El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

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.

	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 (December 4, 2017) ***Information*** b. Research Article c. Patient Story d. FY18 Pacing Plan e. 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: INTERVENTIONAL RADIOLOGY** **ATTACHMENT 6**	Fabio Komlos, MD, Interventional Radiology Bart Dolmatch, MD Interventional Radiology		**Discussion** **5:39 – 5:59**
7.	**WENDY RON'S STORY** **ATTACHMENT 7**	Wendy Ron, Quality Committee Member		**Discussion** **5:59 – 6:09**
8.	**UPDATE ON PATIENT AND FAMILY CENTERED CARE** **ATTACHMENT 8**	Ashlee Fontenot, Manager of Patient Experience		**Discussion** **6:09 – 6:19**
9.	**FY18 QUALITY DASHBOARD** **ATTACHMENT 9**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion** **6:19 – 6:29**
10.	**READMISSION DASHBOARD** **ATTACHMENT 10**	Catherine Carson, Sr. Director of Quality Improvement and Patient Safety		**Discussion** **6:29 – 6:39**

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

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

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

**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.

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 5:35 p.m.	***None***
2. ROLL CALL	Chair Reeder asked Michele Lee to take a silent roll call. Melora Simon joined the meeting via teleconference and Dr. Peter Fung was absence.	***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 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	

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: UROLOGY	DavidKing, 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 Intracoporeal 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.	***None***
7. COMMITTEE MEMBER RECRUITMENT	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.	
8. FY18 QUALITY DASHBOARD	Catherine Carson, Sr. Director/Chief Quality Officer, reviewed the new quality dashboard with the committee.	

Agenda Item	Comments/Discussion	Approvals/Action
	The only concerning trend is some degradation of our sepsis bundle performance, though performance overall remains above comparable hospitals. Regarding Hospital Acquired Infections (HAIs), our area of intense organizational focus, we have had two CLABSIs during the first half of FY18 and are running slightly above target on CAUTIs, but well below target for C. difficile. Many initiatives are under way as a result of the deep analysis that is done by our HAI subcommittees after every hospital acquired infection. Ms. Carson further detailed that the new goal from The geometric LOS Expected for Medicare Population has lower ALOS through Epic banner usage for nursing and care coordination to view and prioritize, while CDI continues to improve GMLOS through better documentation of co-morbidities. She further explained that Sepsis Core Measure compliance is 58% which represents 6 failures: 2 related to Lactate, 1 late ABX, 2 related to Crystalloid fluids, and 1 due to septic shock focused exam. IVF Bolus ordering and giving within 3 hour bundle have a positive effect on the Sepsis mortality rate of 9.3% in first quarter 2018 and at 6.35 in October. CDI has improved clinical documentation affecting the observed/expected mortality rate; as a result, O/E mortality rate is 0.89. The data for October for HCAHPS has improved to 79.5% which is above target goal of 78%.	
9. UPDATE ON PATIENT AND FAMILY CENTERED CARE	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.	***None***
10. PT. EXPERIENCE (HCAHPS)	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.	
11. ED PATIENT SATISFACTION (PRESS GANEY)	Michelle Gabriel, Director of Performance Improvement, explained that the quarter of Jul-Sept 2017 for Patient Satisfaction in our ED Department has increased since	

Agenda Item	Comments/Discussion	Approvals/Action
	last quarter from Apr-Jun 2017. There is room for improvement to reach the 50% PG in our ED Enterprise Patient Satisfaction.	
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.	
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

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

VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

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 of 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

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made graft with special holes and branching limbs to maintain the perfusion of the normal organs, while excluding the aneurysm.

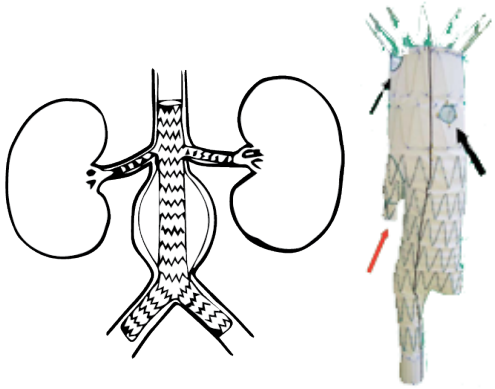


Fig1. Fenestrated endograft: it has special holes within the graft to maintain the blood flow to kidneys and intestine.

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).

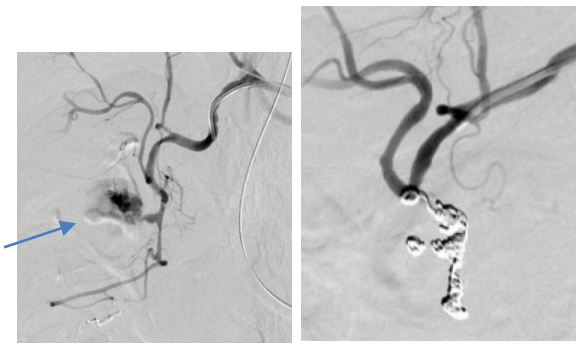
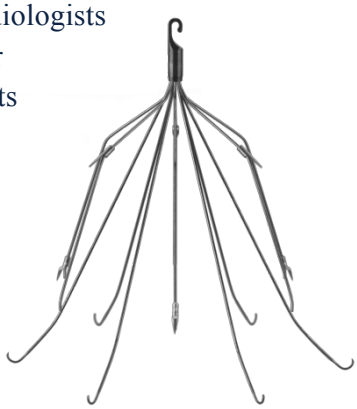


fig2: Duodenal ulcer with active bleeding (arrow) and resolution of the bleeding with embolization.

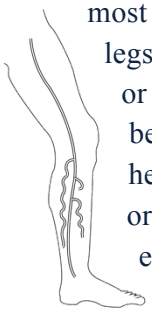
Veins

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.

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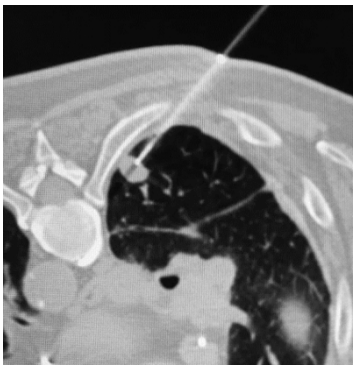
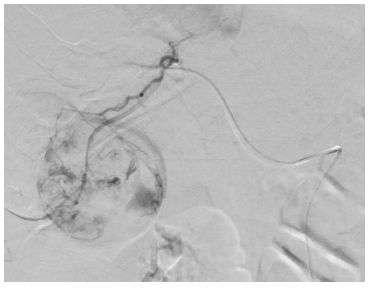
Tumor targeted treatments are intended to shrink or destroy tumors at their primary site or metastasis. Targeted tumor treatment is an area of increasing advancement leading to longer patient survival and reduced morbidity.

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.



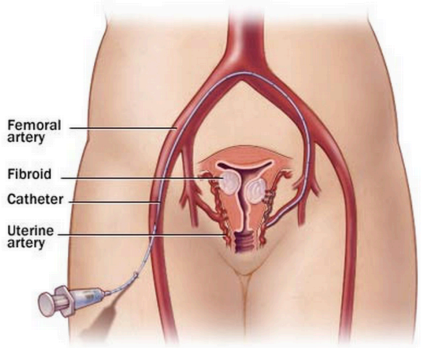
Tumor Embolization: a small catheter in inserted through blood vessels using live x-rays. The catheter can travel all the way to a specific tumor. With the catheter in the correct position chemotherapy or radiation beads can be injected directly into the tumor, therefore minimizing side effects of the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



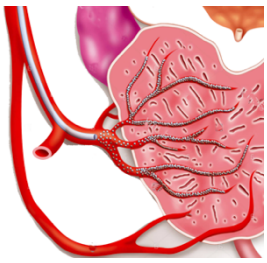
Tumor ablation (liver, kidney bone, lung): IR uses destructive therapies usually involving heat (radiofrequency, laser, microwave, ultrasound) or cold damage (cryotherapy). The treatment is performed and monitored using imaging (ultrasound, computed tomography or magnetic resonance imaging). A small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

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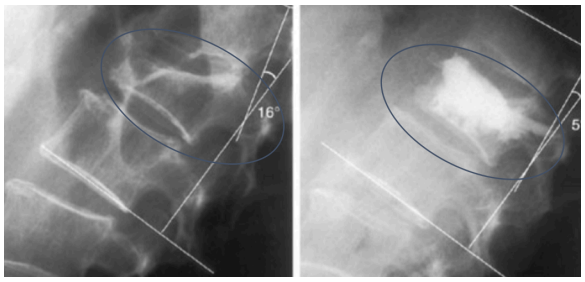
Gastrostomy tubes: are tubes inserted in the stomach for patients with swallowing problems to have nutrition. These are placed using fluoroscopy.

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

Spine interventions and pain management

Kyphoplasty: patients with compression fractures of the spine can take months to recovery. 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.

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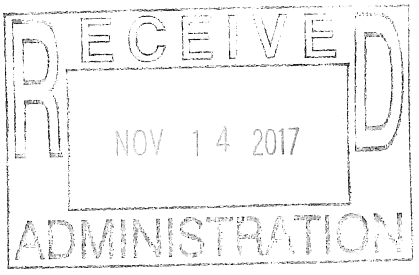
November 2, 2017



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/Stroke 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

Candace J. Larson

cc: Chief Nursing Officer, Cheryl Reinking ✓
Lotta Alba (ED)
Jennifer Borrelli (Telemetry/Stroke Unit)

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. Pt. Experience (HCAHPS) 3. ED Pt. Satisfaction (Press Ganey) 4. 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 5. Opioids Usage Discussion 6. Quality Ratings	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

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~~ 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

		(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

ECH BOARD COMMITTEE MEETING AGENDA ITEM COVER SHEET

	Item:	Report on ECH and ECHD Board Actions Quality Committee Meeting Meeting Date: February 5, 2018
	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 and/or Board members who also serve on 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 and ECHD Board Actions	

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.

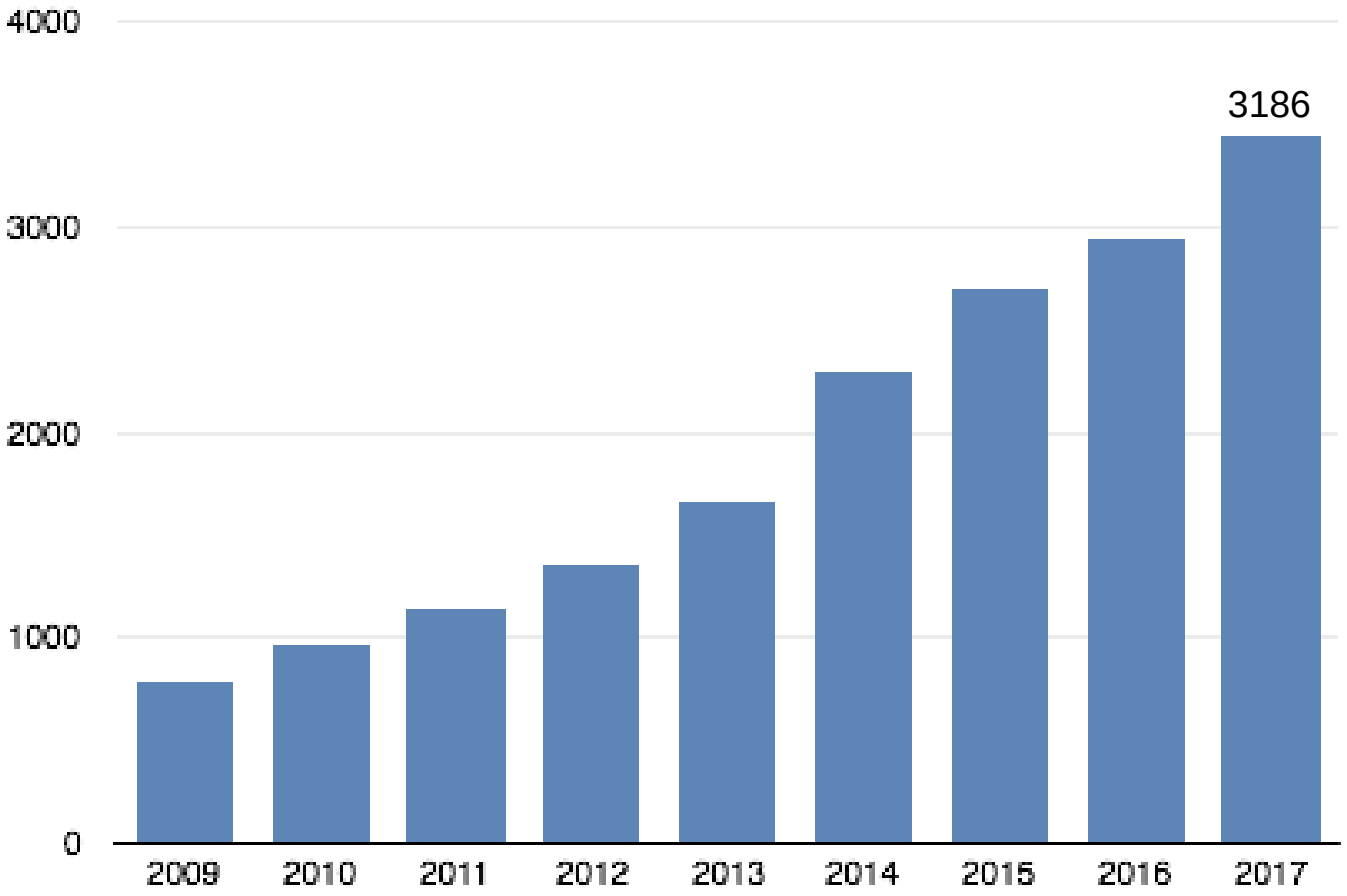
VASCULAR AND INTERVENTIONAL RADIOLOGY

El Camino Hospital

THE HOSPITAL OF SILICON VALLEY

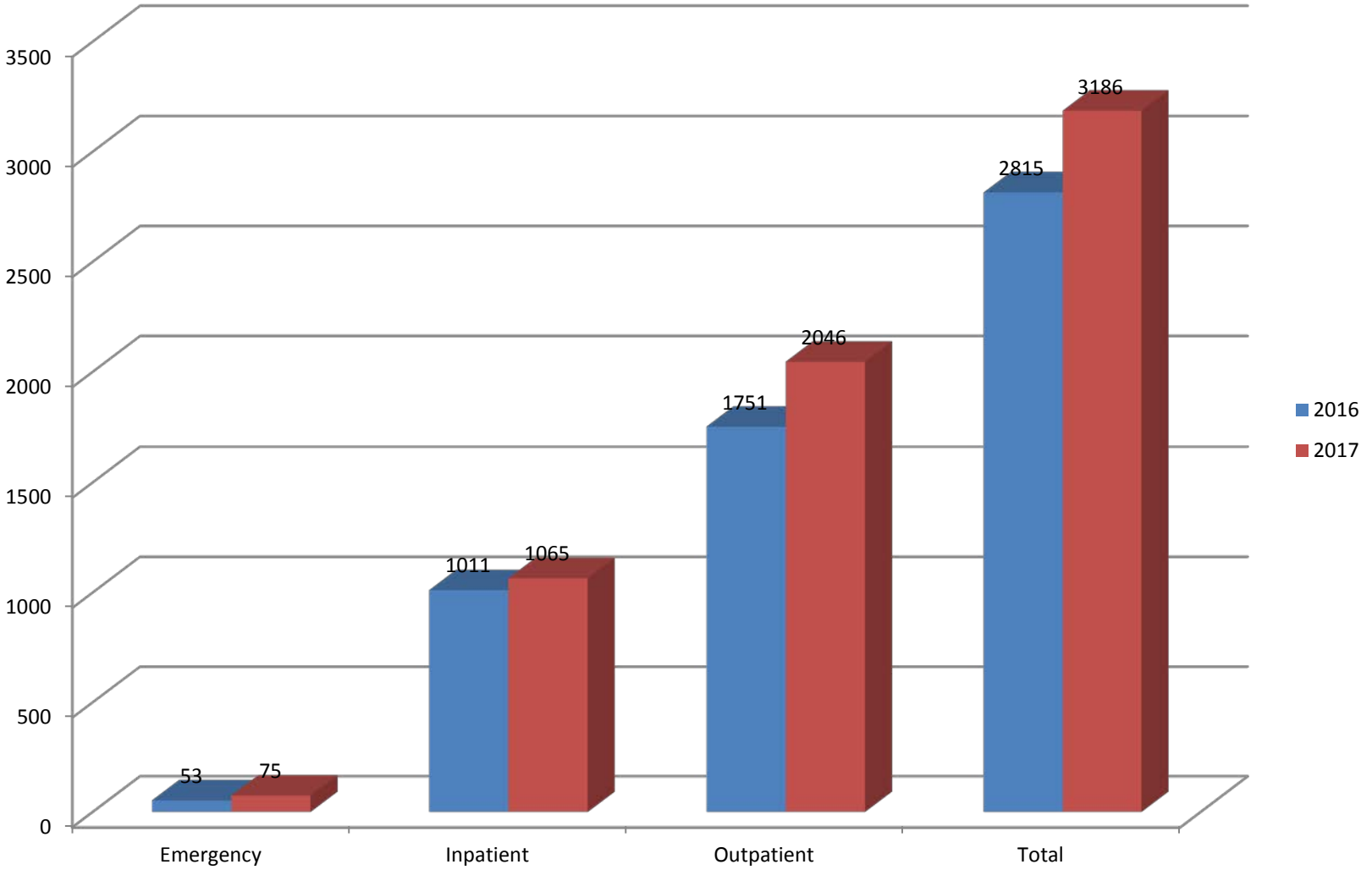
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

IR procedures @ El Camino Hospital



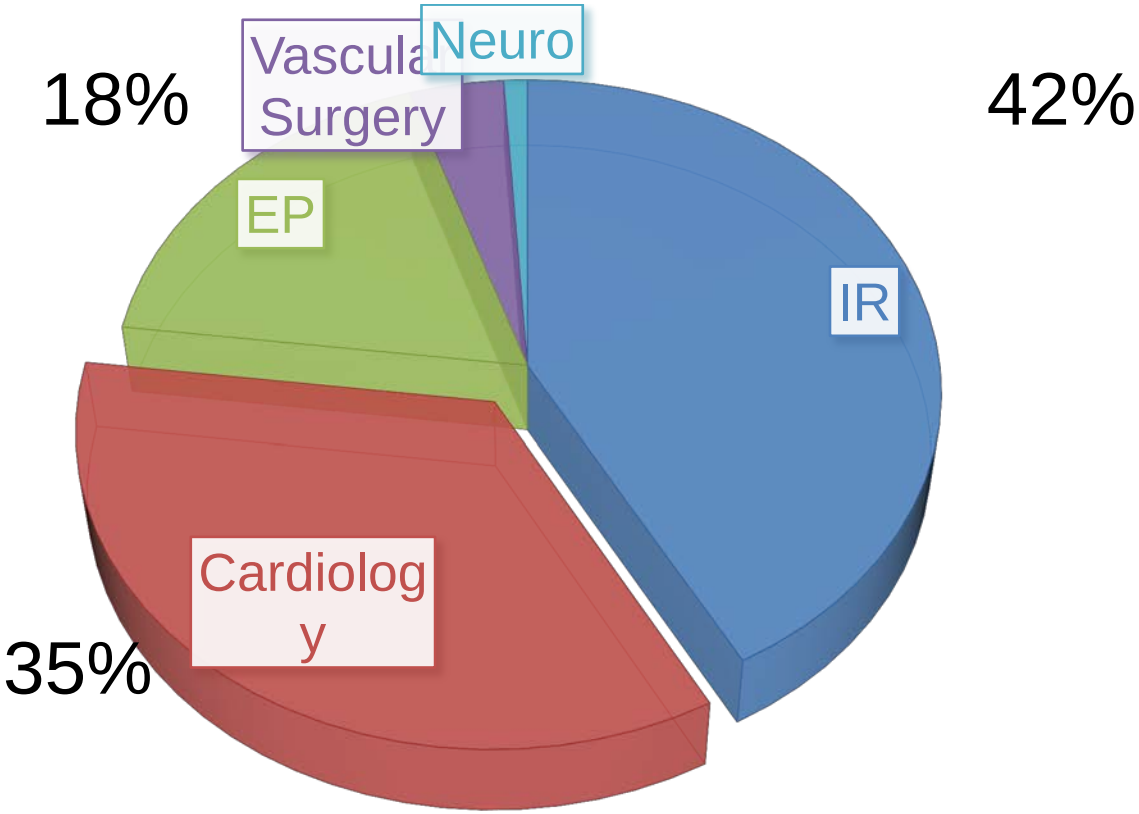
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

Procedures

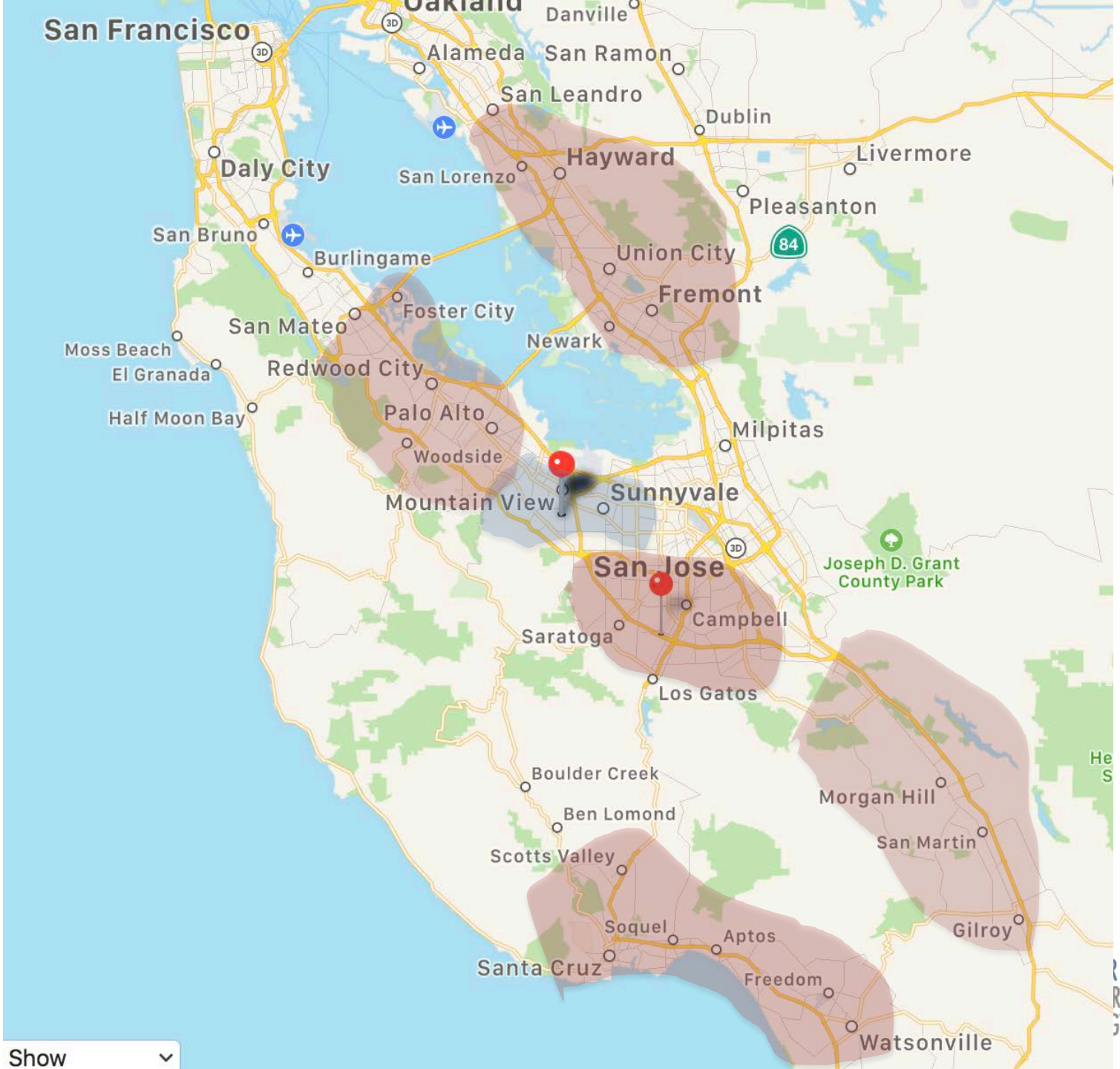


VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

Cath Lab Volume - 2017



VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC


San Francisco
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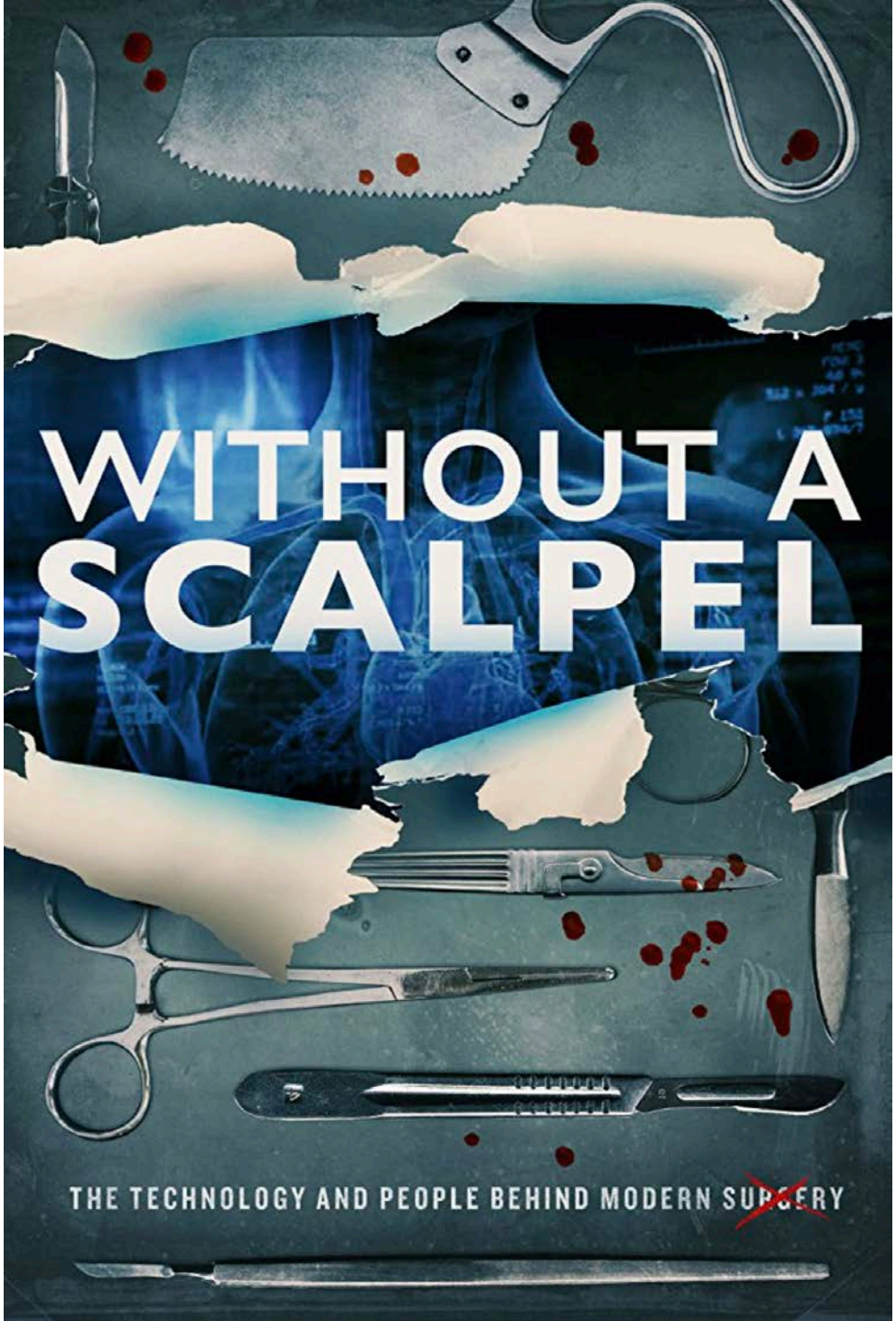
Danville
Alameda
San Ramon
San Leandro
Dublin
Hayward
Livermore
Daly City
San Lorenzo
Pleasanton
San Bruno
Burlingame
Union City
84
Fremont
Foster City
San Mateo
Newark
Moss Beach
El Granada
Redwood City
Half Moon Bay
Palo Alto
Milpitas
Woodside
Mountain View
Sunnyvale
San Jose
Joseph D. Grant
County Park
Campbell
Saratoga
Los Gatos
Boulder Creek
Morgan Hill
Ben Lomond
San Martin
Scotts Valley
Soquel
Aptos
Gilroy
Santa Cruz
Freedom
Watsonville
Show

IR Team

VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

What do we do?

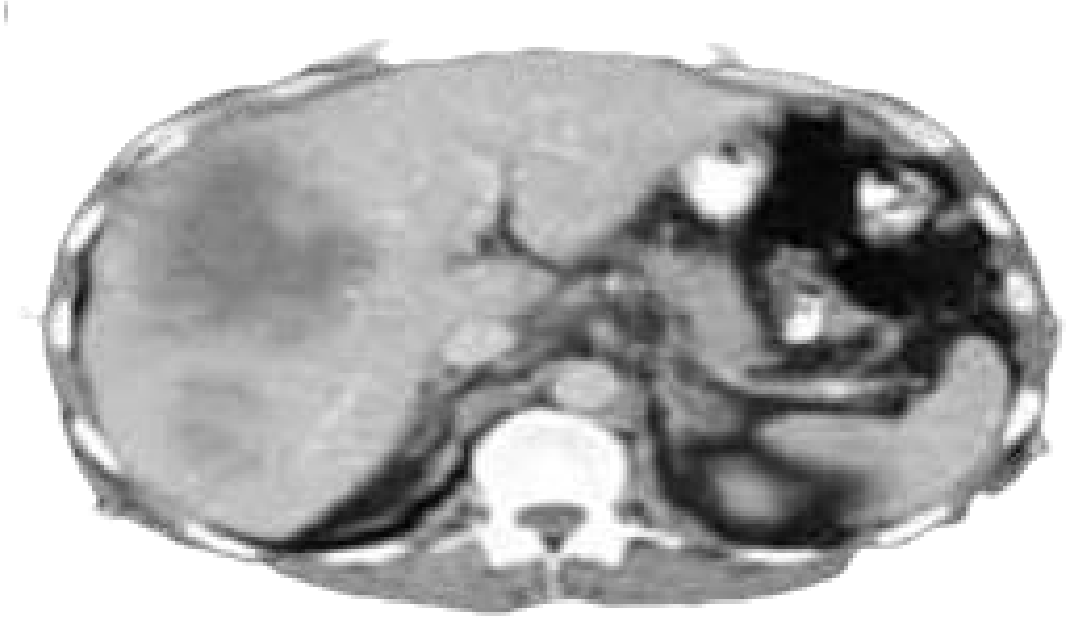
VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC



VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

Interventional Oncology

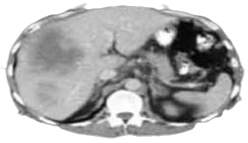
65M with weight loss and abdominal pain



VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

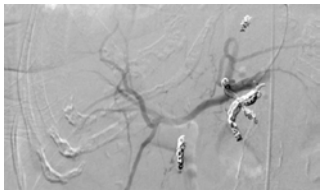
Interventional Oncology

Biopsy

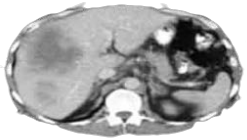


Access for chemo

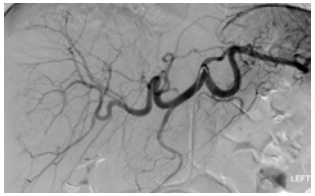
Chemoembo



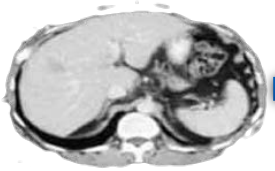
Poor response



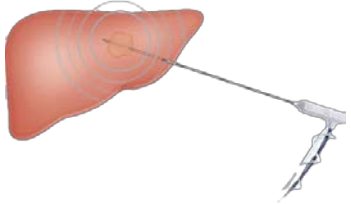
Radioembolization



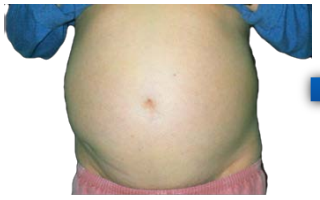
Response



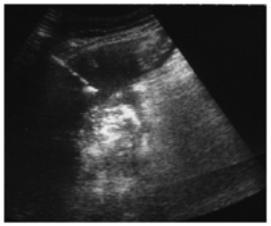
Microwave



Ascites

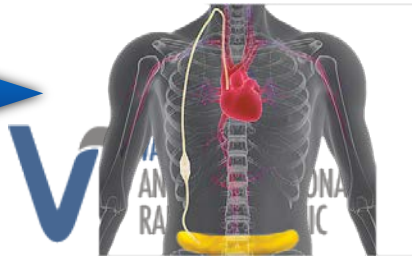


Paracentesis

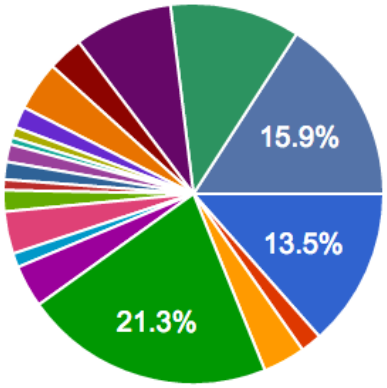


Pleurx catheter

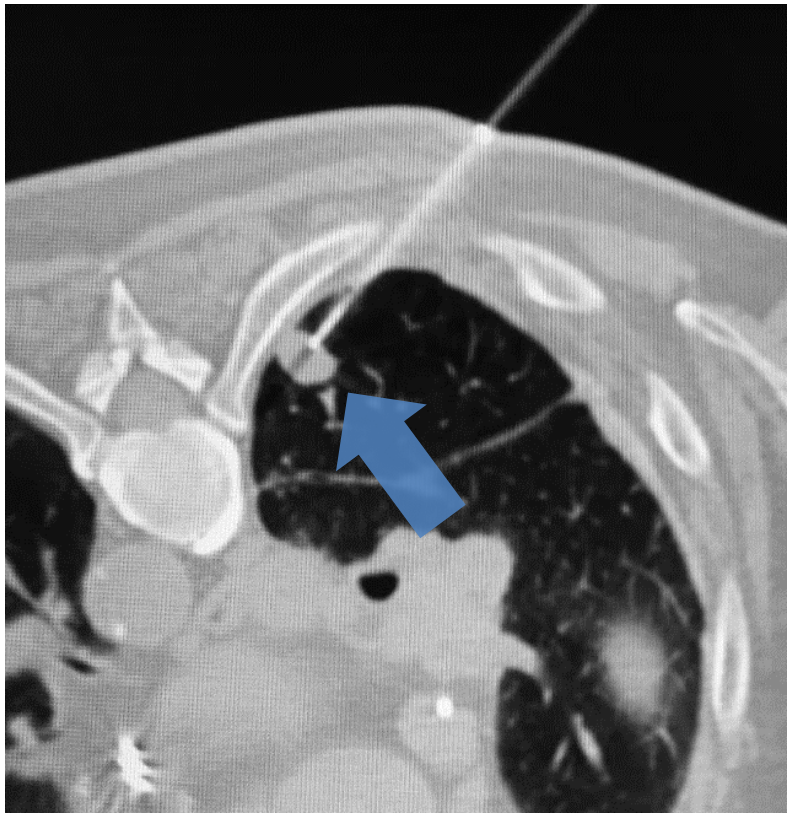
Denver Shunt

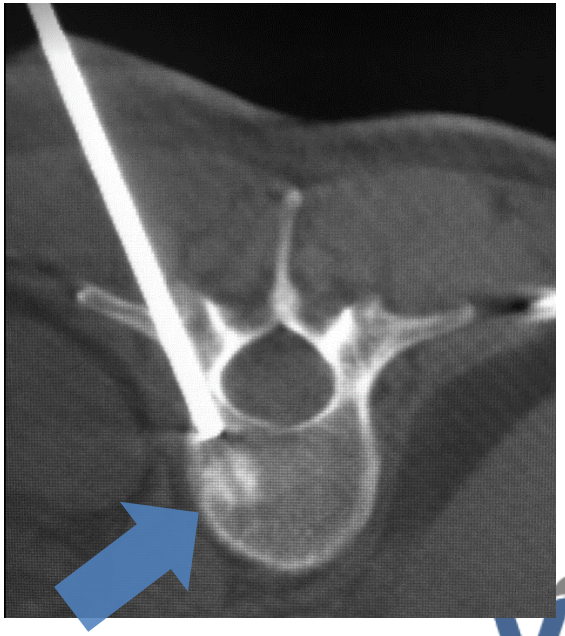


Biopsies



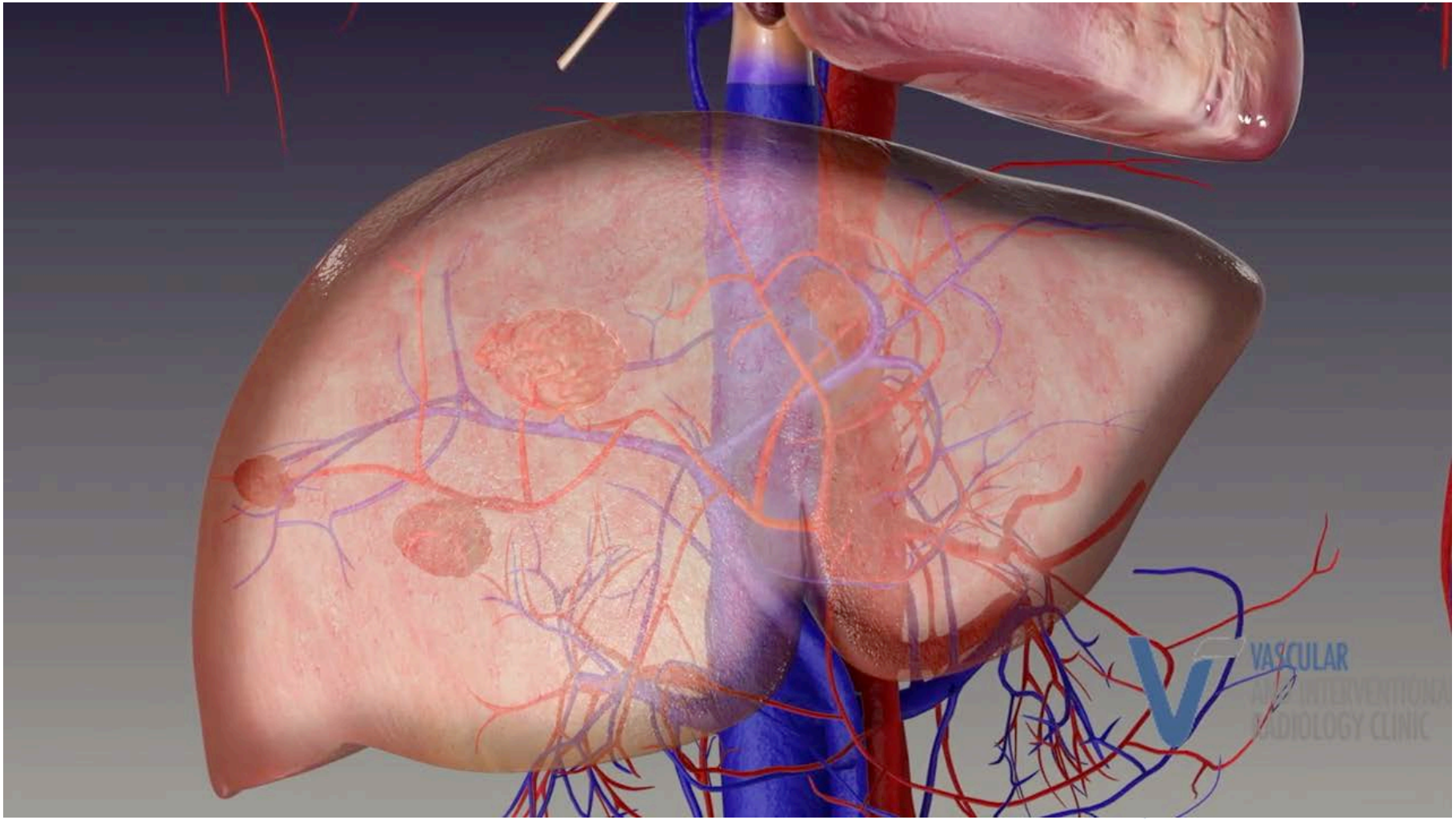
Liver Mass	45
ransjugular Liver biopsy	6
Medical Liver	12
Lung	71
Thyroid	12
Medical Renal	4
Renal Mass	12
Mediastinal	6
Cervical Mass	3
Lymph node groin	5
Lymph node axilla	5
Retroperitoneal	2
Pancreatic	3
Mesenteric	6
Pelvic Mass	14
Soft tissue mass	10
Bone Lesion	28
Bone Marrow	37
Other	53



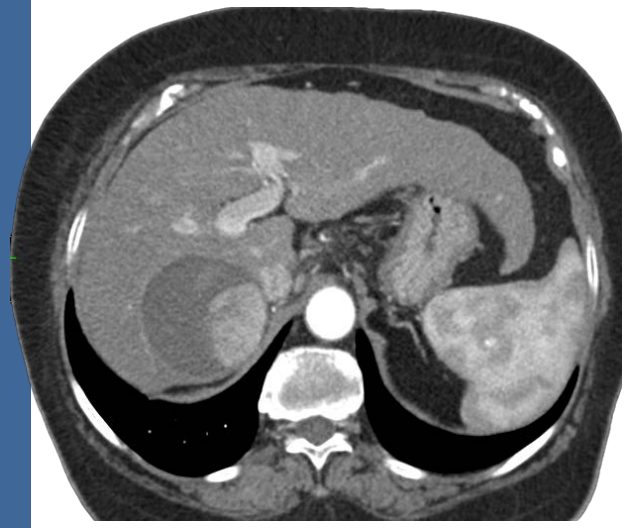


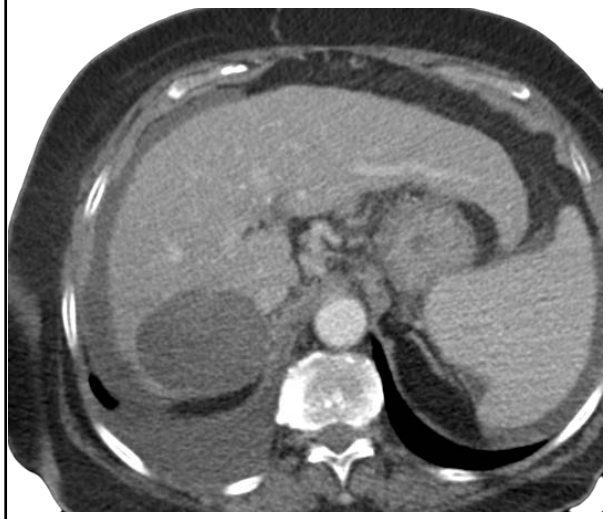
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

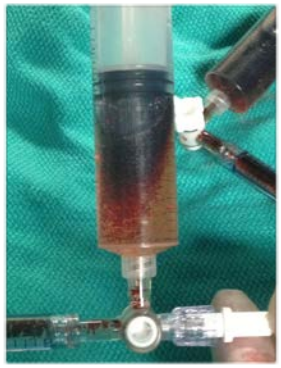
Y90 - Radioembolization

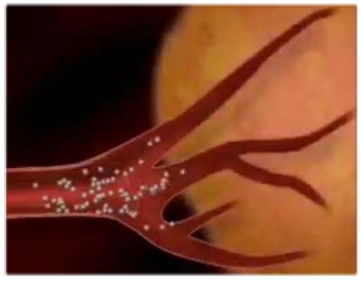


Chemoembolization



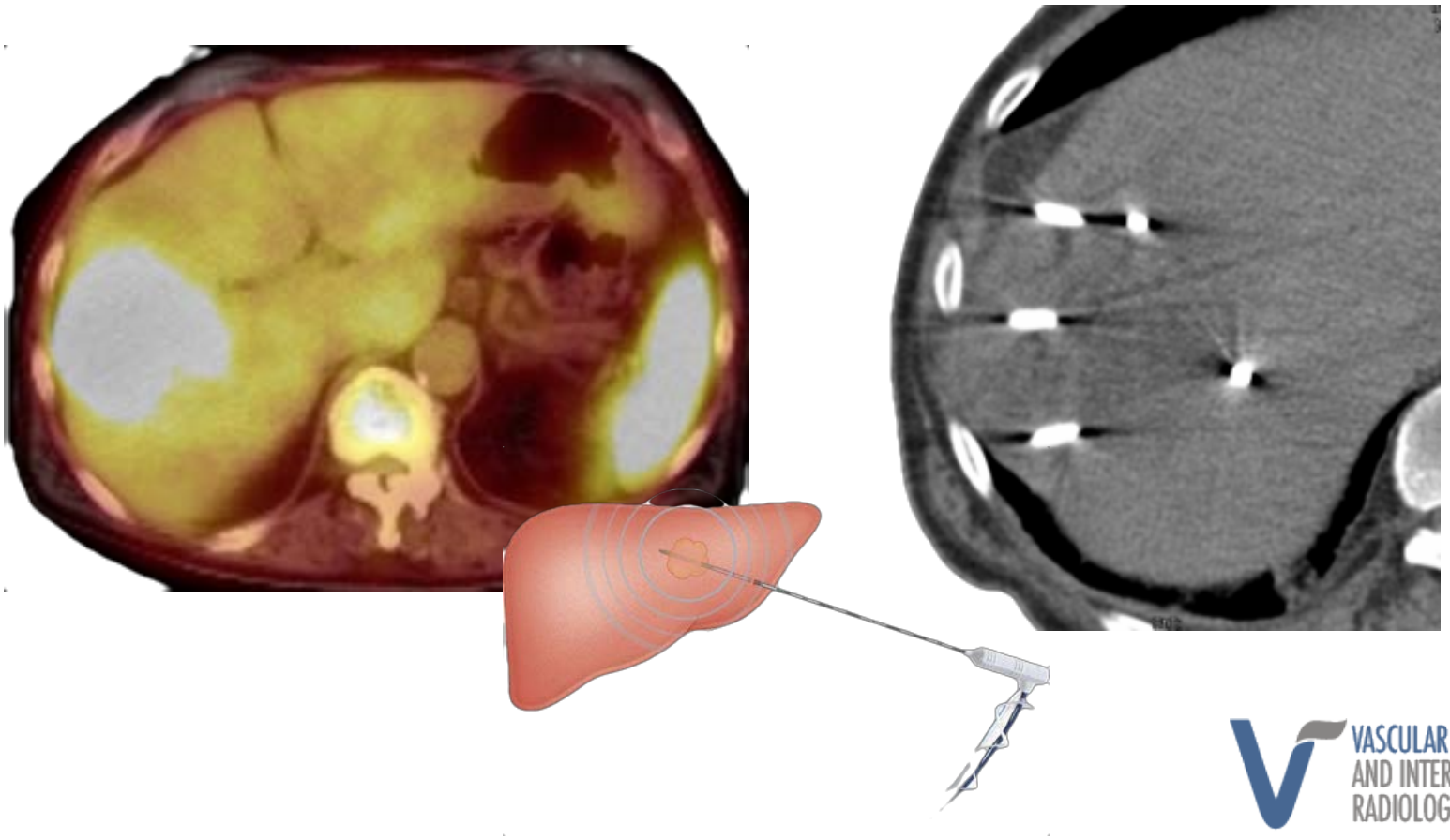






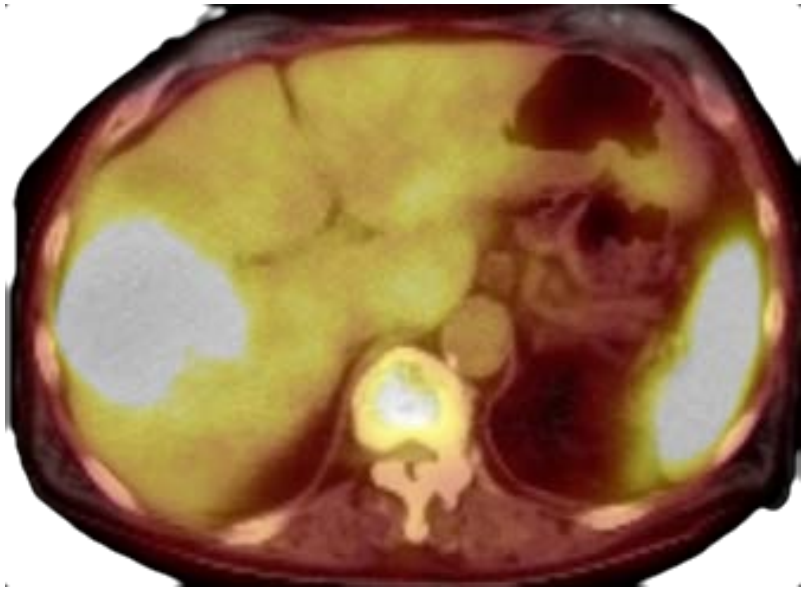
VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

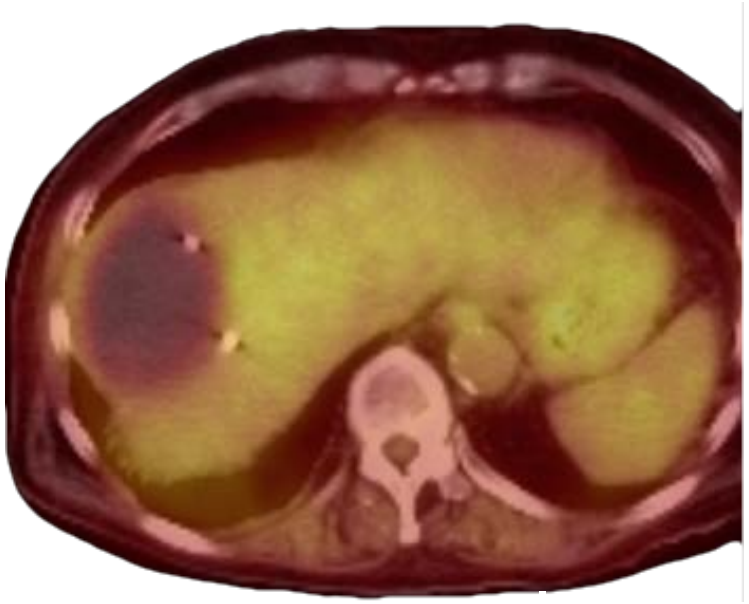
Ablations



VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

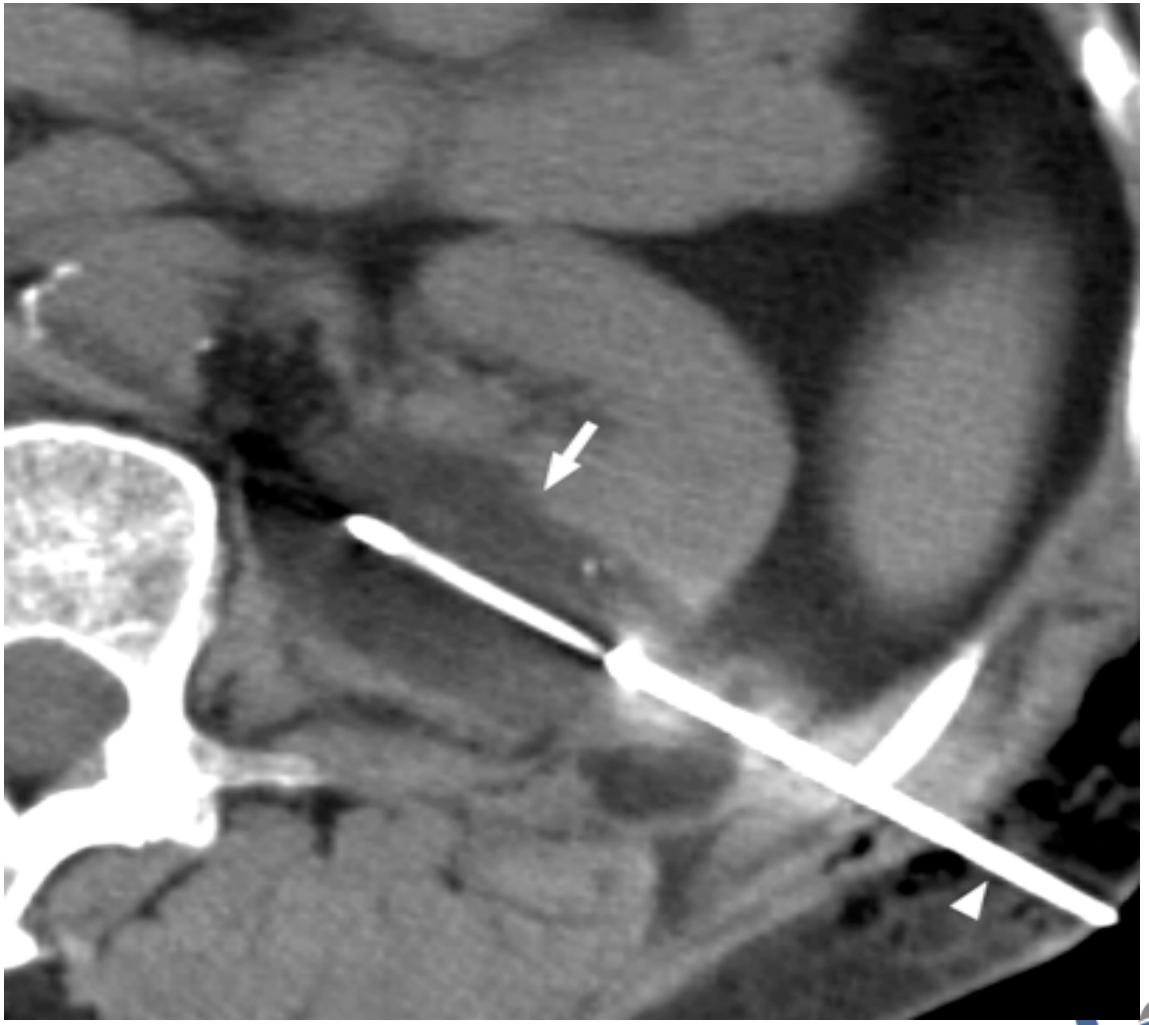
68M with Metastatic Melanoma - Single met





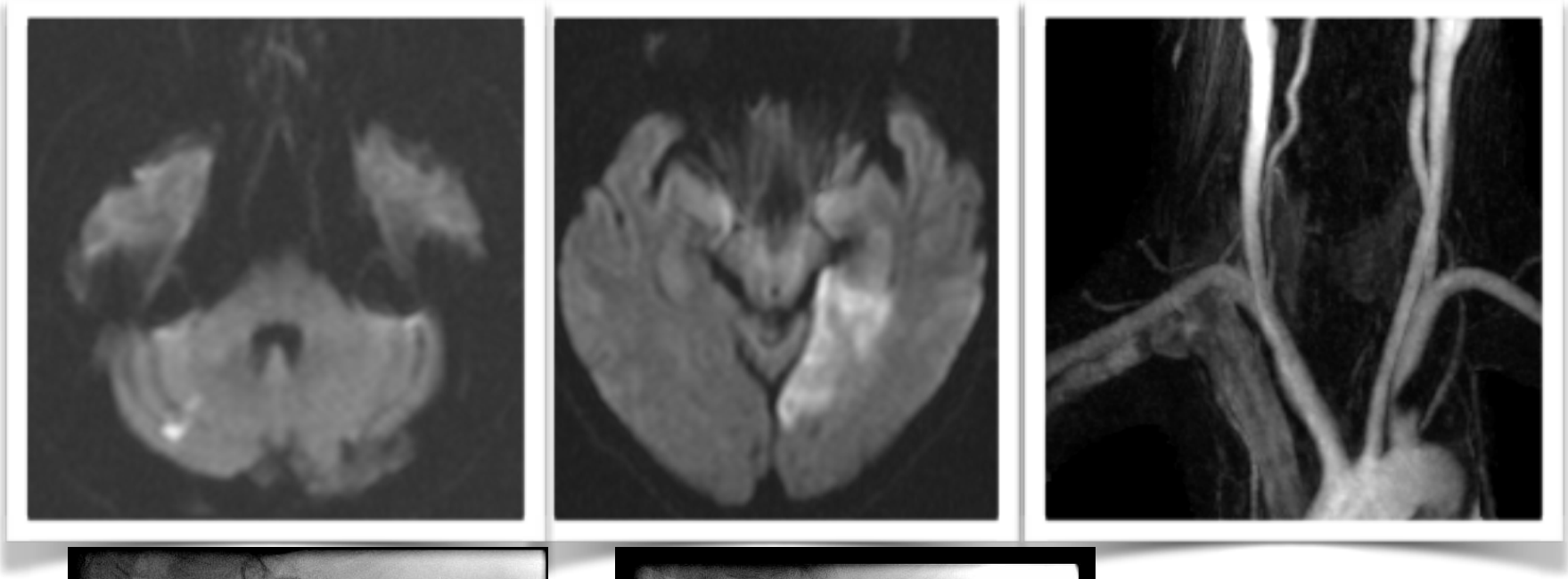
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

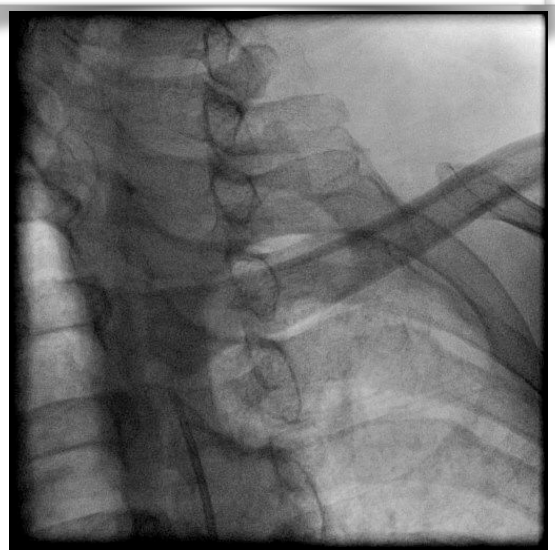
Cryoablation Renal Cancer

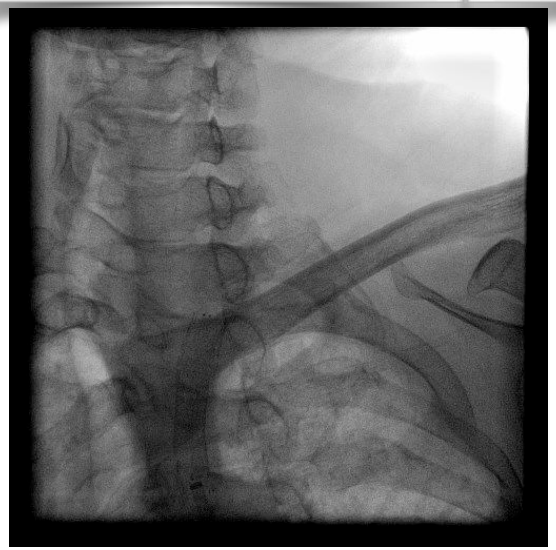


VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

Complex Arterial Disease

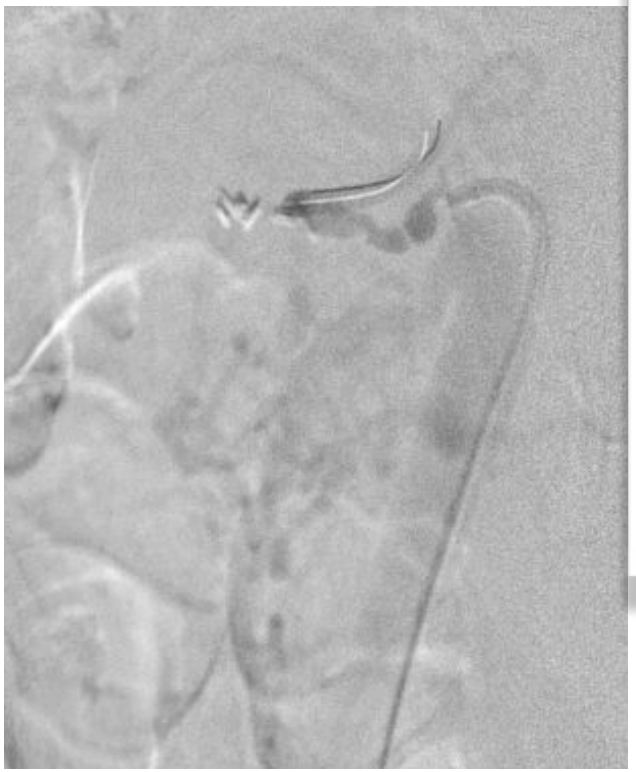


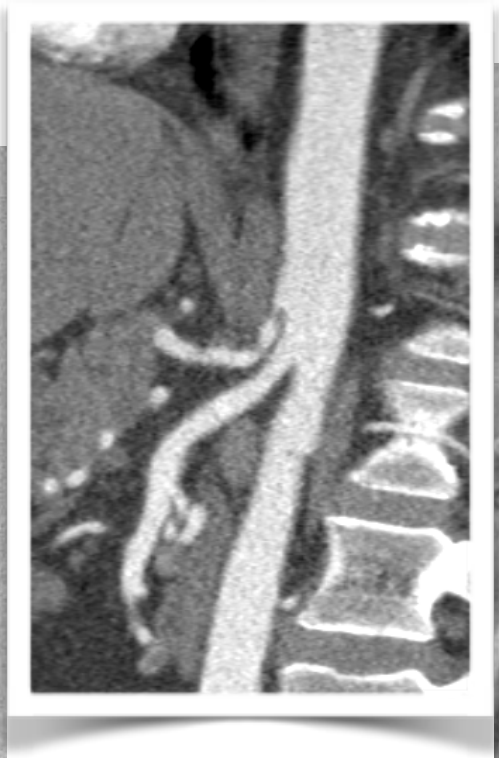




VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

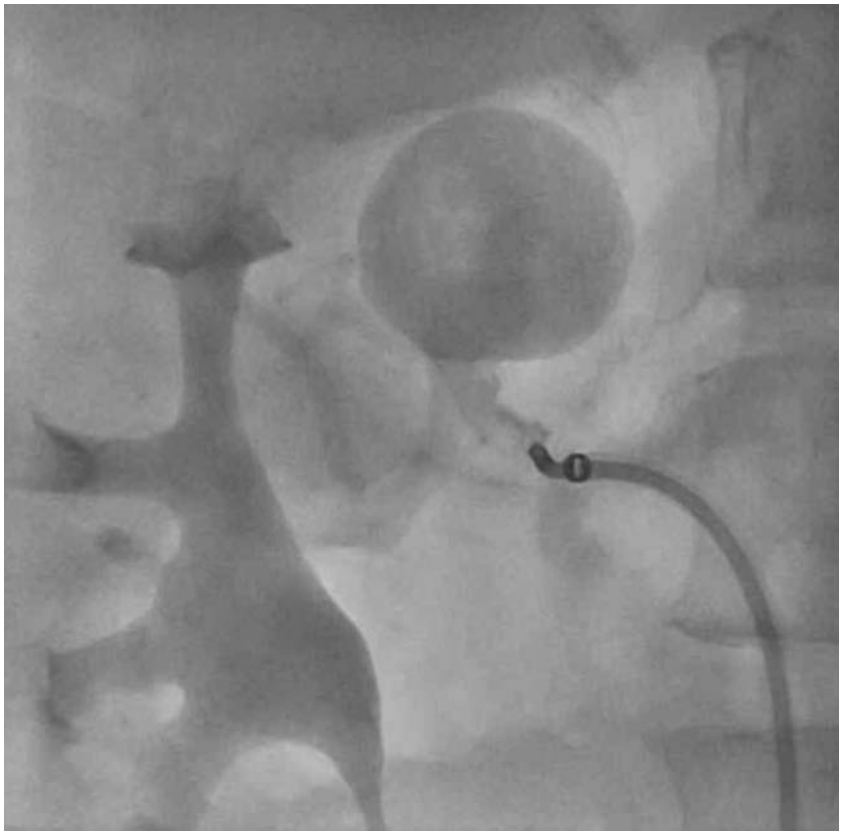
Mesenteric disease/aneurysms

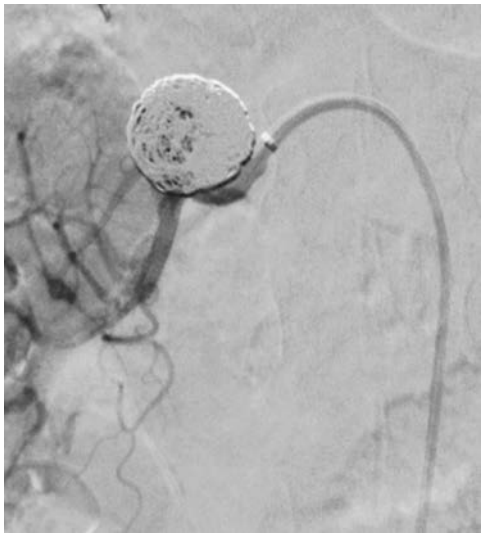




VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

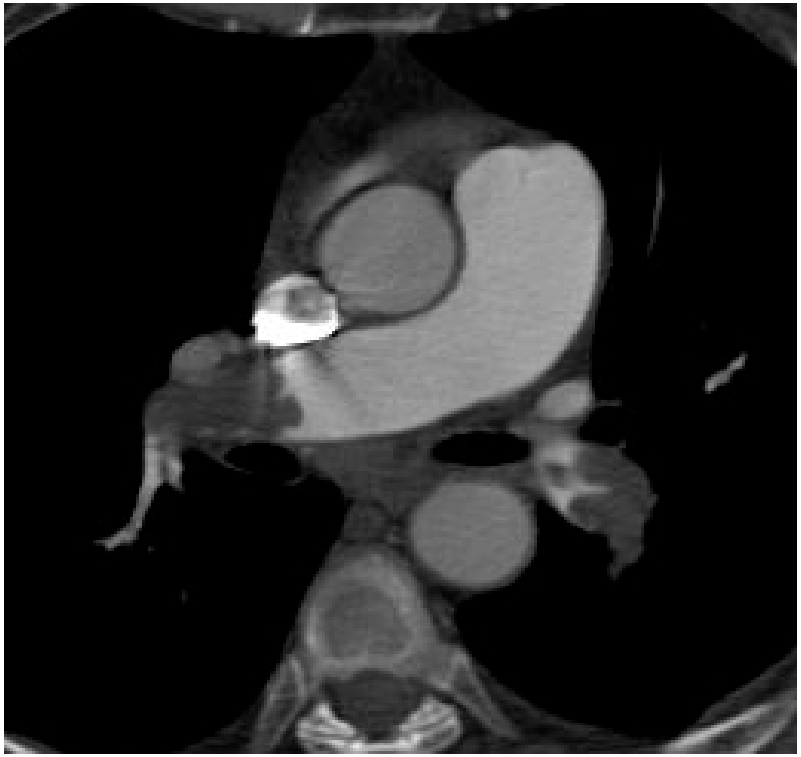
Renal Artery Aneuysm

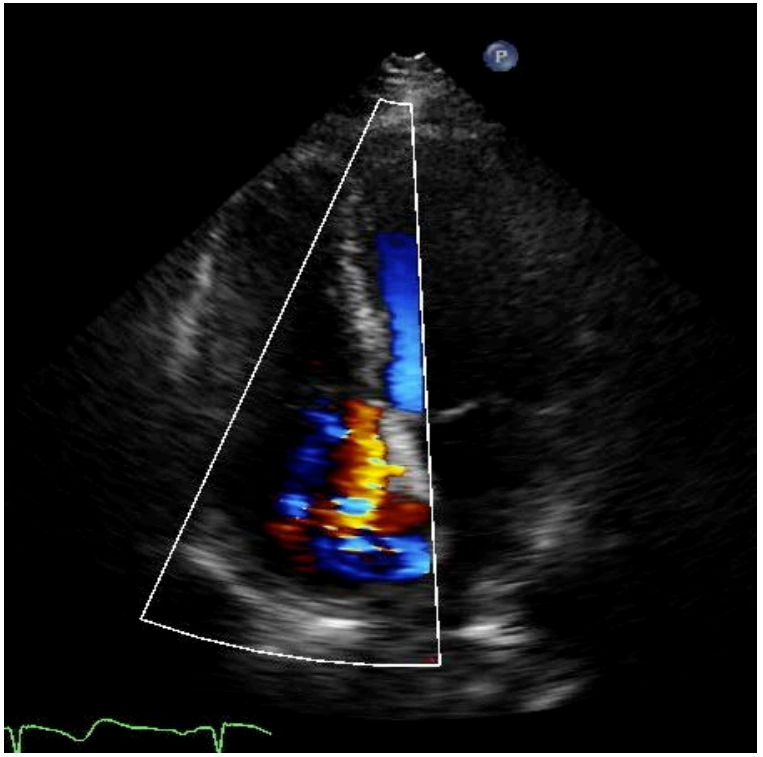




VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

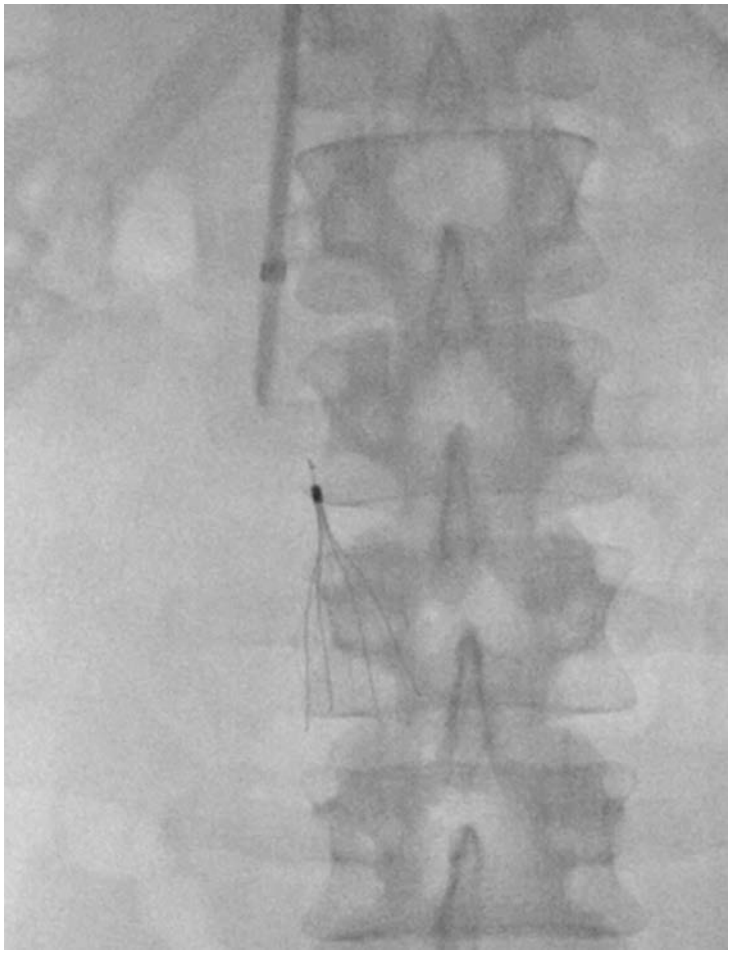
Pulmonary Embolism

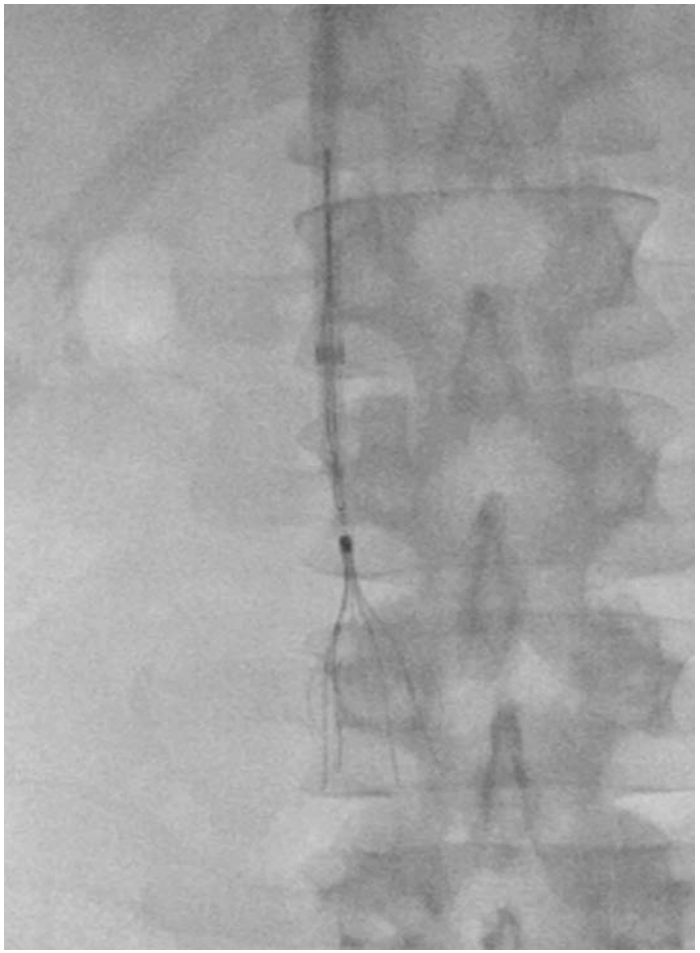




VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

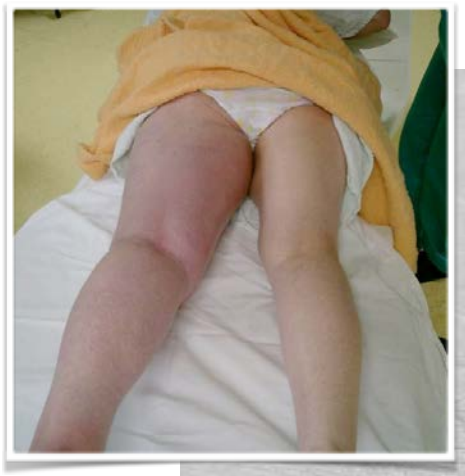
IVC filters

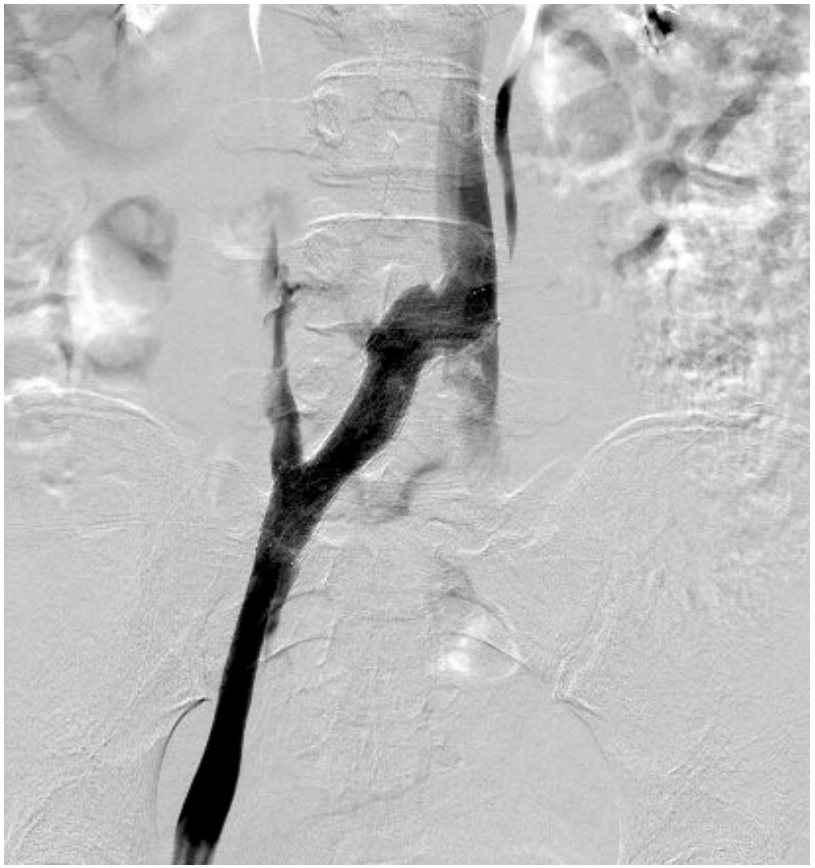




VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

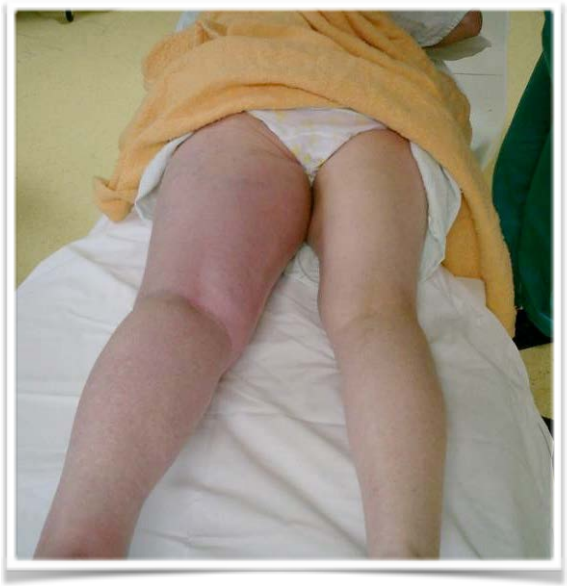
Massive DVT

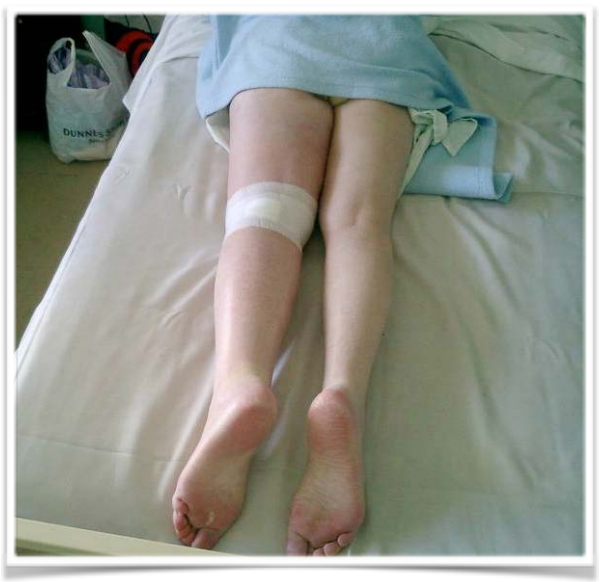


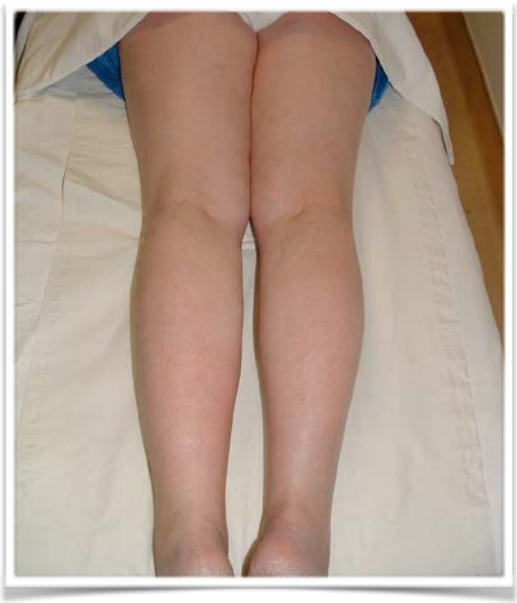


VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

DVT

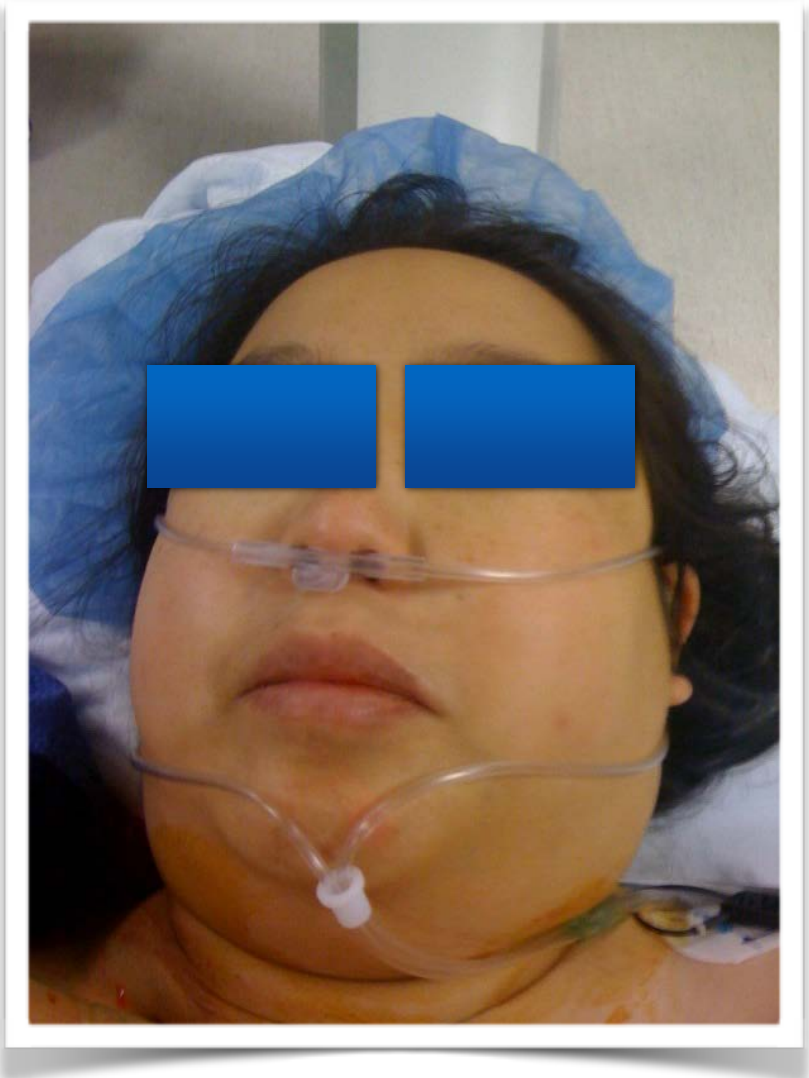






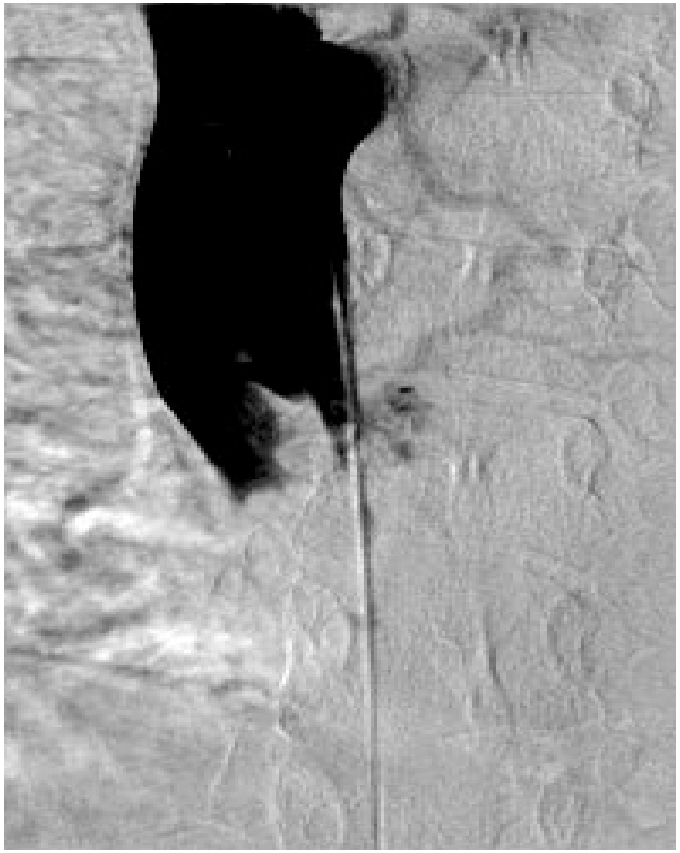
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

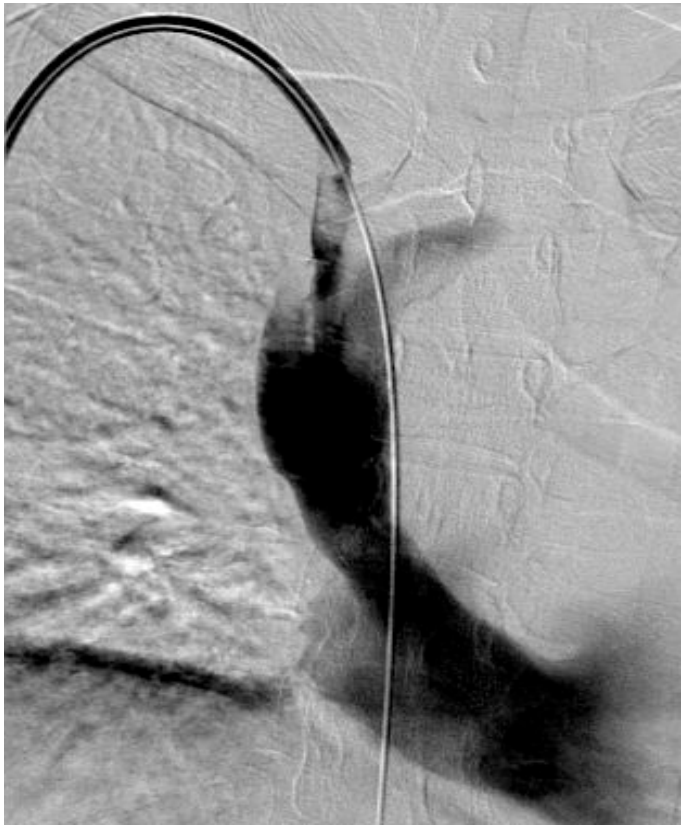
33F with protein S deficiency and SVC syndrome



VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

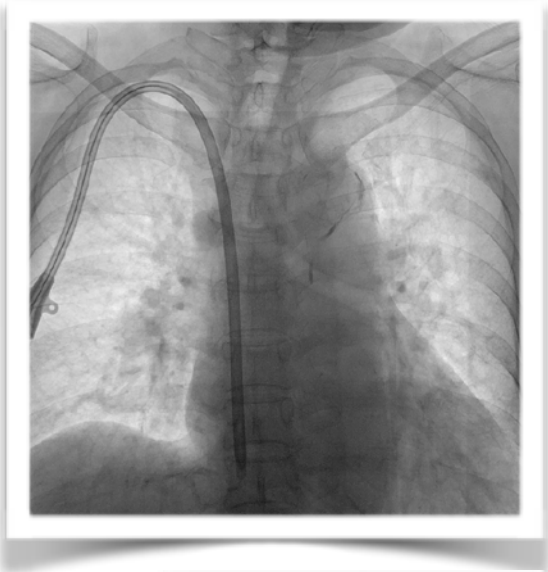
After thrombolysis + angiogjet + PTA

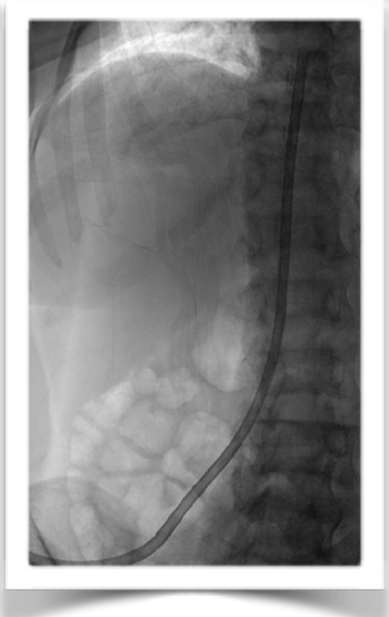


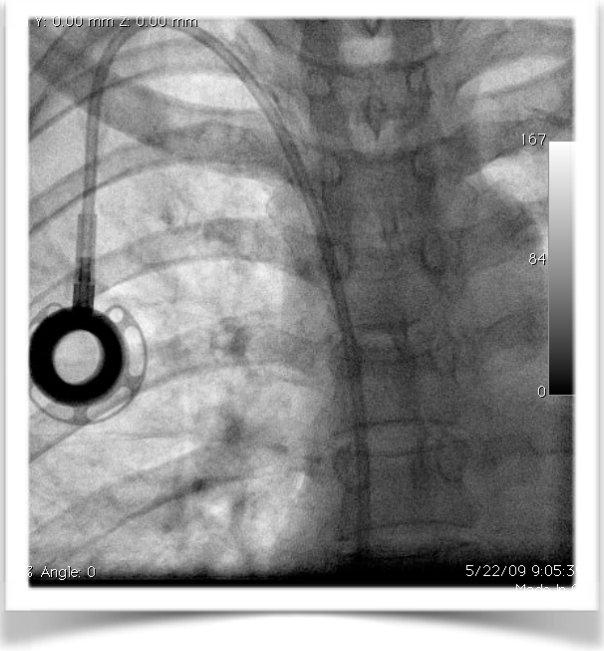


VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

Venous Access

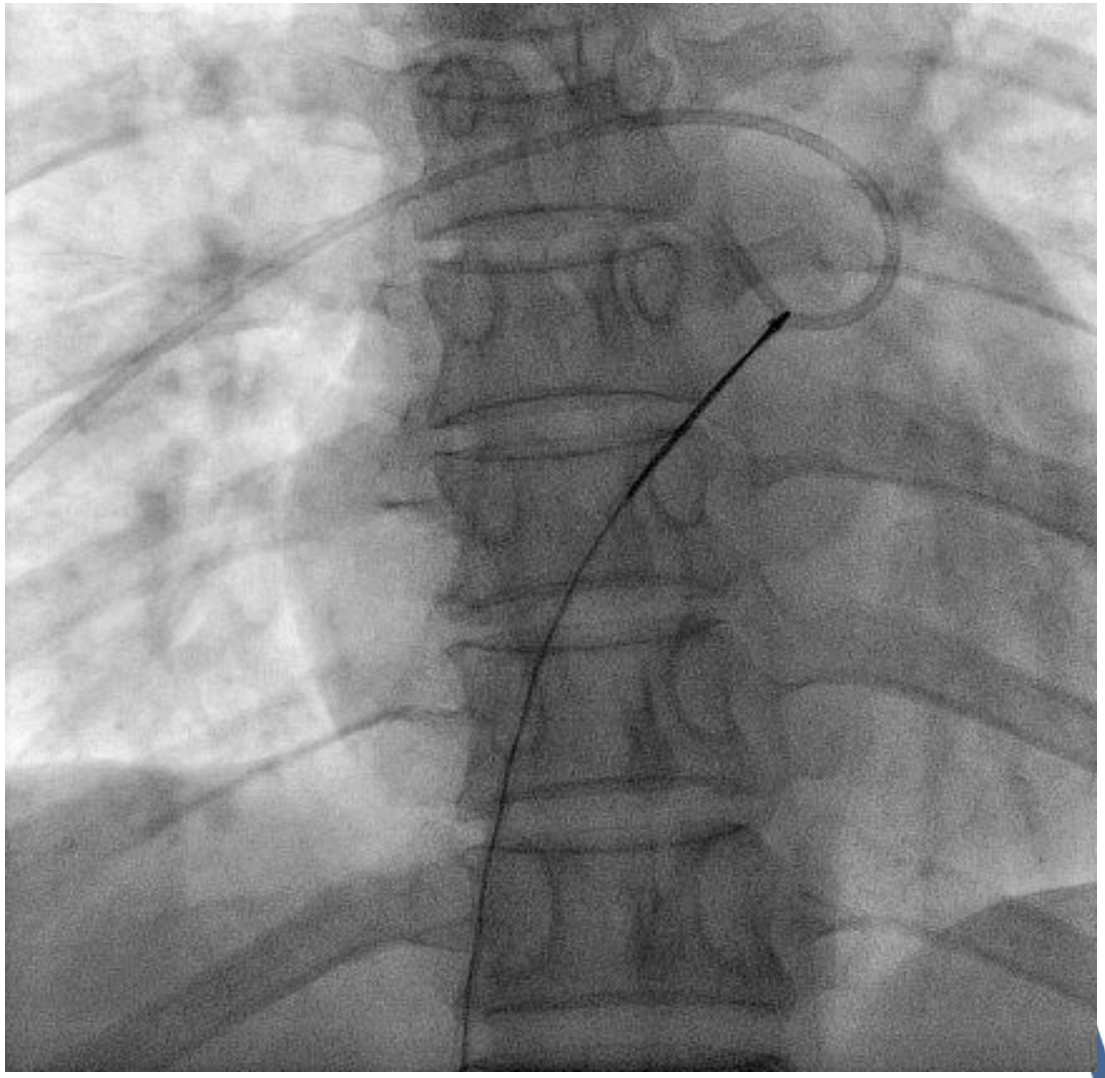






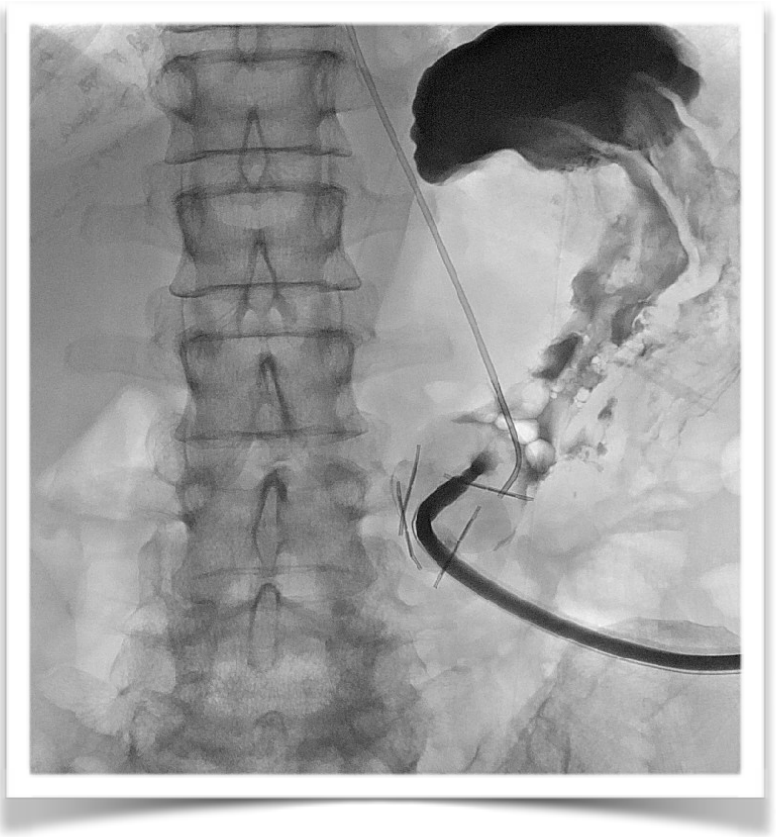
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

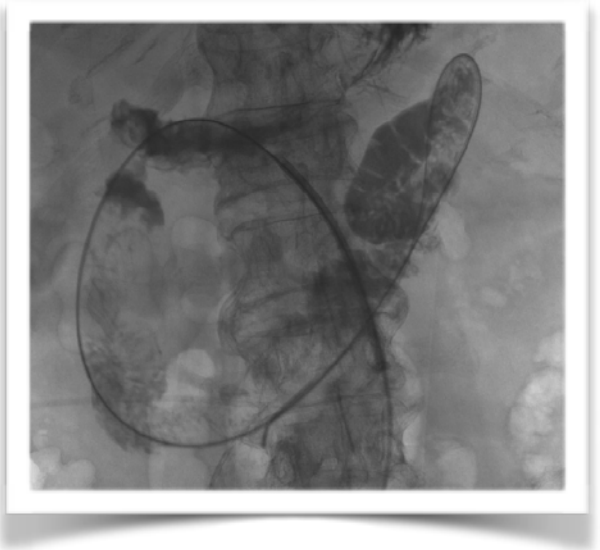
Foreign bodies

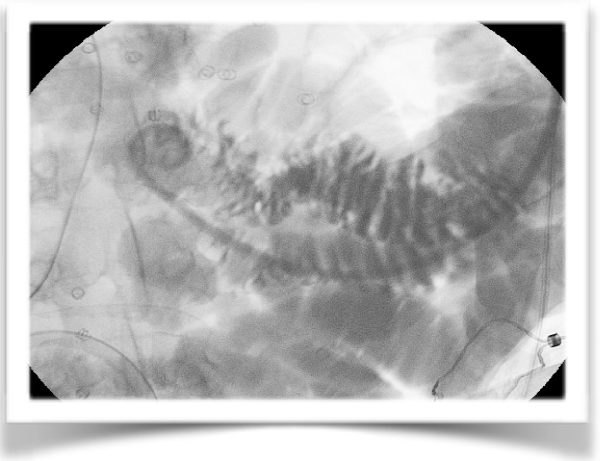


VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

Feeding Tubes

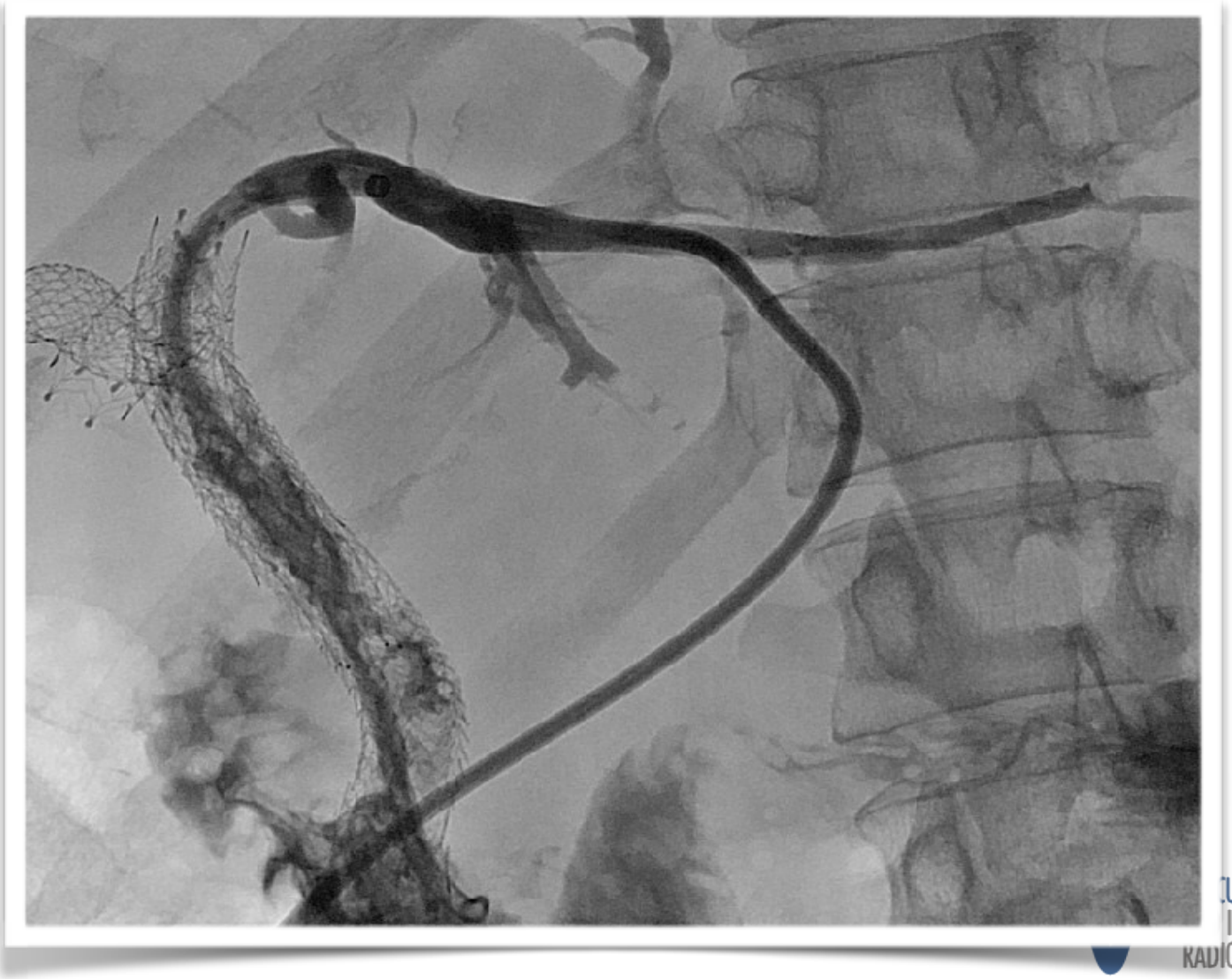




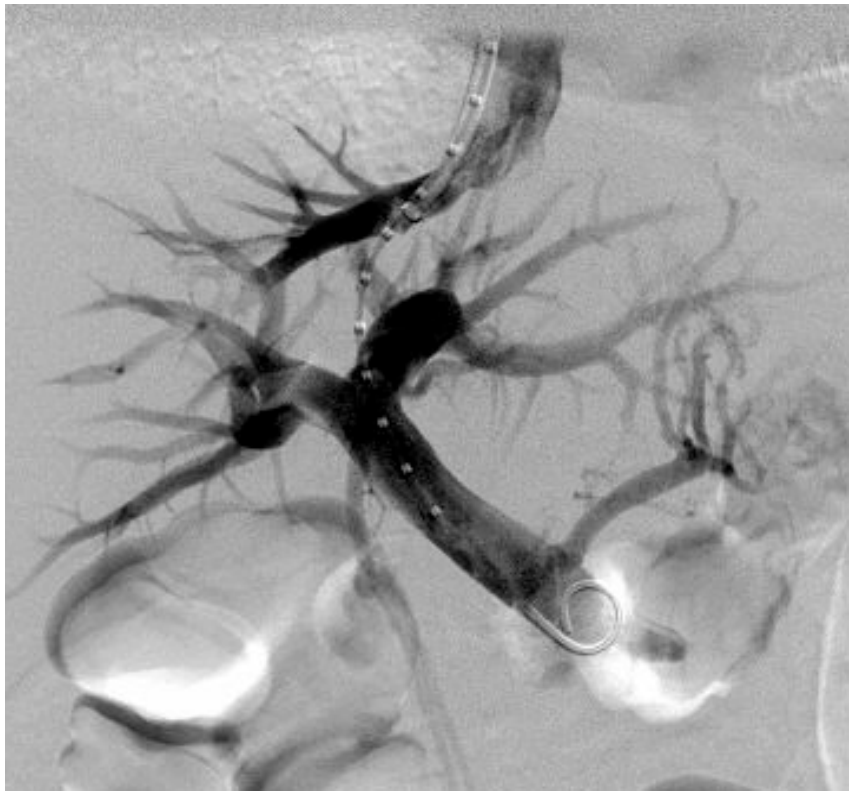


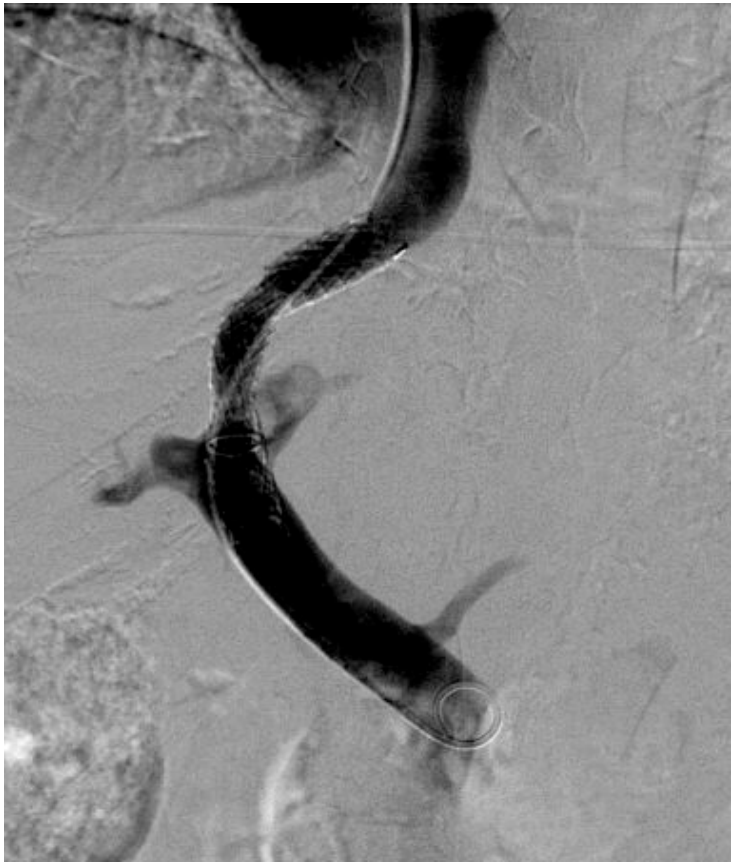
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

Biliary Drainages/Stents



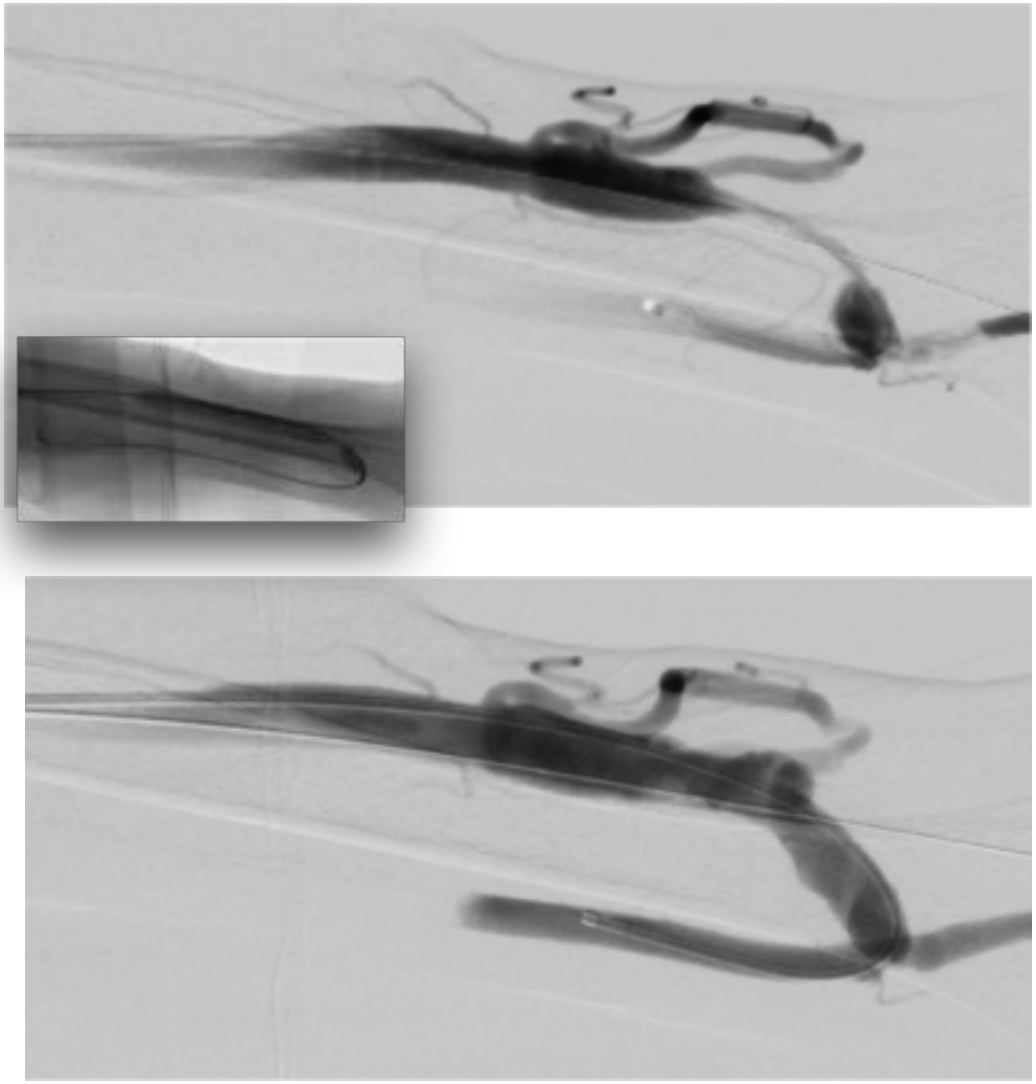
TIPS





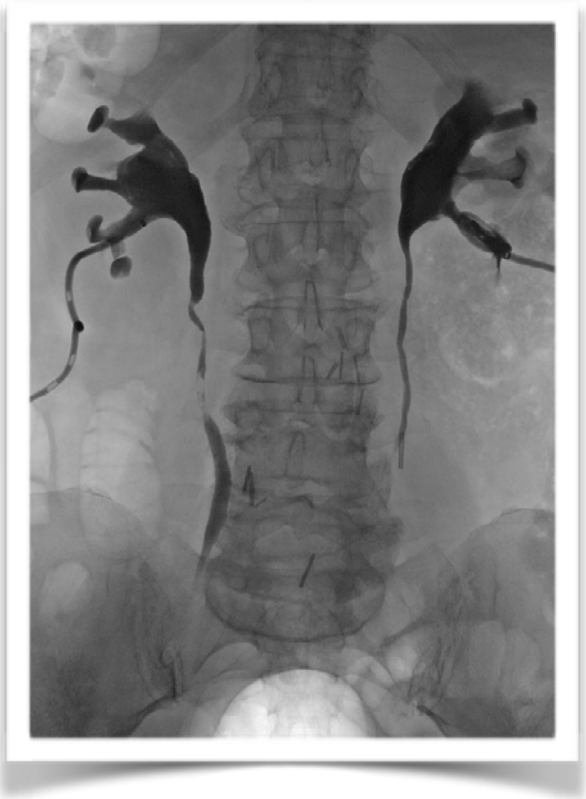
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

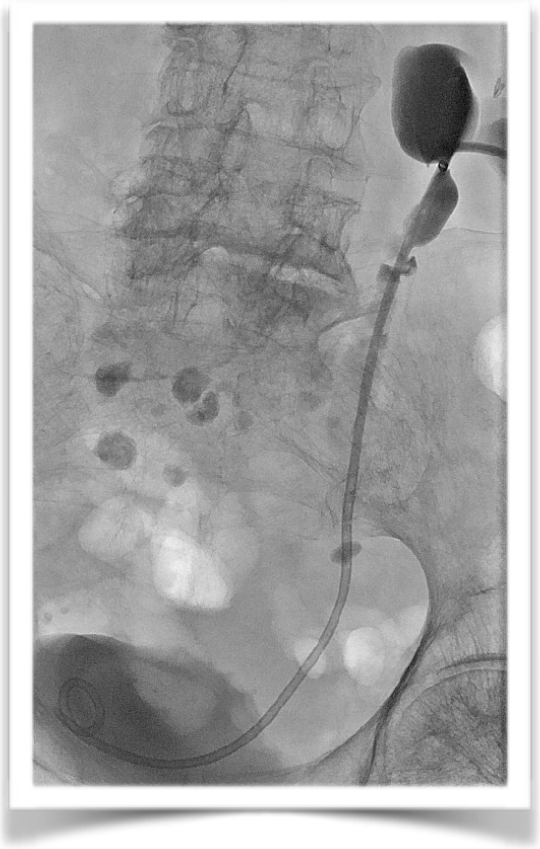
Dialysis Access

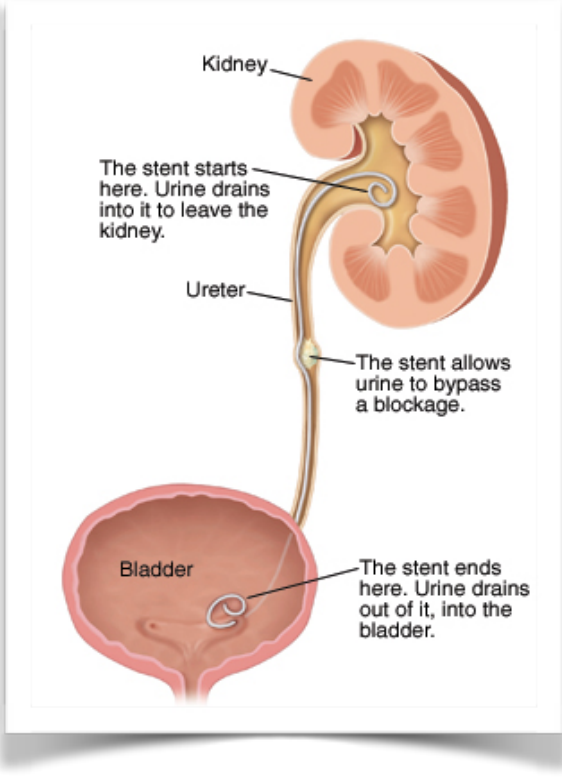


VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

Urology Interventions

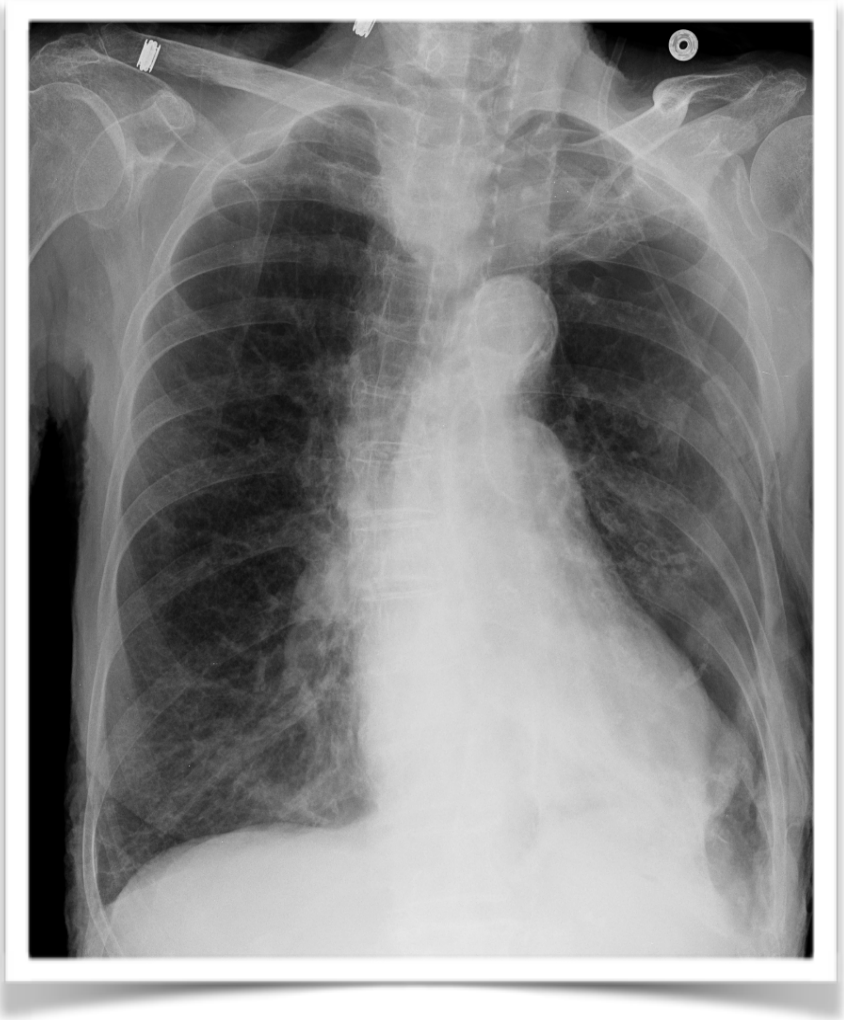


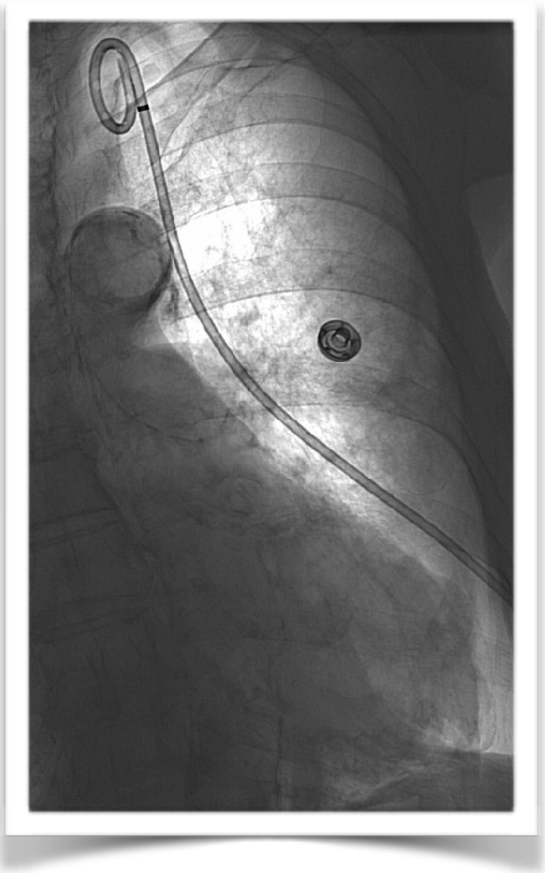




VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

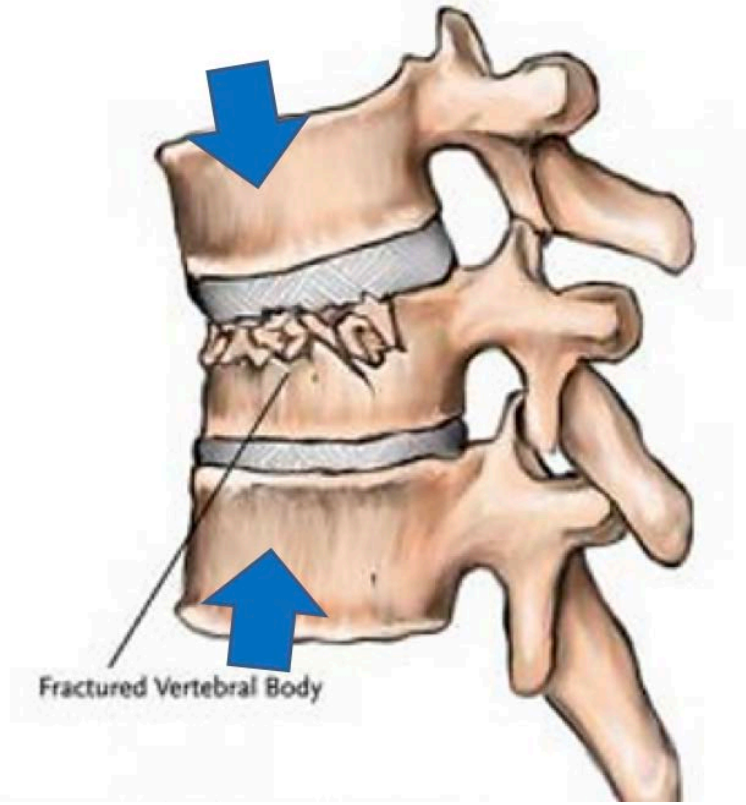
Chest Tubes (PTX, Empyema)





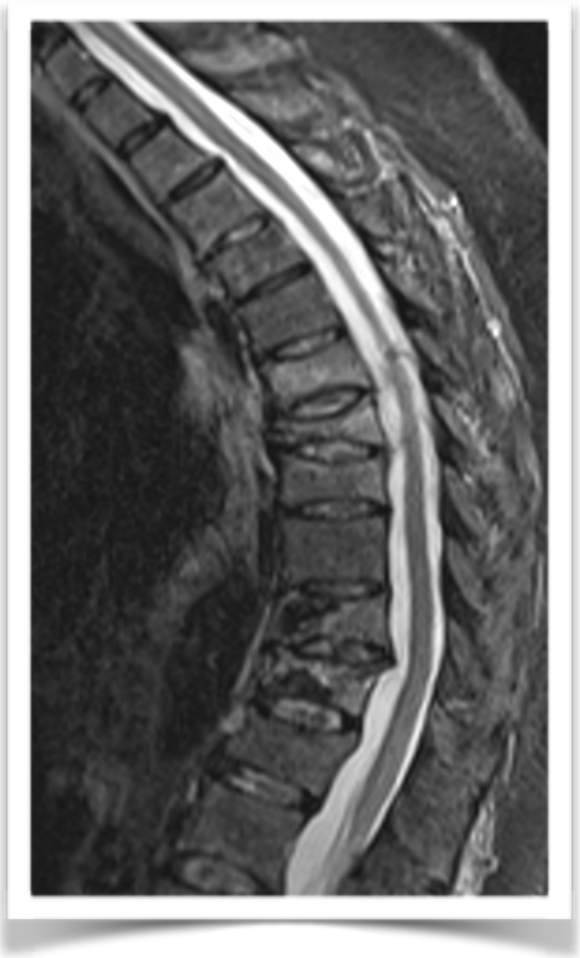
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

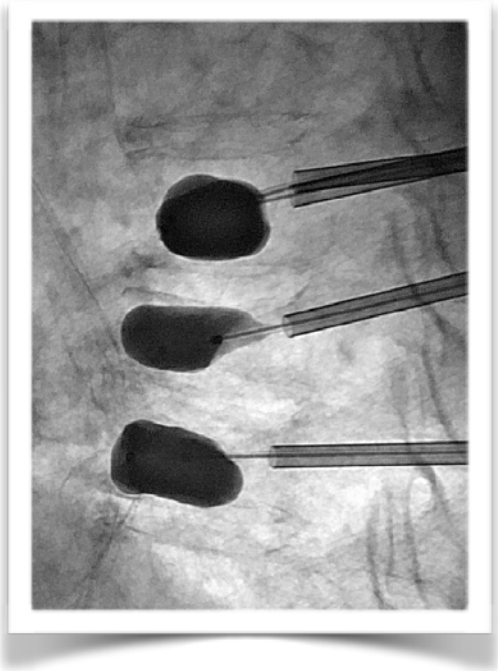
Acute Vertebral Compression Fractures

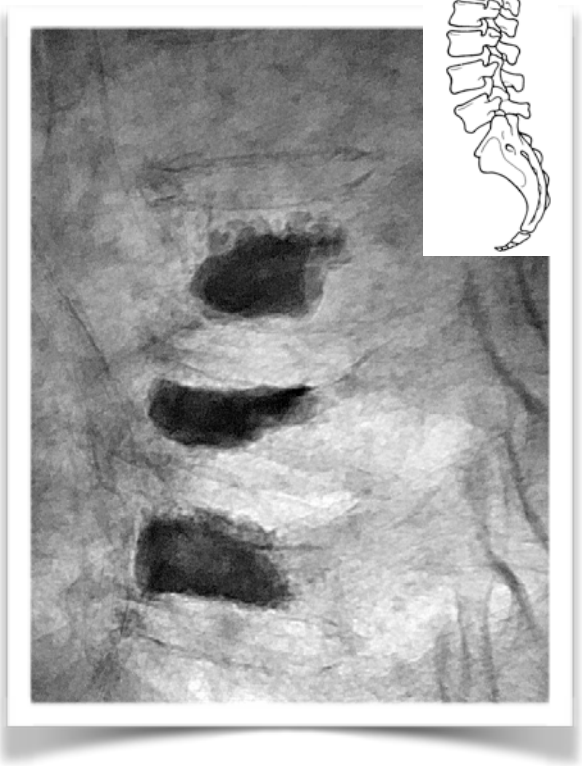


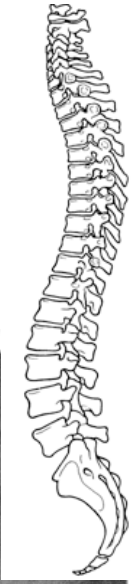
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

Spine Procedures



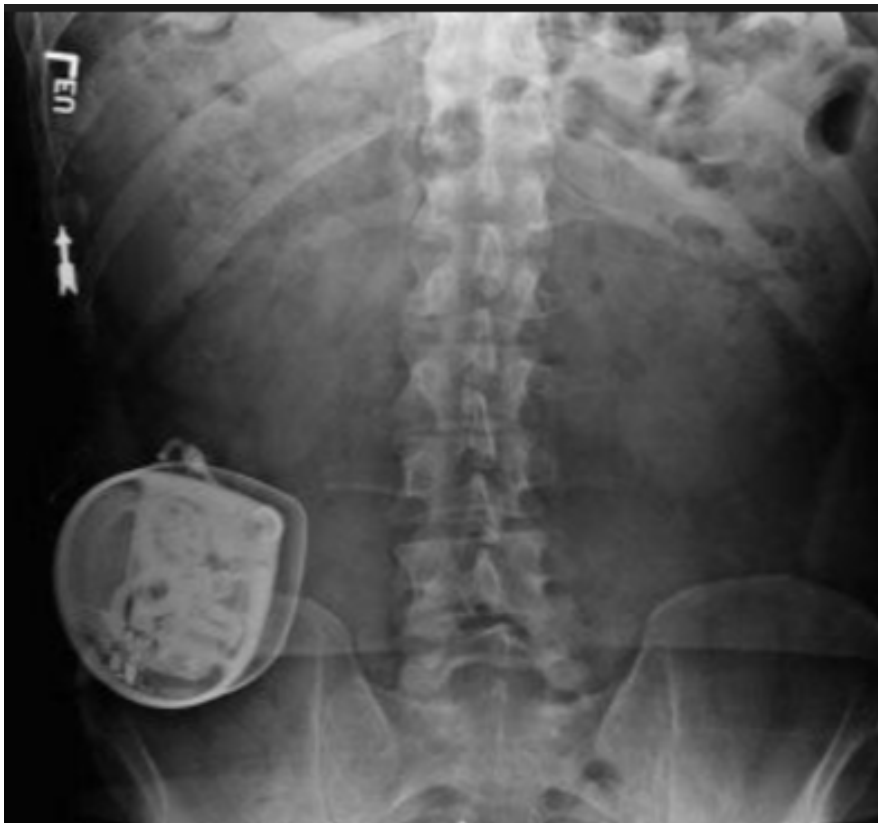






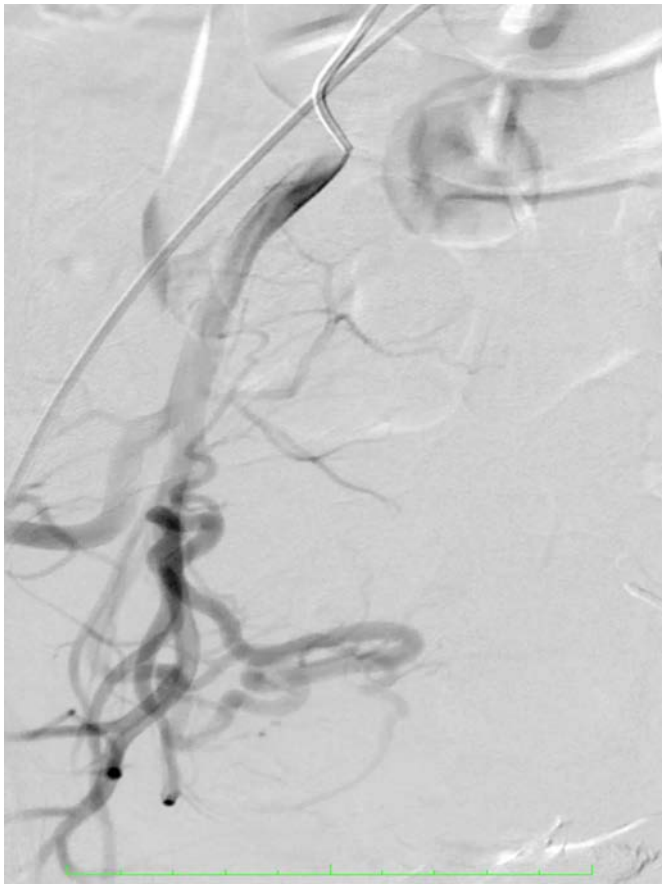
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

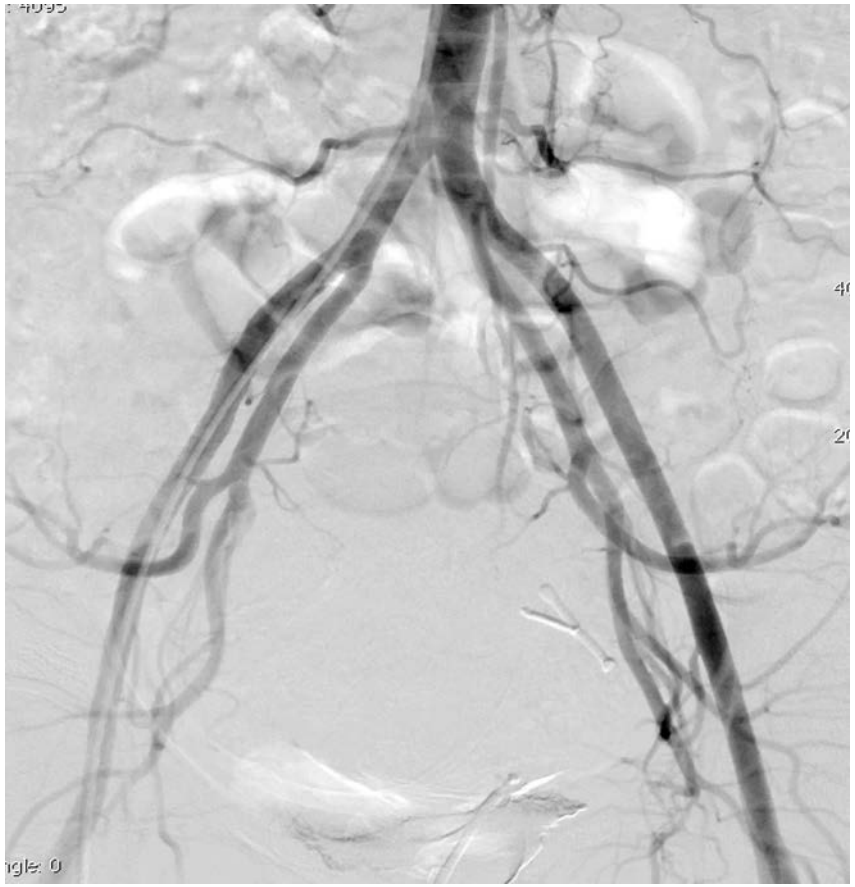
Pain Pumps



VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

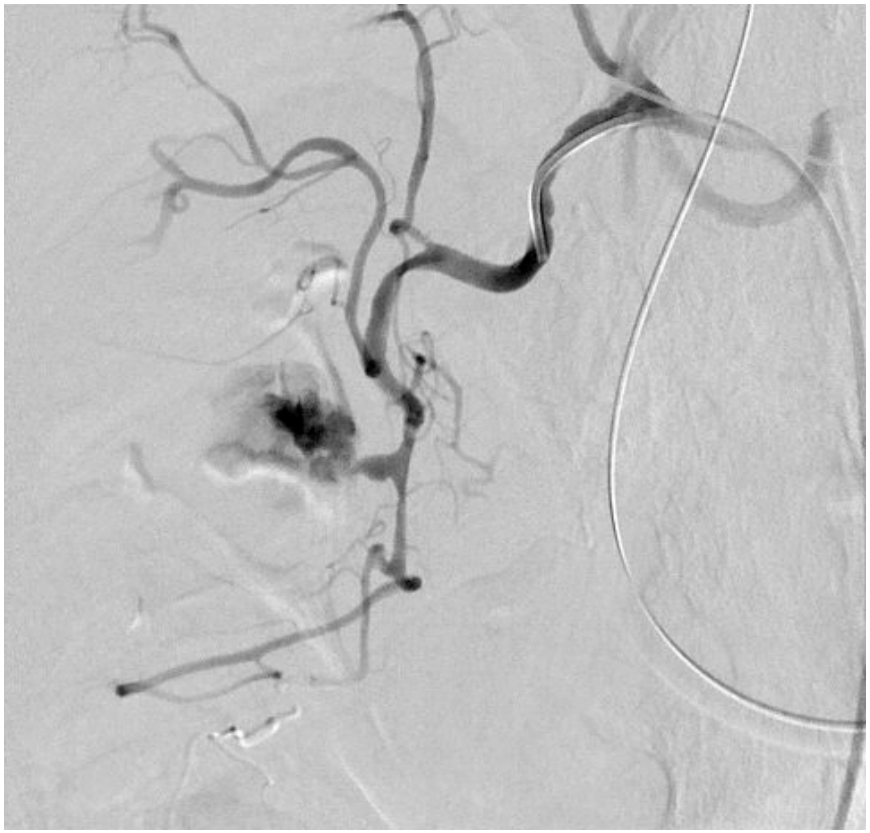
Fibroids/Post partum Bleeding

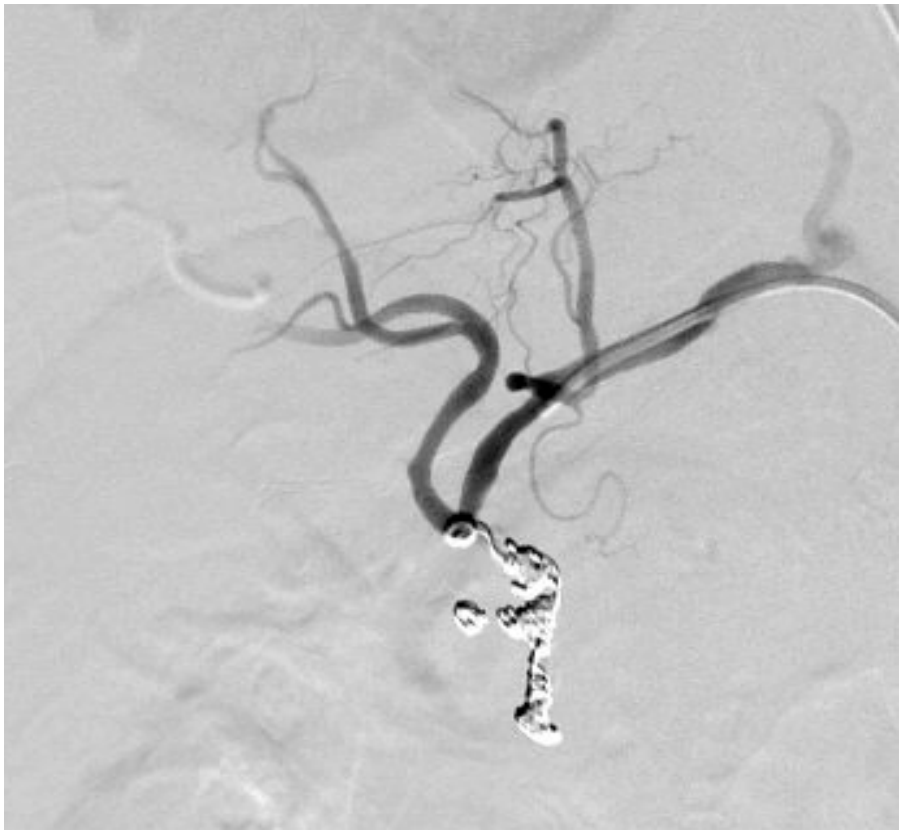




VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

GI Bleeding

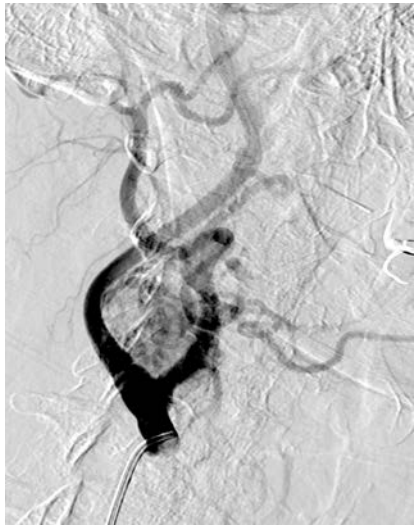




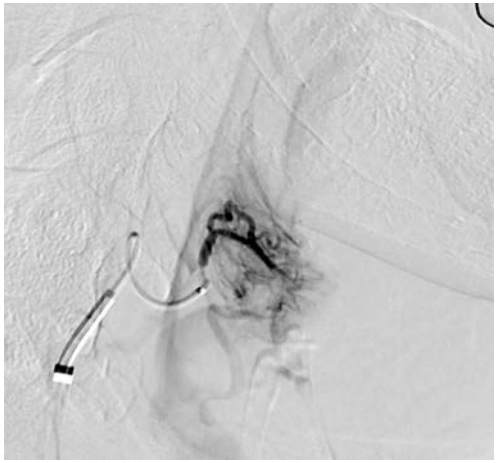
VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

Embolizations

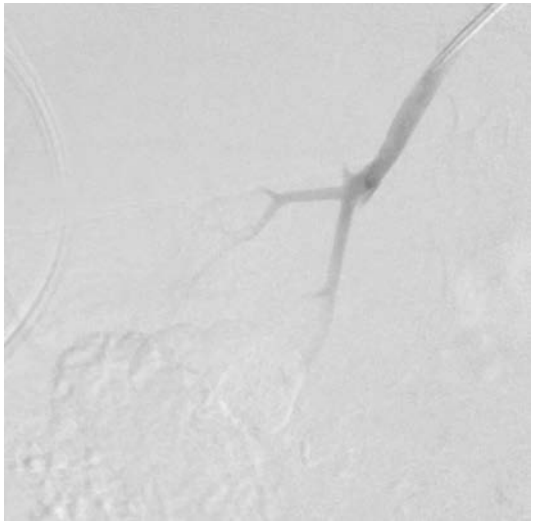
Carotid body tumor



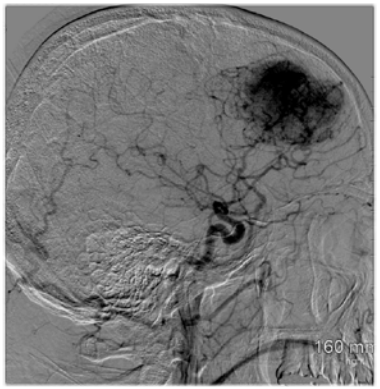
Base of the tongue CA



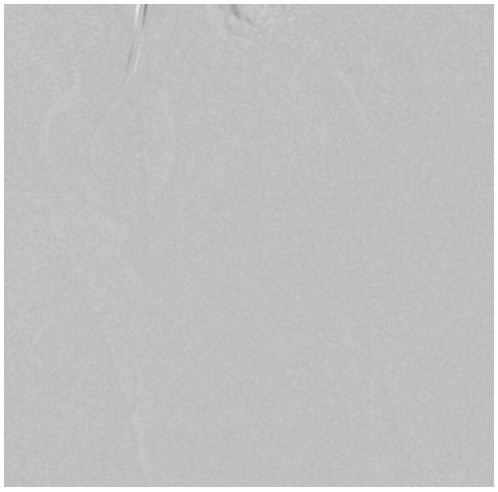
Bleeding renal tumor



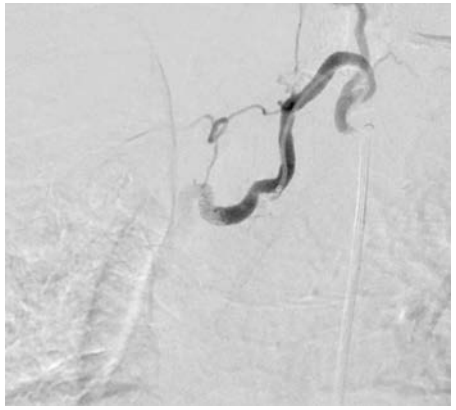
Meningioma



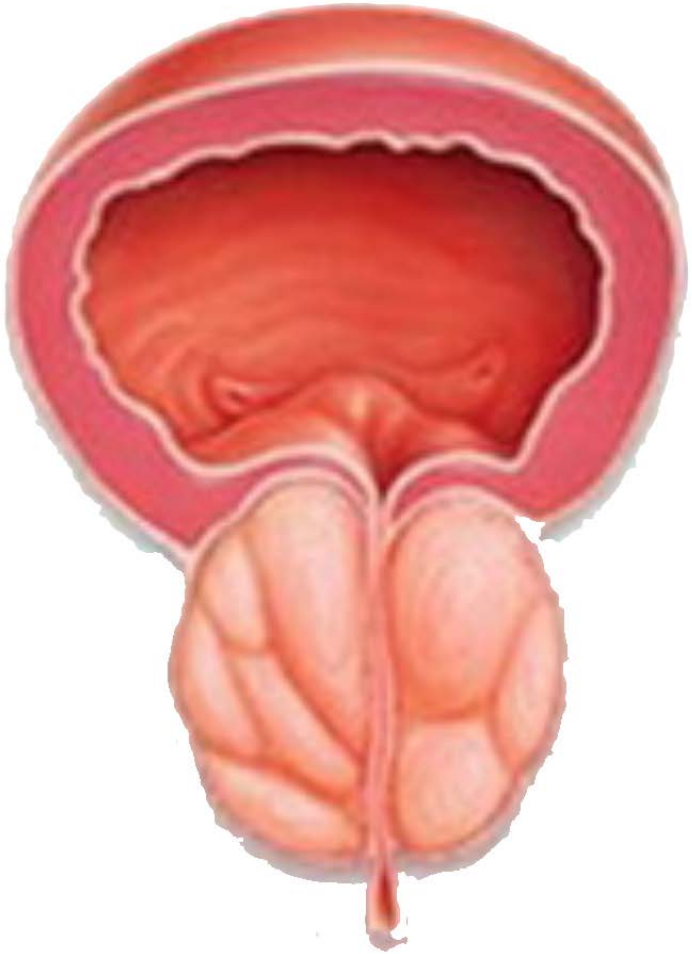
Prostate



Lung Bleeding

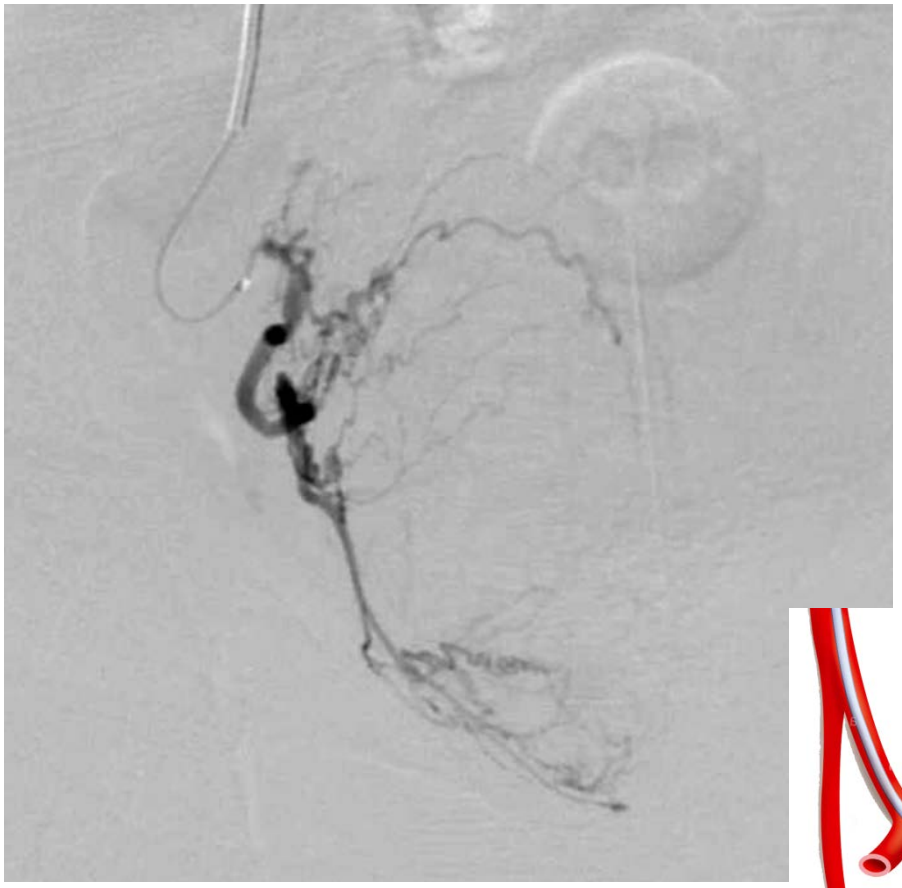


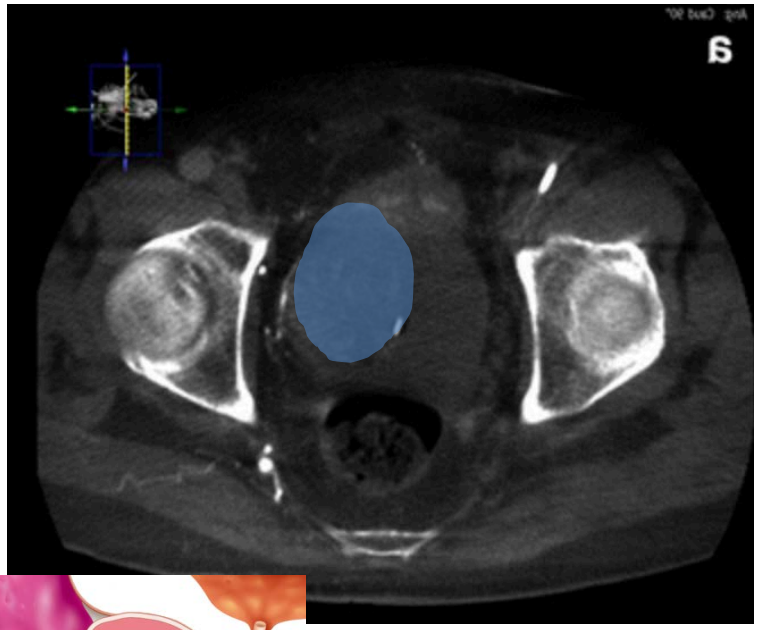
BPH

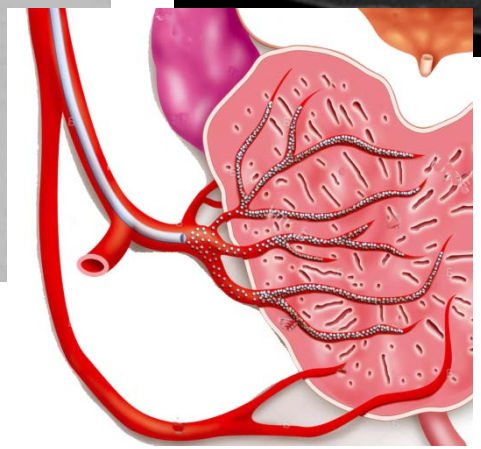


VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

Prostate Embolization







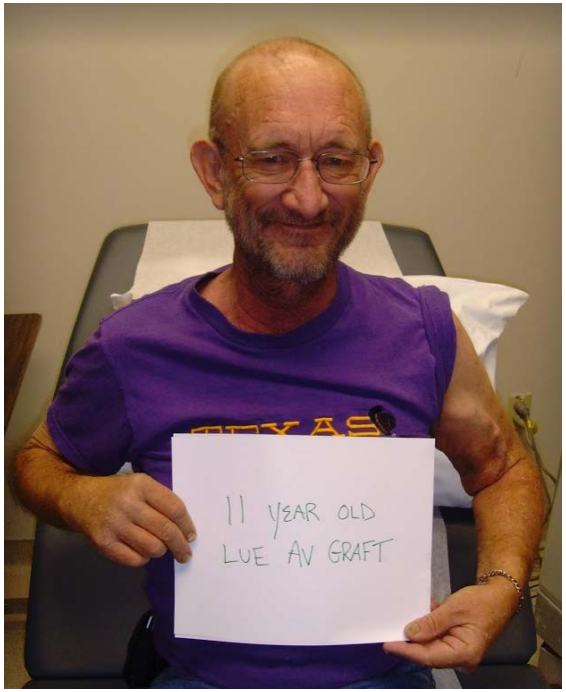
VASCULAR
AND INTERVENTIONAL
RADIOLOGY CLINIC

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,…

VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

IR Programatic Development



- Initiatives to enhance patient satisfaction and further improve patient care quality
- Understand outcomes and compare to benchmarks

VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

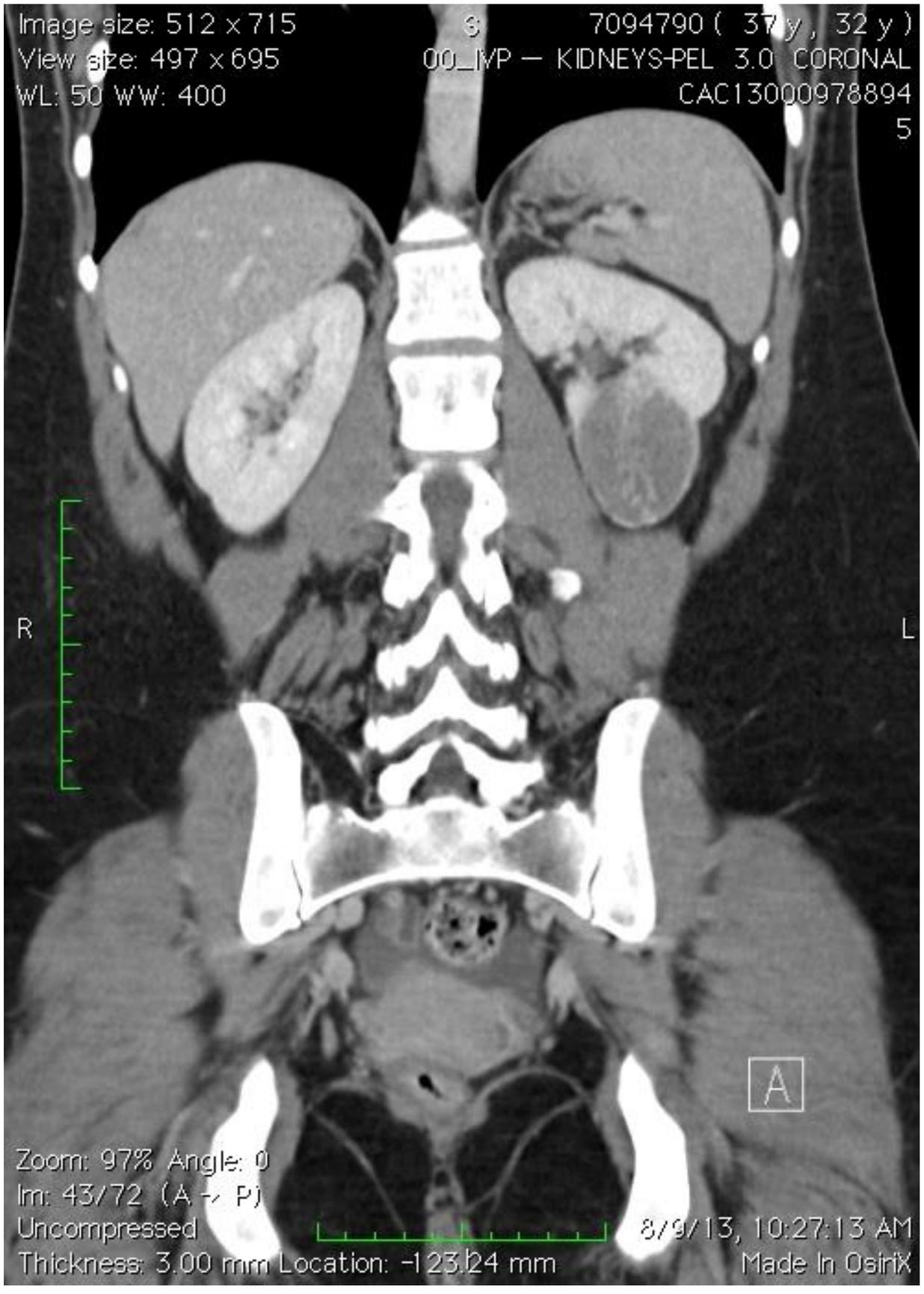
Initiatives to Improve Patient Care Quality

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

VASCULAR AND INTERVENTIONAL RADIOLOGY CLINIC

My Patient Journey:

Wendy Ron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View size: 497 x 695
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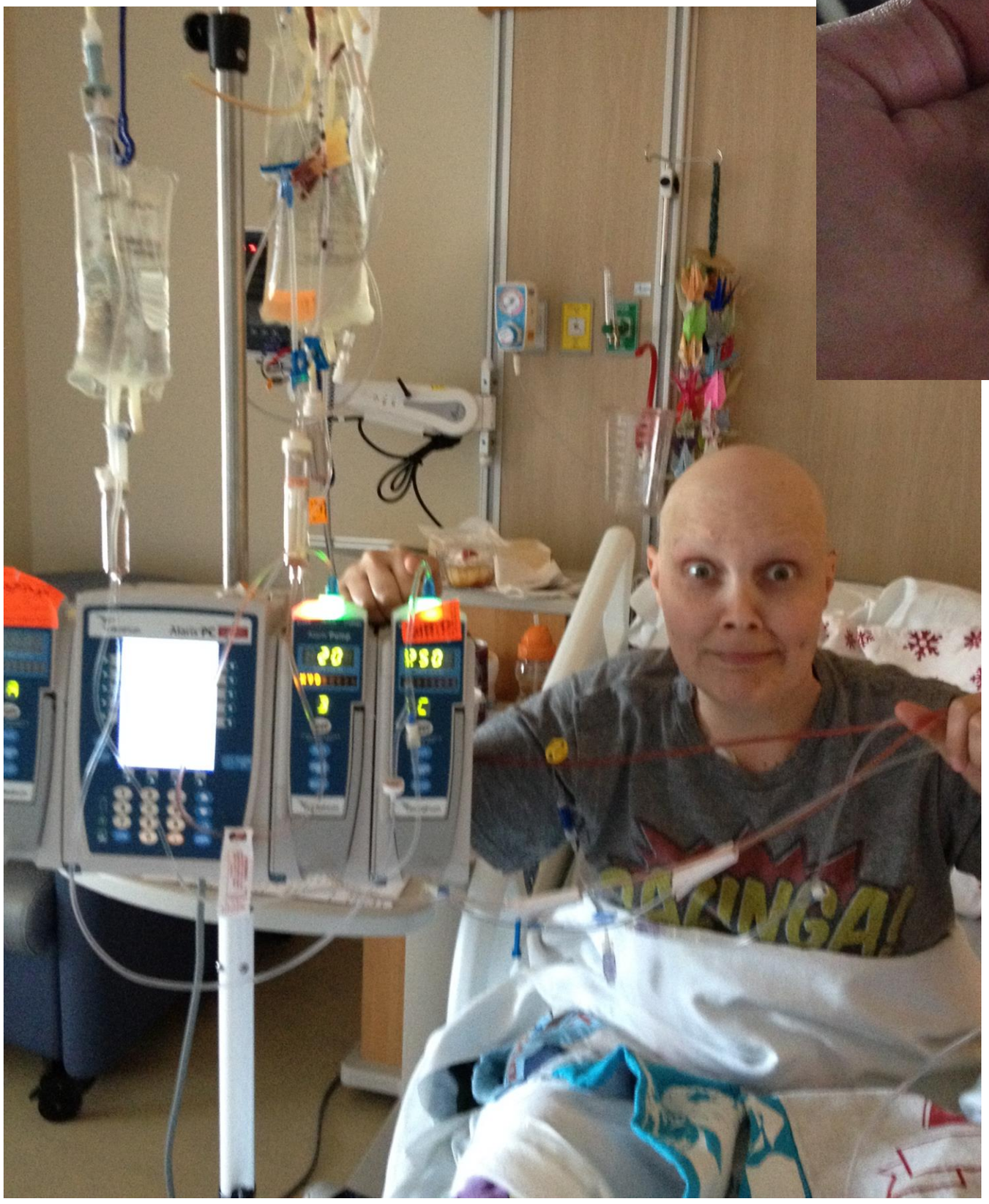
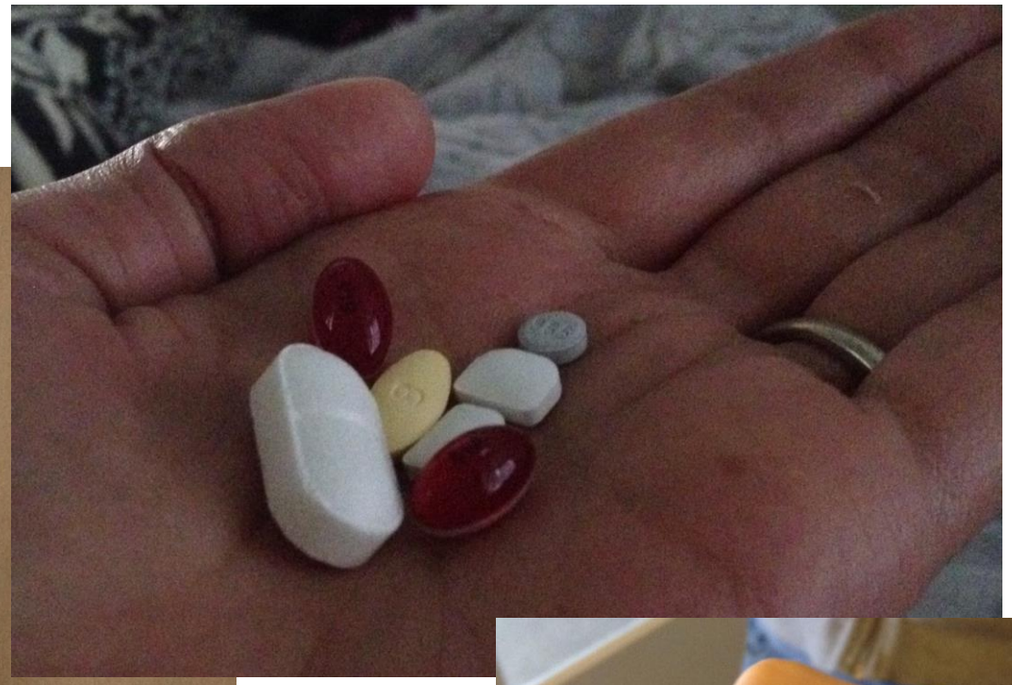
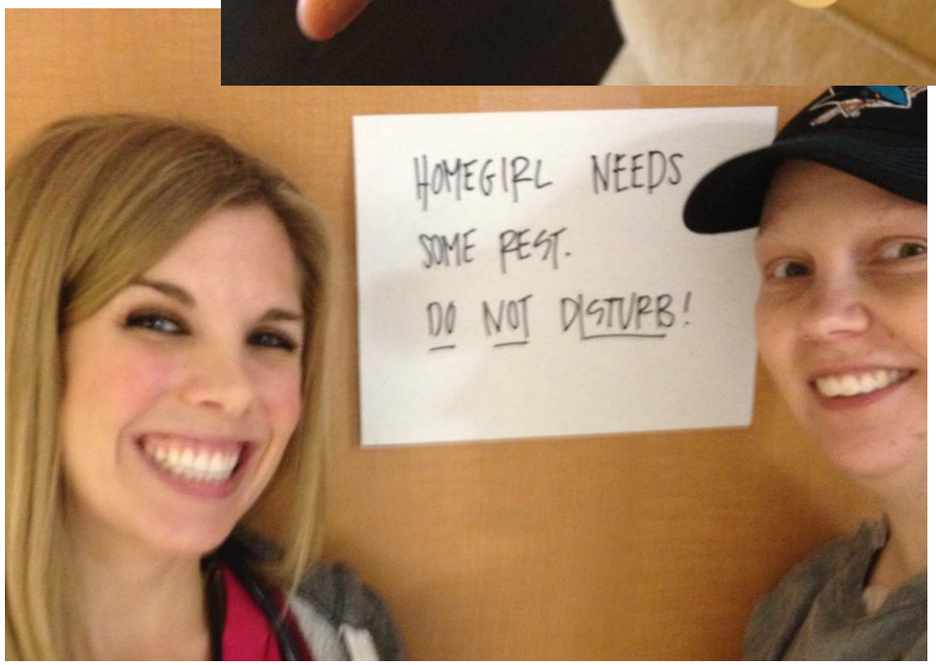
Thickness: 3.00 mm Location: -123.24 mm
Made In OsiriX

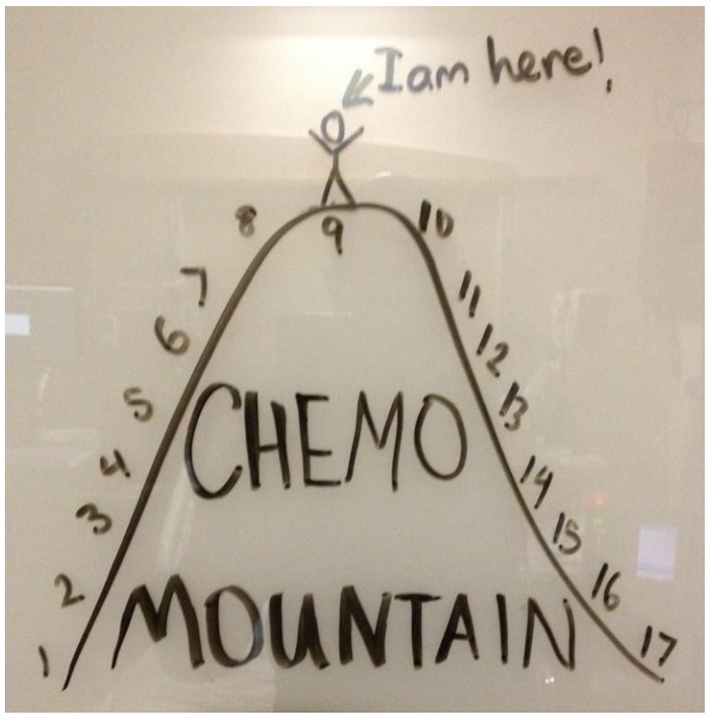





HOMEGIRL NEEDS
SOME REST.
DO NOT DISTURB!


THE SURVIVORSHIP NET
SNOW WHITE
The Pied Piper of Hamelin
Hansel and Gretel
The Brand New Kid
Katie Couric
TOMÁS AND THE LIBRARY LADY


AETHON


I am here!
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
CHEMO
MOUNTAIN

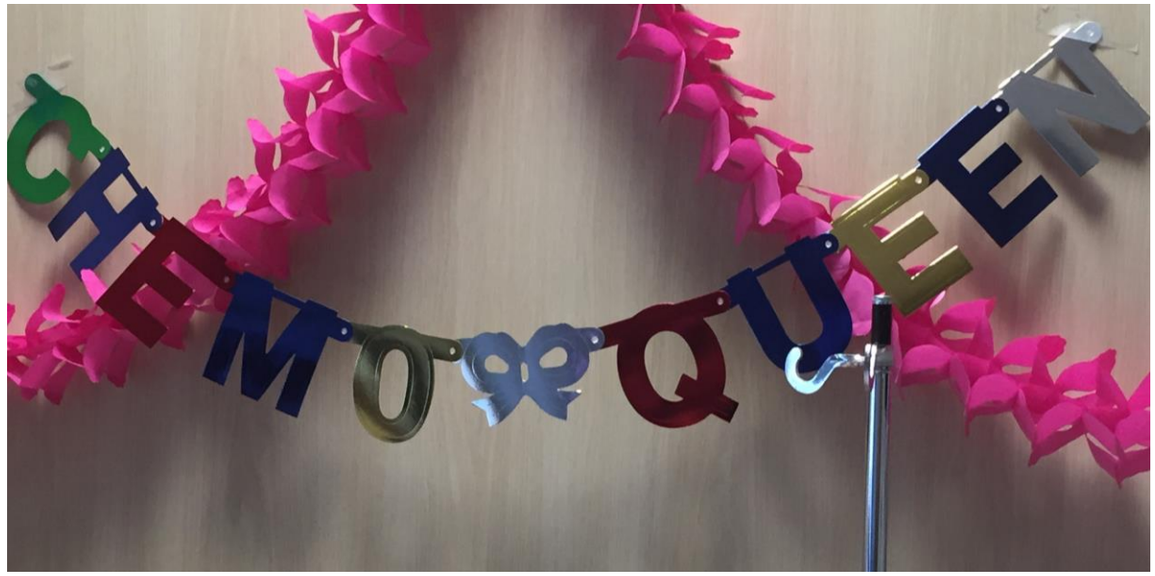

Larry Magee
Robert Zalusky
828
Wendy Ron
Alex Sisler
CANARY CHALLENGE

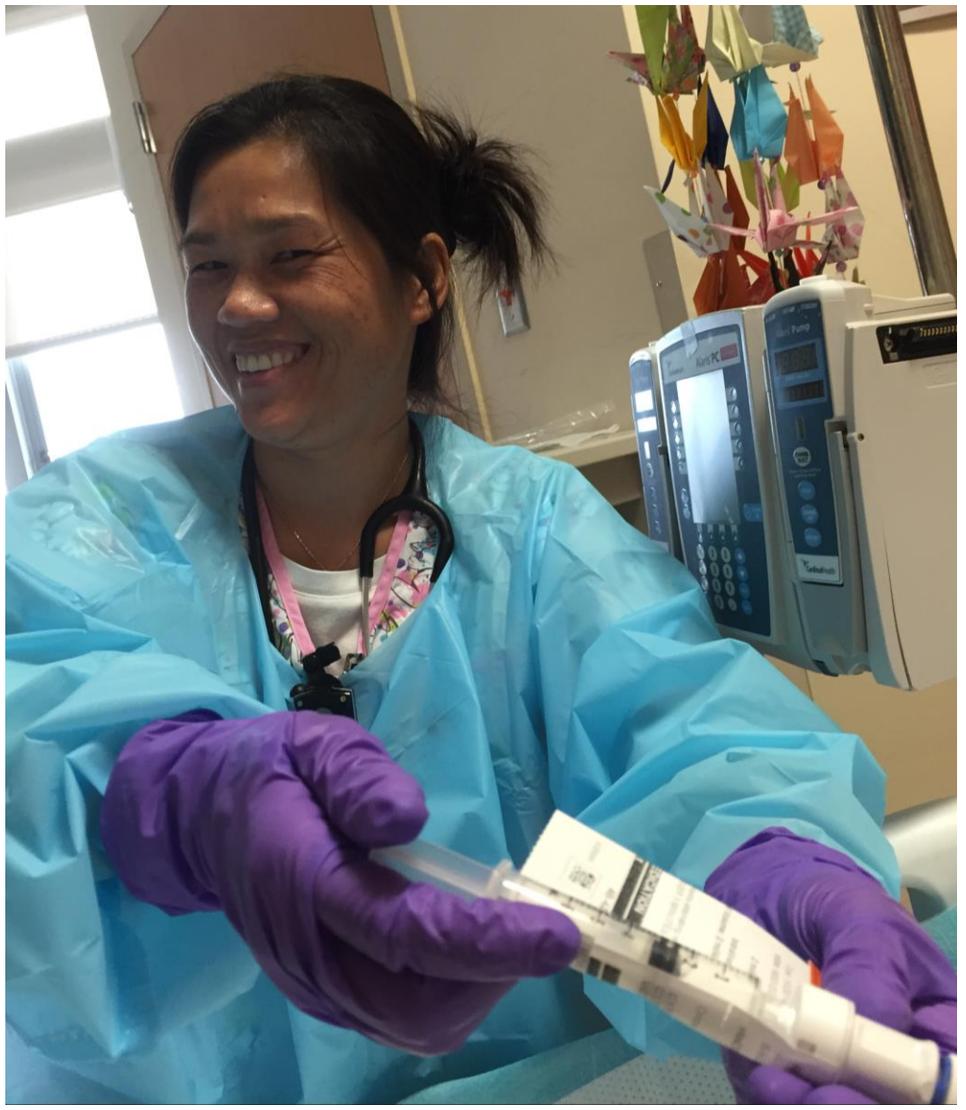

I STAND UP FOR
Wendy Bee!!
S↑2C
MasterCard
standup2cancer.org


PROVIDENCE
PORTLAND TO COAST
2014 WALK RELAY
2370
#FINISHCANCER FOR...
WENDY RON


QUIET ZONE
Wipes


You Did It!!
Wendy Ron
El Camino Hospital
4 B Medical Surgical Oncology
I'm Celebrating!
ZINGA!
Alaris PC
Alaris Pump
50


CHEMO QUEEN



Nurses are the Nicest

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,
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.

Nurses are the nicest,
They do medical stuff and more.
Darren always keeps me up to date,
Like when the Giants score.

Rolando is so jolly,
He's singing in the halls.
But since nurses are the nicest,
I don't mind the thinner walls.

Nurses are the nicest,
They are so sweet and kind.
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.

Nurses are the nicest,
Jessica is my chum.
We swap puppy pictures,
Makes me want another one.

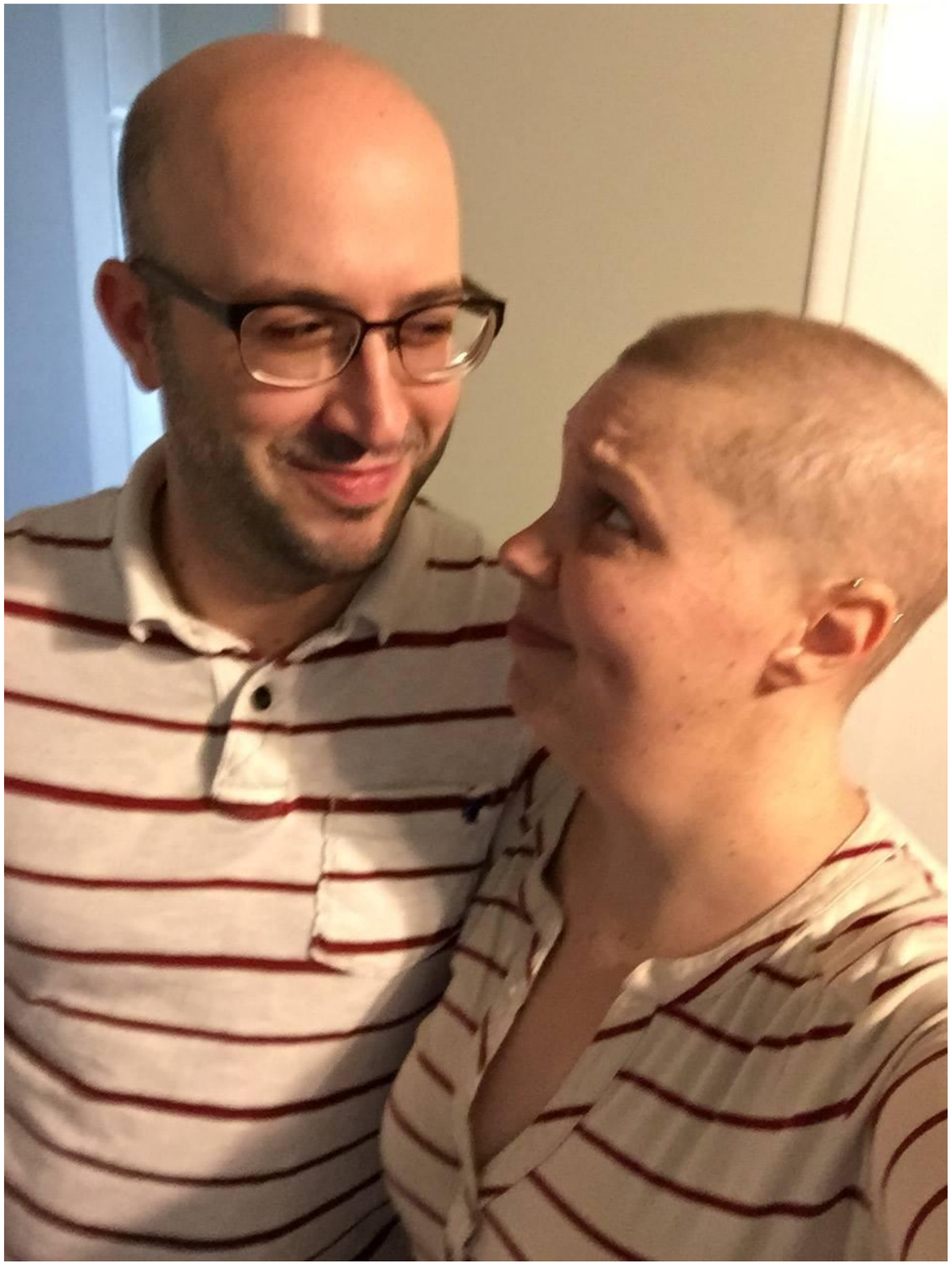
Lily is so lovely,
She makes me feel at ease.
Because nurses are the nicest,
I feel so sad to leave.

Nurses are the nicest,
They hardly make a peep,
Isagani tiptoes in,
To take my vitals as I sleep.

Paula is an angel,
She gently comforts all.
Because nurses are the nicest,
I search for her smile in the hall.

Nurses are the nicest,
They really are a kick.
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

Impression:

1. Status post left nephrectomy.
2. Normal right kidney.


Wendy

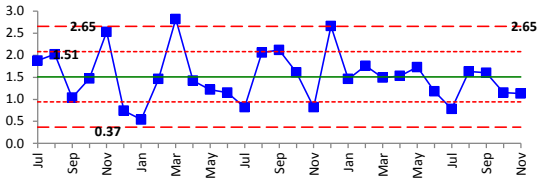
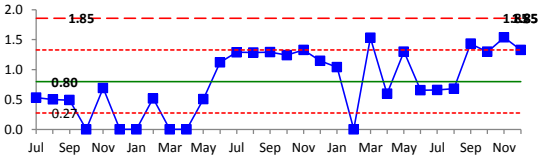
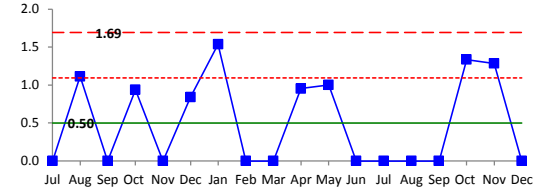
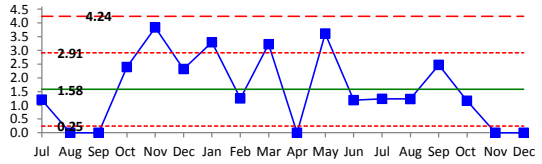
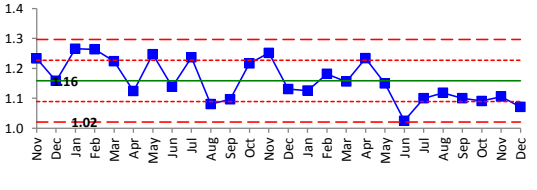

YES
CANCER
FREE!

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

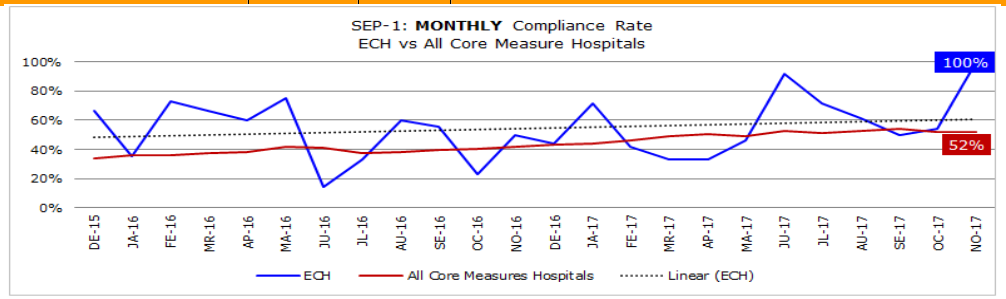
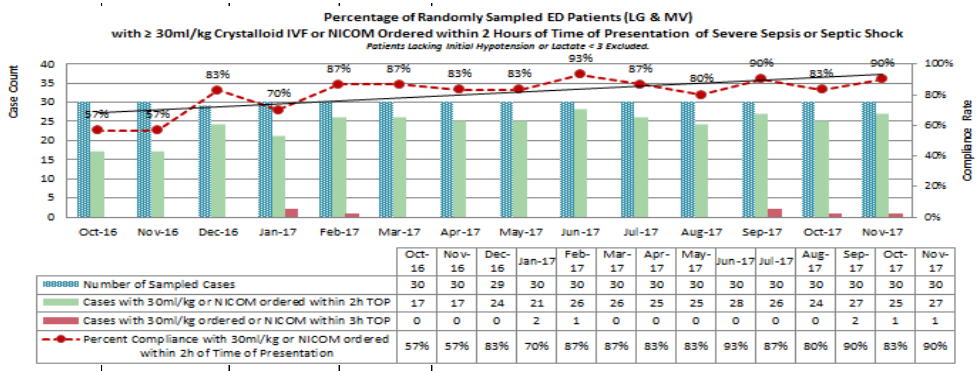
El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Quality and Safety Dashboard (Monthly)

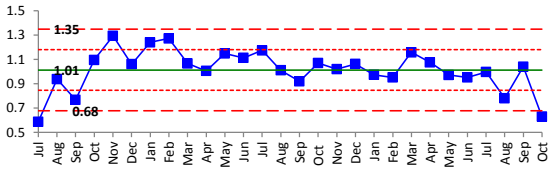
Reports run: 11/20/17			Baseline	FY18 Goal	Trend	Comments
SAFETY EVENTS	Performance Month	Performance FYTD	FY2017 Actual	FY2018 Goal		
1 **Patient Falls** *Med / Surg / CC Falls / 1,000 CALNOC Pt. Days* *Date Period: Nov 2017*	1.13 (6/5,296)	1.26 (32/25496)	1.49	0.74 (Top decile CALNOC)		Only 14 instances of mild injury (f/u x-ray, laceration etc.) 8% did not have Fall Risk Assessment, most were bathroom related, 1/4 were assisted falls, and 14% 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 Aide. Committee recognizing Units who achieved zero falls for 1 year, 30-60-90-120 days without a pt.fall.
2 *Organizational Goal **Hospital Acquired Infection (Infection rate)** *Catheter Associated Urinary Tract Infection (CAUTI)* *per 1,000 urinary catheter days* *Date Period: Dec 2017* *SIR Goal: <= 0.75*	1.33 (2/1,235)	1.1 (10/8735)	1.09	SIR Goal: <= 0.75 SIR July-Dec.2017 = 1.459		2 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/o 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.
3 *Central Line Associated Blood Stream Infection (CLABSI)* *per 1,000 central line days* *Date Period: Dec 2017* *SIR Goal: <= 0.50*	0.0 (0/878)	0.38 (2/5319)	0.56	SIR Goal: <= 0.50 SIR July-Dec.2017 = 0.423		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).
4 *Clostridium Difficile Infection (CDI)* *per 10,000 patient days* *Date Period: Dec 2017* *SIR Goal: <= 0.70*	0.0 (0/8632)	1.01 (5/49,491)	1.89	SIR Goal: <= 0.70 SIR July-Dec.2017 = 0.30		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 "Bristol" stool scale to assist nursing with stool assessment & documentation and improve quality of stool samples sent to Lab for C.Diff. Recommendation approved to Steering Committee to increase EVS staffing to utilize Xenex Ultraviolet machines on all isolation rooms, expand to Imaging and Cath Lab for post discharge & end of day cleaning.
Efficiency	Performance Month	Performance FYTD	FY17 Actual	FY 2018 Goal		
5 ★Organizational Goal **Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)** *(Medicare definition, MS-CC, Inpatient)* *Date Period: Dec 2017*	1.07	1.10	1.16	1.11		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 & HVI Surgeons to explain need for documentation of patient's co-morbidities.

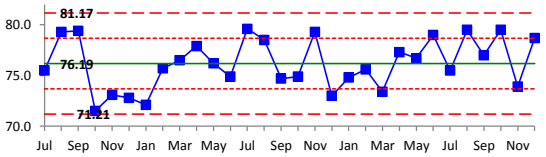
Definitions and Additional Information

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 staff attempts to minimize the impact of the fall, it is still a fall). *Excludes Intentional Falls: When a patient (age 5 or older) falls on purpose or falsely claims to have fallen, it is considered an Intentional Fall and is NOT included. It is NOT considered a fall according to the CALNOC definition.*		**QRR Reporting and Staff Validation**
Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)	Catherine Carson/Catherine Nalesnik				
Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)	Catherine Carson/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) C. Diff (Clostridium Difficile Infection)	Catherine Carson/Catherine Nalesnik				
Arithmetic Observed LOS Average over Geometric LOS Expected.	Cheryl Reinking Catherine Carson (Jessica Hatala)		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.		

Reports run: 9/20/17		Baseline	FY18 Goal	Trend	Comments
6	**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! .
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: 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.

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Number of Sampled Cases	30	30	29	30	30	30	30	30	30	30	30	30	30	30
Cases with 30ml/kg or NICOM ordered within 2h TOP	17	17	24	21	26	26	25	25	28	26	24	27	25	27
Cases with 30ml/kg ordered or NICOM within 3h TOP	0	0	0	2	1	0	0	0	0	0	0	2	1	1
Percent Compliance with 30ml/kg or NICOM ordered within 2h of Time of Presentation	57%	57%	83%	70%	87%	87%	83%	83%	93%	87%	80%	90%	83%	90%

Mortality	Performance Month	Performance FYTD	FY 2017	FY 2018	Trend	Comments
8 **Mortality Rate** ***Observed/Expected*** ***Premier Standard Risk Calculation Mode*** *Date Period: Oct 2017*	0.63 (1.01%/1.61%)	0.86 (1.32%/1.54%)	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 0.63 and approaching our goal of the top decile of western US hospitals.

SERVICE	Performance Month	Performance FYTD	FY 2017 Actual	FY 2018 Goal	Trend	Comments
9 «Organizational Goal **HCAHPS Rate Hospital 0-10 Top Box Rating 9 and 10** *Date Period: Dec 2017*	78.7 (170/230)	77.4 (1086/1404)	76.30	78.0%		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%.

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; Ashley Fontenot Cheryl Reinking	Patient Experience Committee	"'9' or '10' (high)" for the Overall Hospital Rating item	**Press Ganey Tool**

FY 2018 Organizational Goal:
Reduce Hospital-Acquired Infections (HAI)
Update: 1-22-2018

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

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

	Baseline 7/1/2016-6/30/2017*			Qtr 1, FY 2018			Qtr 2 , FY 2018 (through October 2017)			Qtr 3, FY 2018			Qtr 4, FY 2018		
	Observed Rate	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*	*Observed Rate*	*Expected Rate*	*O/E Ratio*
Overall	11.27%	10.63%	1.06	9.57%	9.59%	1.00	4.60%	8.89%	0.52						
Acute Myocaridal Infarction (AMI)	12.20%	10.51%	1.16	6.67%	8.58%	0.78	18.75%	11.93%	1.57						
Chronic Obstructive Pulmonary Disease (COPD)	15.15%	14.52%	1.04	25.00%	14.53%	1.72	0.00%	15.65%	0.00						
Coronary Artery Bypass Graft (CABG)	14.29%	8.03%	1.78	5.88%	8.86%	0.66	0.00%	8.47%	0.00						
Heart Failure	17.88%	14.45%	1.24	14.02%	13.85%	1.01	5.88%	13.03%	0.45						
Pneumonia	11.11%	12.88%	0.86	17.82%	14.91%	1.20	4.35%	10.56%	0.41						
Stroke	6.70%	7.31%	0.92	10.53%	8.24%	1.28	0.00%	7.92%	0.00						
Total Hip Arthroplasty and/or Toal Knee Arthroplasty	2.87%	2.67%	1.07	2.59%	2.56%	1.01	4.55%	2.78%	1.64						

* Source: Premier Quality Advisor- Standard CS 30 day Readmission methodology for CMS Disease Specifc Readmission Populations

QUALITYADVISOR™

PSI - 90 Total Inpatient - Flex Timeframe

Report Filter: ***AHRQ QI Version 5.0***

Facility:El Camino Hospital Los Gatos (661972) (CA) (Facility:07-01-2012 to 10-31-2017) (Peer:07-01-2012 to 09-30-2017), El Camino Hospital Mountain View (635796) (CA) (Facility:07-01-2012 to 10-31-2017) (Peer:07-01-2012 to 09-30-2017)
Month:
JUNE 2017, JULY 2017, AUGUST 2017, SEPTEMBER 2017, OCTOBER 2017
AHRQ QI Version:5.0

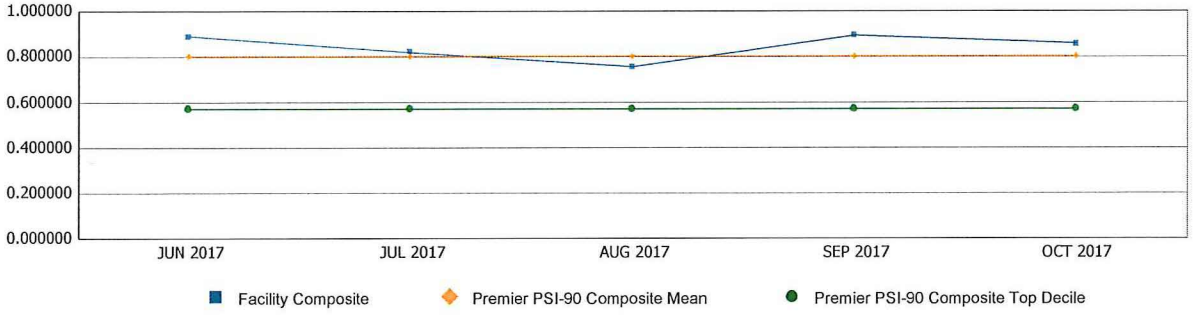
Population Size: 10,022 Drill to Numerator Patients | Drill to Denominator Patients | Switch to Analytical View | Composite by Facility

Patient Safety Indicator	Facility Composite Value	Premier PSI-90 Composite Mean*	Premier PSI-90 Composite Top Decile*
PSI-90 Composite	0.686907	0.80	0.57

Patient Safety Indicator		Numerator	Denominator	Observed Rate/1000	AHRQ Expected Rate	Premier Mean*	Premier Median*	Premier 25th Pctl*	Premier 10th Pctl*
PSI-03	Pressure Ulcer	1	1,570	0.64	0.53	0.47	0.00	0.00	0.00
PSI-06	Iatrogenic Pneumothorax	3	5,462	0.55	0.34	0.21	0.13	0.00	0.00
PSI-07	Central Venous Catheter-Related Blood Stream Infection	0	5,332	0.00	0.18	0.10	0.00	0.00	0.00
PSI-08	Postop Hip Fracture	0	1,069	0.00	0.04	0.05	0.00	0.00	0.00
PSI-12	Perioperative PE or DVT	4	1,996	2.00	5.51	3.71	3.08	1.24	0.00
PSI-13	Postop Sepsis	0	177	0.00	10.74	11.06	5.32	0.00	0.00
PSI-14	Postop Wound Dehiscence	0	305	0.00	1.78	0.09	0.00	0.00	0.00
PSI-15	Accidental Puncture or Laceration	8	5,679	1.41	2.34	0.99	0.76	0.26	0.00

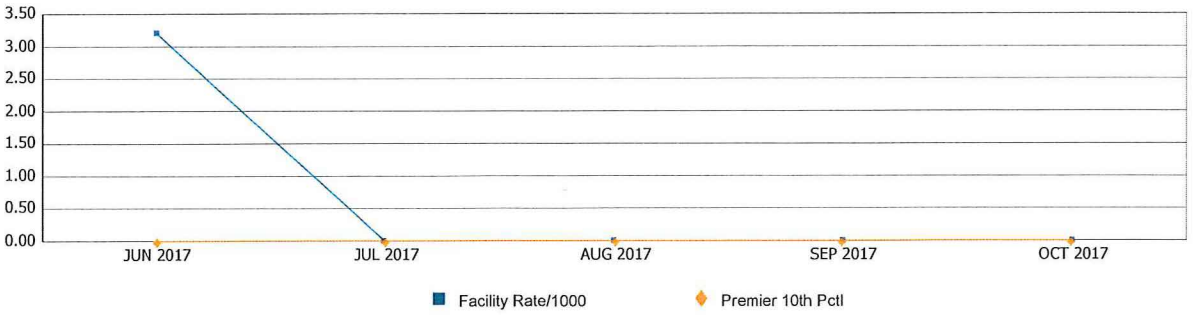
*** Premier Population Statistics (Rate/1000)**
(10-01-2015 to 09-30-2016)

PSI-90 Composite



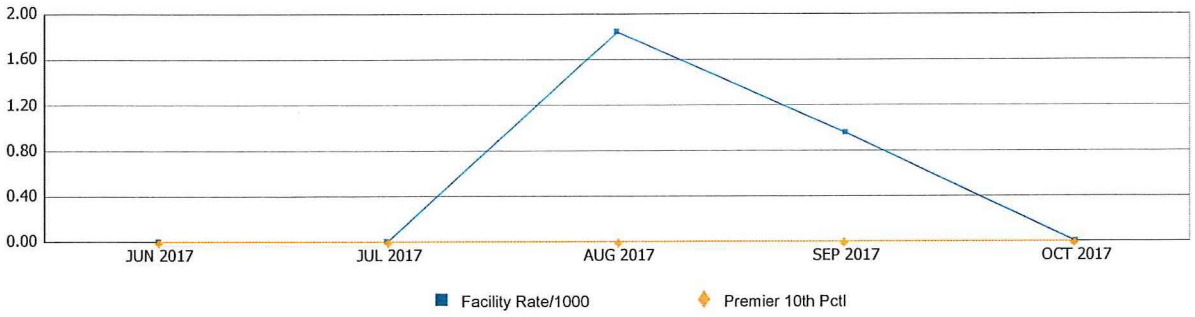
The population for each month is only a fraction of the population for the entire time period of the report. The effect of smoothing is more pronounced for the individual monthly score. Smoothing pulls each monthly score towards 1.0, so this causes the average level of the line plotted on the composite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

PSI-03:Pressure Ulcer



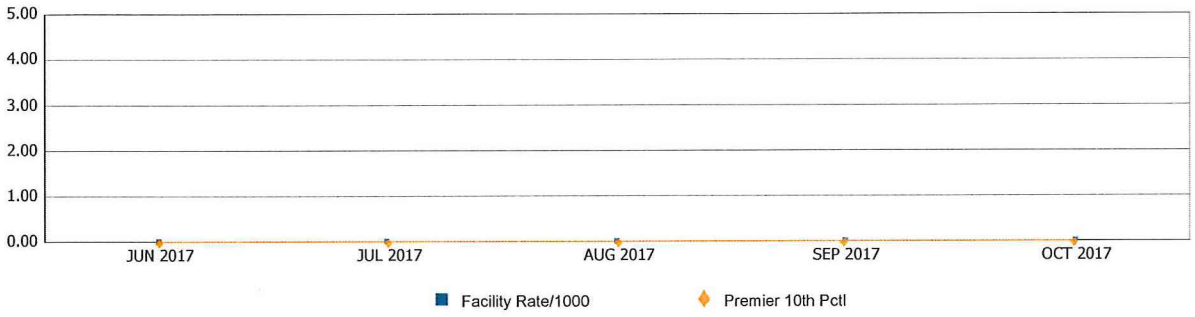
99 yr old w/hx of high blood pressure, heart failure w/chronic renal failure expired with heart failure/ shock after 9 day LOS

PSI-06:Iatrogenic Pneumothorax

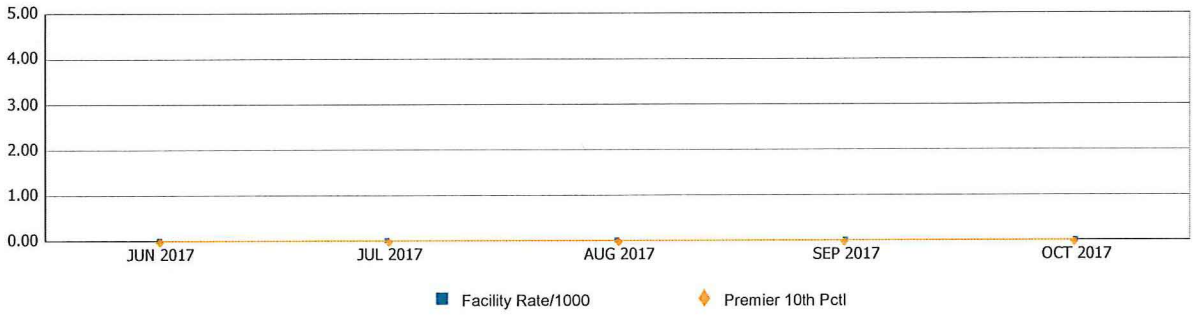


3 cases – 2 spinal surgeries, ~~on~~ kidney resection,
All to Peer Review,
different surgeons

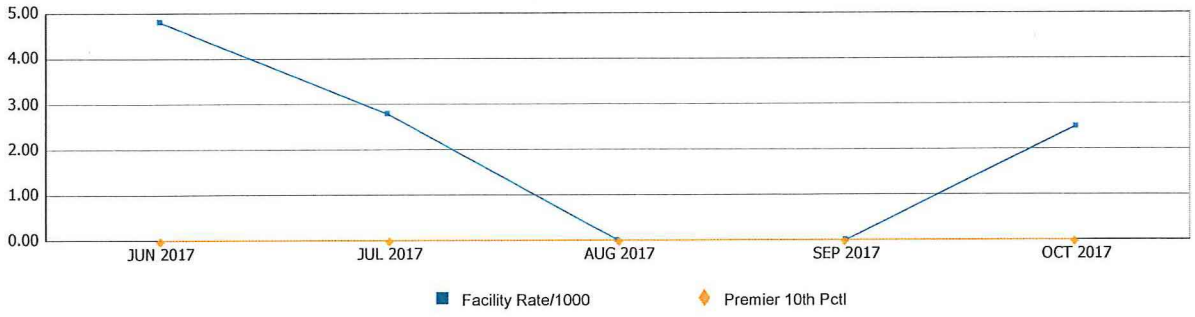
PSI-07:Central Venous Catheter-Related Blood Stream Infection



PSI-08:Postop Hip Fracture

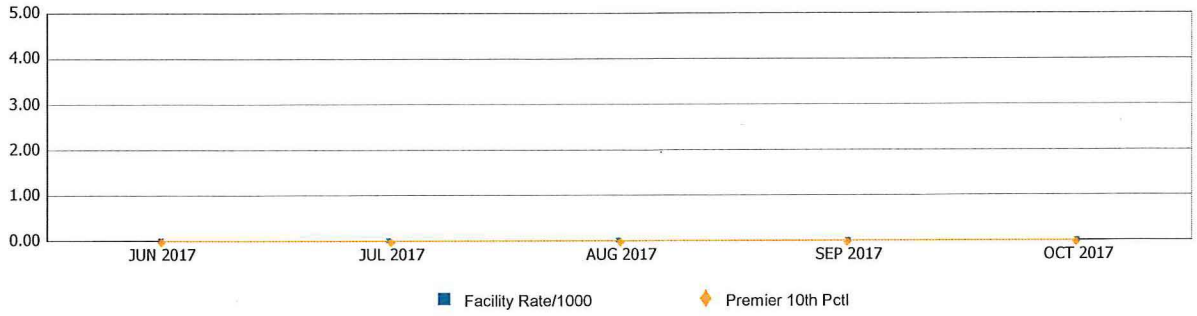


PSI-12:Perioperative PE or DVT

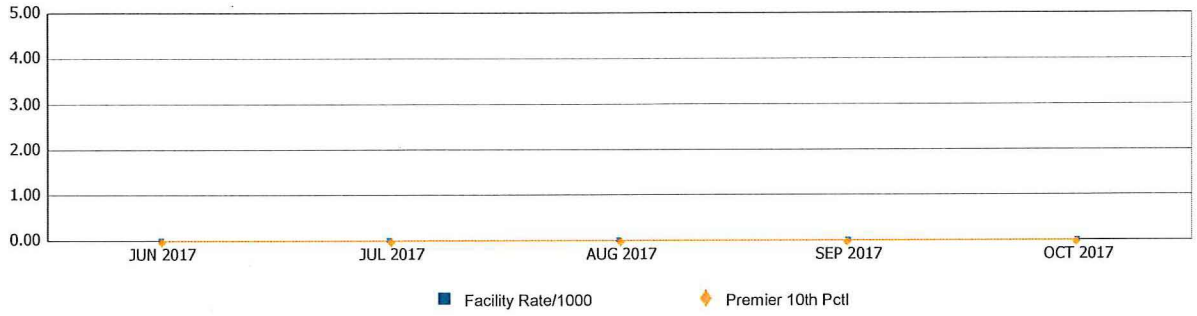


4 cases, all orthopedic:
fx. Femur, fx hip,
hip replacement
Fx humerus

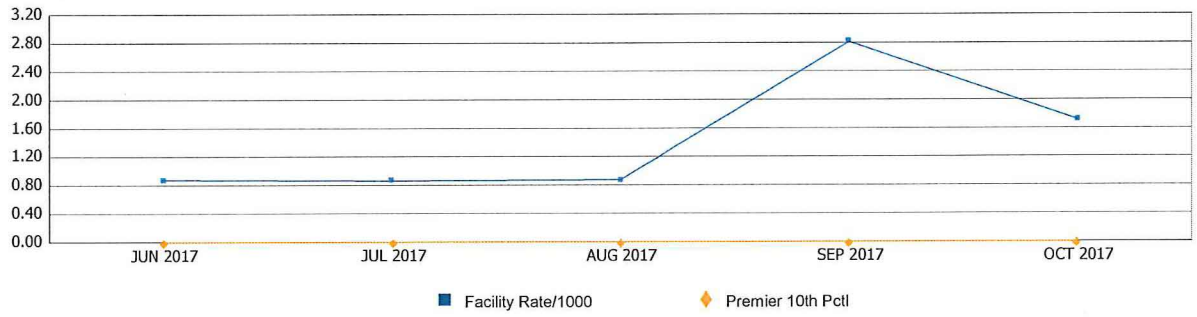
PSI-13:Postop Sepsis



PSI-14:Postop Wound Dehiscence



PSI-15:Accidental Puncture or Laceration



8 surgical cases:
3 GYN, 3 abdominal/
diaphragm, stomach repairs

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Quality Metrics Comparison & Selection
Board Quality Committee
February 2018

Catherine Carson, BSN,MPA, CPHQ

50 YEARS AND GOING STRONG
A half-century of forward thinking.

Publicly Reported Quality Metric Vehicles

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)

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

El Camino Hospital®
THE HOSPITAL OF SILICON VALLEY

Opioids Usage Discussion

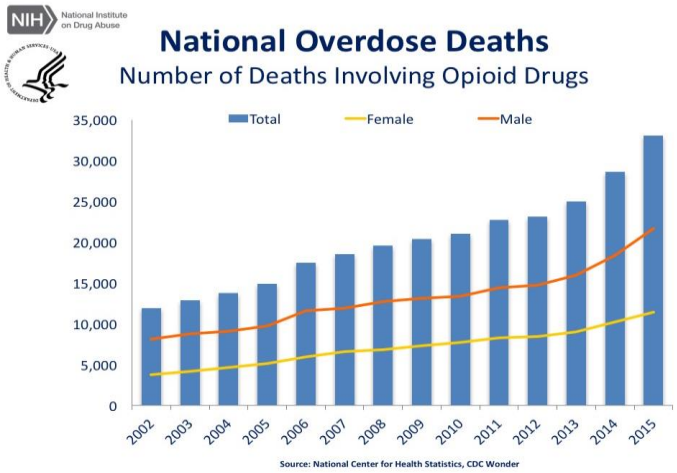
February 5, 2018

The National Crisis

The New York Times

HEALTH

White House Panel Recommends Declaring National Emergency on Opioids



The Mercury News

News > California News

How does California fit into the opioid crisis?

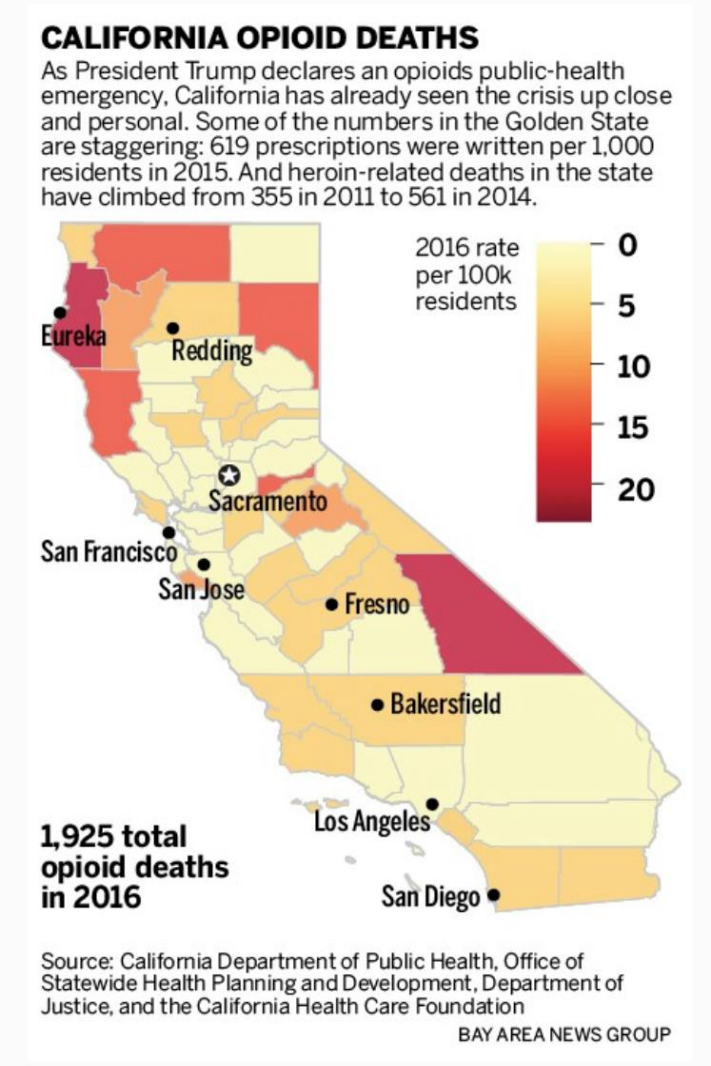
THE WALL STREET JOURNAL.

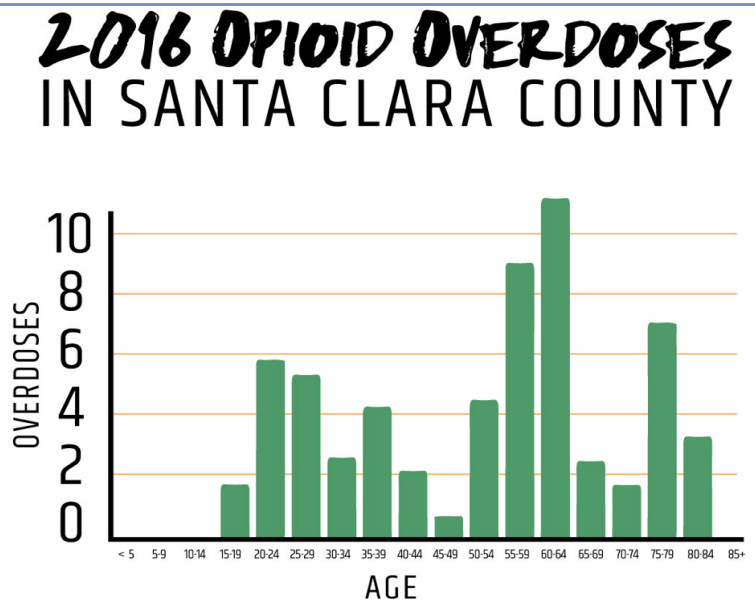
POLITICS | HEALTH POLICY

U.S. Must Do More to Combat Opioid Abuse, Panel Says

- 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.