 50% of men over the age of 60 will have symptoms of benign prostatic hyperplasia (BPH) including frequent urination and urinary retention. Patient who are not surgical candidates or do not want surgery can undergo embolization. This is a minimally invasive procedure in which we block the blood flow to the prostate causing it to shrink, with minimal recovery time.

**Feeding Tubes**
Gastrostomy tubes: are tubes inserted in the stomach for patients with swallowing problems to have nutrition. These are placed using fluoroscopy.

Gastro-jejunostomy tubes: are longer tubes that are advanced into the small bowel under x-ray navigation and can provide nutrition in patients with stomach or pancreas problems.

Spine interventions and pain management

Kyphoplasty: patients with compression fractures of the spine can take months to recover. Interventional Radiologists can inject cement directly into the fracture, expediting healing and making pain better faster.

Nerver blocks: guided by x-rays or a CT scan, medications can be injected directly into painful nerves, reducing the need or narcotics or even surgery.

Pain pumps: these are some of the most sophisticated devices in use. They are very accurate pumps which inject very small doses of narcotics directly into the spinal fluid.

Other Problems

Kidney stones: are not uncommon and cause pain, infection and blockage of the kidney. IR techniques include placing a tube in the kidney (nephrostomy) to allow the urine to drain and removing the stones using a variety of instruments placed through the skin into the kidney.

Gallstones: are one of the most common upper abdominal disorders. Most are dealt with by laparoscopic surgery. When stones or tumor stop bile from draining normally, which causes jaundice, this is usually treated via a telescope passed down the throat (endoscopy) but sometimes requires an Interventional Radiologist to perform drainage by placing catheters through the liver to either remove the stones or place stents to allow proper drainage.
November 2, 2017

Mr. Dan Woods
CEO, El Camino Hospital
2500 Grant Road
Mountain View, CA 94040

Dear Mr. Woods:

I was admitted to ECH this week for a bilateral pulmonary embolism. I just wanted to commend some of the wonderful nurses and staff members on their treatment of patients. Not only were they very professional and efficient, they were extremely pleasant and caring. That is particularly appreciated when someone is in such a vulnerable situation.

Heather Frazee, Ailee Davidson and Madonna Garcia (all in the Tele/Strobe Unit) were particularly comforting and encouraging. But everyone that took care of me for the two days I was there were so helpful and nice I would like to thank them all.

In addition, I particularly wanted to give a special thank you to Claudia O'Connor who was very instrumental in helping me get admitted appropriately. Her obvious concern was extremely appreciated by me.

Kim-Yen Nguyen, PharmD, spent considerable time with me explaining all of the choices and the pros and cons of each. She also went out of her way to assist with the pricing of the meds. She was always willing and able to answer any of my questions.

Linda Huynh, MD, was very helpful in explaining my medical situation and how to deal with it going forward. I appreciate her concern and prompt responses.

Candace J. Larson

cc: Chief Nursing Officer, Cheryl Reinking
    Lotta Alba (ED)
    Jennifer Borrelli (Telemetry/Strobe Unit)
## FY2018 Q1

**JULY 2017**

- 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

**AUGUST 7, 2017**

**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

**August 28, 2017**

(for September’s meeting)

**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 (HCA HPS)
3. ED Pt. Satisfaction (Press Ganey)
4. ECH Strategic Framework

## FY2018 Q2

**OCTOBER 2, 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)

**OCTOBER 30, 2017**

(for November’s 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. 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

**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. Pt. Experience (HCA HPS)
3. ED Pt. Satisfaction (Press Ganey)
4. Committee member recruitment
## QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE

### FY 18 Pacing Plan

### FY2018 Q3

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<th>JANUARY 2018</th>
<th>FEBRUARY 5, 2018</th>
<th>MARCH 5, 2018</th>
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### FY2018 Q4

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<th>APRIL 2, 2018</th>
<th>APRIL 30, 2018 (for May's meeting)</th>
<th>JUNE 4, 2018</th>
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(4/25 – Joint Board and Committee Session)
**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.*

<table>
<thead>
<tr>
<th>GOALS</th>
<th>TIMELINE by Fiscal Year (Timeframe applies to when the Board approves the recommended action from the Committee, if applicable)</th>
<th>METRICS</th>
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</thead>
</table>
| 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 Q4 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 Q3 FY18 | Review the plan and approve |
| 5.    | Monitor the impact of interventions to reduce hospital-acquired infections. | Quarterly | Review process toward meeting quality |
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
| Item: | Report on ECH and ECHD Board Actions  
Quality Committee Meeting  
Meeting Date: February 5, 2018 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible party:</td>
<td>Cindy Murphy, Director of Governance Services</td>
</tr>
<tr>
<td>Action requested:</td>
<td>For Information</td>
</tr>
<tr>
<td>Background:</td>
<td>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 and/or Board members who also serve on the Committee.</td>
</tr>
<tr>
<td>Other Board Advisory Committees that reviewed the issue and recommendation, if any:</td>
<td>None.</td>
</tr>
<tr>
<td>Summary and session objectives:</td>
<td>To inform the Committee about recent Board actions.</td>
</tr>
<tr>
<td>Suggested discussion questions:</td>
<td>None.</td>
</tr>
<tr>
<td>Proposed Committee motion, if any:</td>
<td>None. This is an informational item.</td>
</tr>
<tr>
<td>LIST OF ATTACHMENTS:</td>
<td>Report on ECH and ECHD Board Actions</td>
</tr>
</tbody>
</table>
November 2017 and January 2018 ECH Board Actions*

1. January 10, 2018
   a. Recognized the Los Gatos Operations team for increasing personalized service to physicians and patients.
   b. Approved the FY18 Period 3 and Period 4 Financials.
   c. Approved the Letters of Rebuttable Presumption of Reasonableness (related to Executive Compensation)
   d. Approved the FY18 Salary Range for the new President, SVMD position and its inclusion in the Executive Compensation and Benefits Plans
   e. Approved physician contracts for Ophthalmology Call Coverage, Gastroenterology ED Call, and OB Hospitalist Coverage
   f. Approved the Amended & Restated Limited Liability Company Operating Agreement of Silicon Valley Medical Development, LLC (SVMD)

October 2017 ECHD Board Actions*

1. January 16, 2018
   a. Elected Gary Kalbach and Julie Kliger, RN to the El Camino Hospital Board of Directors. Their terms are effective immediately. Mr. Kalbach’s term expires on June 30, 2021 and Ms. Kliger’s term expires on June 30, 2020.

*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.
IR procedures @ El Camino Hospital
Procedures

<table>
<thead>
<tr>
<th>Category</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>53</td>
<td>75</td>
</tr>
<tr>
<td>Inpatient</td>
<td>1011</td>
<td>1065</td>
</tr>
<tr>
<td>Outpatient</td>
<td>1751</td>
<td>2046</td>
</tr>
<tr>
<td>Total</td>
<td>2815</td>
<td>3186</td>
</tr>
</tbody>
</table>

VASCULAR AND INTERVENTIONAL RADIOLGY CLINIC
What do we do?
 WITHOUT A SCALPEL 

THE TECHNOLOGY AND PEOPLE BEHIND MODERN SURGERY
Interventional Oncology

65M with weight loss and abdominal pain
Interventional Oncology

Biopsy → Access for chemo → Chemoembo

Poor response → Radioembolization → Response

Ascites → Paracentesis → Pleurx catheter → Denver Shunt
Biopsies

- Liver Mass: 45
- Transjugular Liver biopsy: 6
- Medical Liver: 12
- Lung: 71
- Thyroid: 12
- Medical Renal: 4
- Renal Mass: 12
- Mediastinal: 6
- Cervical Mass: 3
- Lymph node groin: 5
- Lymph node axilla: 5
- Retropertoneal: 2
- Pancreatic: 3
- Mesenteric: 6
- Pelvic Mass: 14
- Soft tissue mass: 10
- Bone Lesion: 28
- Bone Marrow: 37
- Other: 53
Y90 - Radioembolization
Chemoembolization
Ablations
68M with Metastatic Melanoma - Single met
Cryoablation Renal Cancer
Complex Arterial Disease
Mesenteric disease/aneurysms
Renal Artery Aneuysm
Pulmonary Embolism
IVC filters
Massive DVT
DVT
33F with protein S deficiency and SVC syndrome
After thrombolysis + angiogjet + PTA
Venous Access
Foreign bodies
Feeding Tubes
Biliary Drainages/Stents
TIPS
Dialysis Access
Urology Interventions

- The stent starts here. Urine drains into it to leave the kidney.
- The stent allows urine to bypass a blockage.
- The stent ends here. Urine drains out of it, into the bladder.
Chest Tubes (PTX, Empyema)
Acute Vertebral Compression Fractures
Spine Procedures
Pain Pumps
Fibroids/Post partum Bleeding
GI Bleeding
Embolizations

- Carotid body tumor
- Base of the tongue CA
- Bleeding renal tumor
- Meningioma
- Prostate
- Lung Bleeding
BPH
Prostate Embolization
How Does IR Improve Care and Quality?

- Inpatient procedures typically performed ≤24 hours
  Reduces LOS
- Most procedures done on outpatient basis
  Puncture or small incision
  Moderate sedation with local anesthesia
- Effective non-surgical treatments
  Tumors, bleeding, PE, abscesses, DVT, arterial occlusion,…
IR Programatic Development

- Initiatives to enhance patient satisfaction and further improve patient care quality
- Understand outcomes and compare to benchmarks
Initiatives to Improve Patient Care Quality

- Develop IR preop protocols to assess patient’s suitability for treatment, avoid unnecessary and prolonged use of beds
- Develop antibiotic prophylaxis protocols to prevent surgical site infections
- Educate staff and Create decision tree to help guide floor nurses in making appropriate communication for patient care.
My Patient Journey:

Wendy Ron
Nurses are the nicest,
Karen greets me at the desk.
She finds me the nicest room,
So I can get lots of rest.

Anne Higa helps with transfusions,
And unties my lines.
Since nurses are the nicest,
I can count on her anytime.

Nurses are the nicest,
Cesar answers all my calls.
And when patients really need it,
He rushes to them through the halls.

Miradel's delightful,
She really is just that.
Nurses are the nicest,
Please give them the right hats.

Nurses are the nicest,
Brenda is so dear.
She is supportive and so thoughtful,
For my kidney she does cheer.

Liz Pretends she's angry,
But really it's a game.
Because nurses are the nicest,
I'm glad she's in my life again.

Nurses are the nicest,
They like Disney too.
Lora Lee loves Mickey,
Alice,
B Buzz and Winnie the Pooh.

Hannah is Macgyver,
She can craft anything.
'Cause nurses are the nicest,
Who knows what her skills will bring.

Nurses are the nicest,
They also have great appetites.
As long as Irene gets some muffins,
There won't be any fights.

Bre's a little mischievous,
She lets me put eyeballs on the tugs.
But since nurses are the nicest,
She's also great for hugs.

Lora Lee loves Mickey,
Alice,
B Buzz and Winnie the Pooh.

Mabel's the night ninja,
She medicates my dreams.
Because nurses are the nicest,
Through her whole shift I sleep it seems.

Kawa is so friendly,
Her infusions I don't mind.

Mabel's the night ninja,
She medicates my dreams.
Because nurses are the nicest,
Through her whole shift I sleep it seems.

Brenda is so dear.
She is supportive and so thoughtful,
For my kidney she does cheer.

Michelle is friendly and kind,
She dotes on everyone who's sick.

Kristy is my homegirl,
She takes good care of me.
These nurses are the nicest,
I can't believe I'm free!
Impression:
1. Status post left nephrectomy.
2. Normal right kidney.
Patient and Family-Centered Care Update

• **Nurse Communication Workgroup**
  - Working with MBU and 4A on bedside hand-off
  - Will be working with 3B and PCU on hourly rounding
  - Trophies ordered for monthly roving nursing unit awards
  - Thank you discharge cards
  - Joy Committee
  - Getting to Know You Project
  - Nurse Listening Toolkit

• **Data**
  - Daily files to Press Ganey
  - Reviewing data processes

• **DTA assessment complete**--PE Steering Committee will be looking at prioritization:
  - Data
  - Rounding
  - Care team coaching
## Quality and Safety Dashboard (Monthly)

### SAFETY EVENTS

<table>
<thead>
<tr>
<th>Event</th>
<th>Performance</th>
<th>Baseline</th>
<th>Trend</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Falls</strong>&lt;br&gt;Med / Surg / CC Falls / 1,000 CALNOC Pt. Days</td>
<td>FYTD 1.13 (32/5496)</td>
<td>FY2017 Actual 1.26 (32/5496)</td>
<td>FY2018 Goal 1.49</td>
<td>Only 14 instances of mild injury (flu x-ray, laceration etc.)&lt;br&gt;81 did not have Fall Risk Assessment, most were bathroom related, 1/4 were assisted falls, and 1/4 were while ambulating. Reasons for Falls: bed alarm not set, patient confused, change in pt's condition (lightheaded, dizzy), family assisting pt. to bathroom or pt fell with Pt. Safety Aids. Committee recognizing units who achieved zero falls for 1 year, 30-60-90-120 days without a pt.fall.</td>
</tr>
<tr>
<td><strong>Hospital Acquired Infection</strong>&lt;br&gt;Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 urinary catheter days</td>
<td>FYTD 1.33 (29/235)</td>
<td>FY2017 Actual 1.1 (10/8735)</td>
<td>FY2018 Goal 1.09</td>
<td>No new CLABSI infections in December! CLABSI Team adopted Central Line Mgmt. Bundle from Lippincott. All nurses will have 1/1 Peer education on CLABSI dressing changes with their patient, new CLABSI Dressing Kit developed with coaching cards. Adoption of CHG bath best practice for all Central lines in all locations, dressing change to move from every Sunday to every 7 days (best practice).&lt;br&gt;No new C.Diff infections in Dec. Alert to nursing in EPIC to begin contact isolation when order placed for C.Diff Lab test. Development of &quot;Bristol&quot; stool scale to assist nursing with stool contact isolation when order placed for C.Diff lab test. Recommendation approved to Steering Committee to increase EVS staffing to utilize Xenex Ultraviolet machines on all isolation rooms, expand to Imaging and Cath Lab.</td>
</tr>
<tr>
<td><strong>Central Line Associated Blood Stream Infection (CLABSI)</strong> per 1,000 central line days</td>
<td>FYTD 0.0 (0/878)</td>
<td>FY2017 Actual 0.38 (2/5319)</td>
<td>FY2018 Goal 0.56</td>
<td>No new CAUTI’s in Dec: a. 71 y/o female on medical floor for 21 days. Good bathing/C, pericare documented, related to insertion. B. 57 y/o female in critical care, Foley insertion w/ MD order, related to insertion, good bathing, pericare, F/C documentation. All OR, PACU, Critical staff have taken new Foley kit and insertion education. Now to be assigned to remaining nursing staff.</td>
</tr>
<tr>
<td><strong>Clostridium Difficile Infection</strong> (CDI) per 10,000 patient days</td>
<td>FYTD 0.0 (0/8632)</td>
<td>FY2017 Actual 1.01 (5/49,491)</td>
<td>FY2018 Goal 1.89</td>
<td>Use of individual GMLOS 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. CDI has met with Orthopedic &amp; HVI Surgeons to explain need for documentation of patient's co-morbidities.</td>
</tr>
</tbody>
</table>

### Efficiency

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Performance</th>
<th>FY2017 Actual</th>
<th>FY2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arithmetic Observed LOS</strong>&lt;br&gt;Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)</td>
<td>FYTD 1.07</td>
<td>FY2017 Actual 1.10</td>
<td>FY2018 Goal 1.16</td>
</tr>
</tbody>
</table>

*(Medicare definition, MS-CC, Inpatient)*<br>Date Period: Nov 2017
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Definition Owner</th>
<th>Work Group</th>
<th>FY 2017 Definition</th>
<th>FY 2018 Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Falls</td>
<td>Sheetal Shah; Cheryl Reinking</td>
<td>Falls Committee</td>
<td>All Med/Surg/CC falls reported to CALNOC per 1,000 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.</td>
<td></td>
<td>QRR Reporting and Staff Validation</td>
</tr>
<tr>
<td>Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)</td>
<td>Catherine Carson/Catherine Nalesnik</td>
<td></td>
<td>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 predicted, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)</td>
<td>Catherine Carson/Catherine Nalesnik</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)</td>
<td>Catherine Carson/Catherine Nalesnik</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arithmetic Observed LOS Average over Geometric LOS Expected.</td>
<td>Cheryl Reinking</td>
<td></td>
<td>The Observed LOS over the Expected LOS Ratio is determined by calculating the average length of stay of all Medicare financial class divided by the GMLOS (geometric LOS associated with each patient’s MD-DRG).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Sepsis Core Measure**

SEP-1 100% or O%

*Date Period: Nov 2017*

First time since this core measure began, ECH achieved 100% compliance with the Sep-1 measure.

**IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock** (Patients lacking initial hypotension or lactate <3 excluded)

*Date Period: Nov 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 November, then Sepsis mortality rate down to 11% for 1st Qtr. 2018. ECH applying for TJC Disease-specific Certification for the Sepsis program in January 2018.

**Mortality**

<table>
<thead>
<tr>
<th>Performance</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>FYTD</td>
<td></td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>0.63</td>
<td>0.86</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1.0</th>
<th>1.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>FYTD</td>
<td></td>
</tr>
<tr>
<td>Date Period: Oct 2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 0.63 and approaching our goal of the top decile of western US hospitals.

**Service**

<table>
<thead>
<tr>
<th>Performance</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>FYTD</td>
<td>Goal</td>
</tr>
<tr>
<td>«Organizational Goal»</td>
<td>78.7</td>
<td>77.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>81.87</th>
<th>76.80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>FYTD</td>
<td>Goal</td>
</tr>
<tr>
<td>Date Period: Dec 2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The data is now by "received date" so we are able to report December 2017; now at 78.7%, and close to the Maximum goal achievement of 79%.
<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Definition Owner</th>
<th>Work Group</th>
<th>FY 2017 Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sepsis Core Measure: SEP-1: MONTHLY Compliance Rate ECH vs. All Core Measure Hospitals</strong></td>
<td>Catherine Carson/Kelly Nguyen</td>
<td>Sepsis Steering Committee</td>
<td>New Core Measure from Oct. 2015. Severe sepsis is defined as sepsis plus a lactate &gt; 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.</td>
<td>EPIC Chart Review</td>
</tr>
<tr>
<td><strong>IVF Bolus Ordered within 2 Hours of TOP of Severe Sepsis or Septic Shock</strong></td>
<td>Catherine Carson</td>
<td></td>
<td>Percentage of Randomly Sampled ED Patients (LG &amp; MV) who had IVF &gt;=30 ml/kg ordered within 2 Hours of Time of Presentation of Severe Sepsis or Septic Shock (Patients Lacking Initial Hypotension or Lactate &lt;3 Excluded)</td>
<td>EPIC Chart Review</td>
</tr>
<tr>
<td><strong>Mortality Rate (Observed/Expected)</strong></td>
<td>Catherine Carson</td>
<td></td>
<td></td>
<td>Premier Quality Advisor</td>
</tr>
<tr>
<td><strong>HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10</strong></td>
<td>Michelle Gabriel; Ashley Fontenot Cheryl Reinking</td>
<td>Patient Experience Committee</td>
<td>&quot;‘9’ or ‘10’ (High)&quot; for the Overall Hospital Rating Item</td>
<td>Press Ganey Tool</td>
</tr>
</tbody>
</table>
## FY 2018 Organizational Goal: Reduce Hospital-Acquired Infections (HAI)

### Update: 1-22-2018

<table>
<thead>
<tr>
<th>HAI</th>
<th>Enterprise Goal NHSN SIR*</th>
<th>NSHN: Predicted Number of HAI to Meet SIR Goal</th>
<th>FY 2018 1st Q: (July – Sept.) Number of Infections</th>
<th>FY 2018 2nd Q: (October-Dec.) Total Number Infections</th>
<th>FY 2018 3rd Q to date: (January-March 2018) Total Number Infections</th>
<th>Number of Infections MV-LG for remaining 2Q to Meet Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAUTI Catheter Associated Urinary Tract Infection</td>
<td>SIR \leq 0.75</td>
<td>11 MV: 10 / LG:1</td>
<td>4 (MV: 3 / LG:1)</td>
<td>6 (MV: 6 / LG:0)</td>
<td>0</td>
<td>1 (MV: 1 / LG:0) SIR July-Dec. 2017 1.459</td>
</tr>
<tr>
<td>CLABSI Central Line Associated Bloodstream Infection</td>
<td>SIR \leq 0.5</td>
<td>4 MV:4/ LG:0</td>
<td>0</td>
<td>2 (MV: 2 / LG:0)</td>
<td>0</td>
<td>2 (MV: 2 / LG:0) SIR July-Dec. 2017 0.423</td>
</tr>
<tr>
<td>C. Diff Clostridium difficile</td>
<td>SIR \leq 0.7</td>
<td>25 MV: 22/ LG: 3</td>
<td>4 (MV: 4 / LG:0)</td>
<td>1 (MV: 1 / LG:0)</td>
<td>1</td>
<td>19 (MV: 16 / LG:3) SIR July-Dec. 2017 0.30</td>
</tr>
</tbody>
</table>

**July-Dec.2017 SIR Update regarding Quality Goal: MV SIR Composite = 0.72, LG SIR Composite = 0.33**

*As of Jan.2018 SIR rate for Enterprise = 0.525*

**Target = 0.602  Max = 0.534**
# FY 2018 30 Day All-Cause, Unplanned Readmission Dashboard

Premier Standard Medicare Groupings, All Ages

<table>
<thead>
<tr>
<th></th>
<th>Baseline 7/1/2016-6/30/2017*</th>
<th>Qtr 1, FY 2018</th>
<th>Qtr 2, FY 2018 (through October 2017)</th>
<th>Qtr 3, FY 2018</th>
<th>Qtr 4, FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observed Rate</td>
<td>Expected Rate</td>
<td>O/E Ratio</td>
<td>Observed Rate</td>
<td>Expected Rate</td>
</tr>
<tr>
<td>Overall</td>
<td>11.27%</td>
<td>10.63%</td>
<td>1.06</td>
<td>9.57%</td>
<td>9.59%</td>
</tr>
<tr>
<td>Acute Myocardial Infarction (AMI)</td>
<td>12.20%</td>
<td>10.51%</td>
<td>1.16</td>
<td>6.67%</td>
<td>8.58%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>15.15%</td>
<td>14.52%</td>
<td>1.04</td>
<td>25.00%</td>
<td>14.53%</td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft (CABG)</td>
<td>14.29%</td>
<td>8.03%</td>
<td>1.78</td>
<td>5.88%</td>
<td>8.86%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>17.88%</td>
<td>14.45%</td>
<td>1.24</td>
<td>14.02%</td>
<td>13.85%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>11.11%</td>
<td>12.88%</td>
<td>0.86</td>
<td>17.82%</td>
<td>14.91%</td>
</tr>
<tr>
<td>Stroke</td>
<td>6.70%</td>
<td>7.31%</td>
<td>0.92</td>
<td>10.53%</td>
<td>8.24%</td>
</tr>
<tr>
<td>Total Hip Arthroplasty and/or Total Knee Arthroplasty</td>
<td>2.87%</td>
<td>2.67%</td>
<td>1.07</td>
<td>2.59%</td>
<td>2.56%</td>
</tr>
</tbody>
</table>

* Source: Premier Quality Advisor- Standard CS 30 day Readmission methodology for CMS Disease Specific Readmission Populations
PSI - 90 Total Inpatient - Flex Timeframe

Report Filter:
AHRQ QI Version 5.0

Population Size: 10,022

<table>
<thead>
<tr>
<th>Patient Safety Indicator</th>
<th>Facility Composite Value</th>
</tr>
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<tbody>
<tr>
<td>PSI-90 Composite</td>
<td>0.689907</td>
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<tr>
<th>Patient Safety Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Observed Rate/1000</th>
<th>AHRQ Expected Rate</th>
<th>Premier Mean*</th>
<th>Premier Median*</th>
<th>Premier 25th Pctl*</th>
<th>Premier 10th Pctl*</th>
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<tbody>
<tr>
<td>PSI-03 Pressure Ulcer</td>
<td>1</td>
<td>1,570</td>
<td>0.64</td>
<td>0.53</td>
<td>0.47</td>
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<tr>
<td>PSI-06 Iatrogenic Pneumothorax</td>
<td>3</td>
<td>5,462</td>
<td>0.55</td>
<td>0.34</td>
<td>0.21</td>
<td>0.13</td>
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<tr>
<td>PSI-07 Central Venous Catheter-Related Blood Stream Infection</td>
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<td>0.10</td>
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<tr>
<td>PSI-08 Postop Hip Fracture</td>
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<td>1,069</td>
<td>0.00</td>
<td>0.04</td>
<td>0.05</td>
<td>0.00</td>
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<tr>
<td>PSI-12 Perioperative PE or DVT</td>
<td>4</td>
<td>1,906</td>
<td>2.00</td>
<td>5.51</td>
<td>3.71</td>
<td>3.08</td>
<td>1.24</td>
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<tr>
<td>PSI-13 Postop Sepsis</td>
<td>0</td>
<td>177</td>
<td>0.09</td>
<td>10.74</td>
<td>11.06</td>
<td>5.32</td>
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<td>PSI-14 Postop Wound Dehiscence</td>
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<td>305</td>
<td>0.00</td>
<td>1.78</td>
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<tr>
<td>PSI-15 Accidental Puncture or Laceration</td>
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<td>5,679</td>
<td>1.41</td>
<td>2.34</td>
<td>0.99</td>
<td>0.76</td>
<td>0.26</td>
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</tbody>
</table>

Premier Population Statistics (Rate/1000) (10-01-2015 to 09-30-2016)

PSI-90 Composite

The population for each month is only a fraction of the population for the entire time period of the report. The effect of smoothing is more pronounced for the individual monthly score. Smoothing pulls each monthly score towards 1.0, so this causes the average level of the line plotted to sit on the composite score to be closer to 1.0.

PSI-03: Pressure Ulcer

99 yr old w/hx of high blood pressure, heart failure w/chronic renal failure expired with heart failure/shock after 9 day LOS

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Report Generated on 1/10/2018 2:20:42 PM
PSI-06: Iatrogenic Pneumothorax

3 cases – 2 spinal surgeries, 1 kidney resection, All to Peer Review, different surgeons

PSI-07: Central Venous Catheter-Related Blood Stream Infection

PSI-08: Postop Hip Fracture

PSI-12: Perioperative PE or DVT

4 cases, all orthopedic: fx. Femur, fx. hip, hip replacement Fx humerus
PSI-13: Postop Sepsis

PSI-14: Postop Wound Dehiscence

PSI-15: Accidental Puncture or Laceration

8 surgical cases:
3 GYN, 3 abdominal/diaphragm, stomach repairs
Quality Metrics Comparison & Selection
Board Quality Committee
February 2018

Catherine Carson, BSN, MPA, CPHQ
The following organizations were considered for ECH to pursue for recognition or replication:

- **Leapfrog**: consists of *Leapfrog Hospital Survey*, when completed data is combined with publicly reported data and a *Leapfrog Hospital Grade* is reported. ECH completed the Survey first time Dec. 2017; Grade will be reported in Apr. 2018. Oct. 2017 ECH given a *Grade A*.

- **CMS Five Star**: Star rating 1-5 based on Inpt & Outpt Quality Reporting data, publicly reported on *Hospital Compare*, based on 50 measures of 7 aspects of quality. Recent Dec. 2017 release. ECH is 4-Star.

- **Truven 100 Top Hospitals**: Annual quantitative study that lists the 100 hospitals in the U.S. with the highest achievement on Truven scorecard, based on 11 performance measures centered on quality, efficiency, finance, and consumer assessment of care.

- **Premier QUEST**: A Premier member Collaborative, 250 hospitals, that share data and best practices to escalate improvements in care. No publication of “best” performers.
ECH to replicate Truven Quality Metrics

- The Truven Quality Metrics will be measured and reported for ECH
- Two Finance measures will not be considered:
  - Case Mix- & wage-adjusted inpatient expense per discharge
  - Medicare spend per beneficiary index
  - These measures preclude ECH’s ability to achieve 100 Top recognition
- Replication of Truven 100 Top measures involve use of CMS 5-Star measures; available sooner than Truven data, and replicating these measures through Premier Quality Advisor
- Goals for Quality Metric results will include more specific metrics behind the Truven measures:
  - Mortality rates for 6 diseases (Premier data) for the Truven Risk-adjusted Inpatient Mortality rates, etc.
Truven 100 Top Measures

- Data is from Medicare Provider Analysis/Review data set (MEDPAR), CMS Hospital Compare, and Medicare Cost Report
- Award winners are ranked relative to comparative group (ECH= Large hospital)

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Current Performance (100 Top Award Selection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk-Adjusted Inpatient Mortality Index</td>
<td>MEDPAR Federal Fiscal year</td>
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<tr>
<td>Risk-Adjusted Complications Index</td>
<td>MEDPAR FFY</td>
</tr>
<tr>
<td>Core Measures Mean Percent (Stroke, Blood Clot)</td>
<td>CMS Hospital Compare</td>
</tr>
<tr>
<td>Mean 30-Day Mortality Rate (AMI, Heart Failure, Pneumonia, COPD, Stroke)</td>
<td>CMS Hospital Compare</td>
</tr>
<tr>
<td>Mean 30-Day Readmission Rate (AMI, Heart Failure, Pneumonia, Hip/Knee, COPD, Stroke)</td>
<td>CMS Hospital Compare</td>
</tr>
<tr>
<td>Severity-Adjusted Average Length of Stay</td>
<td>MEDPAR</td>
</tr>
<tr>
<td>Mean Emergency Department Throughput</td>
<td>CMS Hospital Compare Calendar Year</td>
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<tr>
<td>Inpatient Expense per Discharge (Case mix- and wage-adjusted)</td>
<td>HCRIS Medicare Cost</td>
</tr>
<tr>
<td>Medicare Spend per Beneficiary Index</td>
<td>CMS Hospital Compare CY</td>
</tr>
<tr>
<td>Adjusted Operating Profit Margin</td>
<td>HCRIS Medicare Cost reports</td>
</tr>
<tr>
<td>HCAHPS Score (Overall Hospital Rating)</td>
<td>CMS Hospital Compare CY</td>
</tr>
</tbody>
</table>
The National Crisis

National Cost estimated at $600 billion in crime and lost productivity
Now the leading cause of accidental death in the US (passed car deaths 2008)
91 Americans die every day from opioid overdose (CDC August 2017)
More opioid deaths are now due to heroin than prescription narcotics
The Local Impact of the Opioid Crisis

- Between 2011 and 2015, there was a 126% jump in heroin overdose cases in Santa Clara County.

- In 2016, 1,925 people died in California from opioid related deaths. California Opioid Overdose Surveillance Dashboard.

- One Response: Santa Clara County Opioid Overdose Prevention Project.
El Camino Approaches

• The Opioid Crisis is *primarily* a problem of non-hospital treatment of chronic pain, heroin use and diversion of high potency drugs like fentanyl; nevertheless we can help in the acute care setting.

• ECH now has a Pain Pharmacist and an improved Palliative Care program and these each offer assistance to physicians on appropriate pain medication ordering and administration, monitoring usage and suggesting appropriate alternates to controlled substances.

• Our pain management steering committee is currently developing an opioid risk screening tool to identify patients who may be at increased risk. These patients may be monitored more closely during their admission.
El Camino Approaches

• ECH uses the CURES program to monitor patients’ controlled substance use. This is a registry of all controlled substances prescribed in California. Our doctors and pharmacists can check whether their patients are getting opioids elsewhere.

• Our ED group has protocols limiting the number of opioids prescribed (e.g. the default order is for no more than 15 tablets of Norco, a relatively mild opioid). Stronger narcotics are not prescribed and patients with chronic pain conditions are not prescribed to.

• ECH has instituted monitoring on patients receiving intravenous opioids to detect and alarm respiratory depression; the number one cause of death from opioid use.
El Camino Approaches

• The ECH pharmacy uses Pharmacy One Source Access to review adverse events for opioids and reviews naloxone (opioid antagonist) usage. The Pain Pharmacist runs reports for opioid-delivering devices and long-acting opioids to review appropriate usage.

• Instituting an outpatient pharmacy on site at ECH Mountain View (scheduled to open in the spring of 2018) will decrease the risk of opioid diversion for illicit use.
El Camino Hospital Addiction Services

• Dual Diagnosis program: co-occurring mental health and substance use disorders; 4-6 weeks.
• Dr. Evan Garner, Medical Director
• Chemical dependence program: 3 months, expanding to one year.
• Chemical dependency consultation services: consultation to the patients on the medical and surgical floors.
• Staff education: grand rounds and focused educational sessions with individual departments.
CMO Report

• Fran Franks has started as our Manager of Clinical Variation
• California Health and Human Services recognized 111 hospitals for reducing cesarean births for first-time mothers with low-risk pregnancies. EGH Los Gatos was on the 2017 Hospital C-Section Honor Roll
• Due to personal illness, we have had a setback in the start date of our new Director of Medical Staff services.