El Camino Health

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, August 14, 2024 – 5:30 pm

El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 935 1961 2560# No participant code. Just press #.**

To watch the meeting, please visit: ECH Board Meeting Link

Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

NOTE: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

A copy of the agenda for the Regular Board 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) 988-3218** 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	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 pm**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
4	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Bob Rebitzer, Board Chair	Information	**5:30 pm**
5	**RECEIVE QUALITY COMMITTEE REPORT** - FY24 Q4 STEEEP Update - Follow Up Discussion on Mortality Index	Carol Somersille, MD Quality Committee Chair Shreyas Mallur, MD Chief Quality Officer	Discussion	**5:30 – 6:00**
6	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required	**6:00 – 6:01**
7	**CEO UPDATE** **- PRELIMINARY FY24 STRATEGIC PLAN METRICS** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets.*	Dan Woods, CEO	Discussion	**6:01 – 7:01**
8	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of*	Mark Adams, MD, CMO	Motion Required	**7:02 – 7:05**

	the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters.			
9	**CONFLICT OF INTEREST MATTER** *Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation*	Theresa Fuentes, Chief Legal Officer Diane Wigglesworth, VP, Compliance and Privacy Officer	Information	**7:05 – 7:10**
10	**EXECUTIVE SESSION** *Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management.*	Bob Rebitzer, Board Chair	Discussion	**7:10 – 7:15**
11	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**7:15 – 7:16**
12	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	**7:16 – 7:17**
13	**POLICY UPDATE: COMMITTEE GOVERNANCE POLICY**	Theresa Fuentes, Chief Legal Officer	Motion Required	**7:18 – 7:23**
14	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (06/12/2024) b. Approve Hospital Board Closed Session Minutes (06/12/2024) c. Approve Policies, Plans and Scopes of Service as Reviewed and Recommended for Approval by Medical Executive Committee	Bob Rebitzer, Board Chair	Motion Required	**7:23 – 7:25**
15	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**7:25 – 7:30**
16	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:30 – 7:35**
17	**ADJOURNMENT** **APPENDIX**	Bob Rebitzer, Board Chair	Motion Required	**7:35**

El Camino Health

El Camino Hospital Board of Directors
Board Meeting Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: August 14, 2024
Subject: STEEEP Dashboard through June 2024

Purpose:

To update the El Camino Hospital Board of Directors on quality improvement activities and results as displayed in the Q4 FY24 STEEEP (Safe, Timely, Effective, Efficient, Equitable, and Patient Centered) dashboard (unless otherwise noted).

Summary:

The STEEEP dashboard is updated each quarter and contains twenty measures. The STEEEP dashboard is intended to be a Governance Level report, which is shared with the El Camino Hospital Board of Directors on behalf of the Quality Committee once a quarter.

Assessment:

A. SAFE CARE

Hospital Acquired Condition Index 2.0 -
This measure is a composite of four measures as illustrated below.

FY 24 HAC 2.0 weighting and targets			
Component	**Denominator**	**Weighting**	**Weighted Rate**
CLABSI	per 1,000 central line days	25%	aa
CAUTI	per 1,000 catheter days	25%	bb
C. Diff	per patient days x 10,000	25%	cc
nvHAP	per patient days x 1,000	25%	dd
		SUM	HAC Index

1. **HAC Index 2.0** is the strategic quality and safety goal for FY24. For the month of June (0.6584) and Fiscal Year-To-Date (0.9851) we are favorable to target of (1.201).

   a. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (0.300) for the fourth quarter and year to date (0.669) are favorable to target (0.805). There have been 28 hospital acquired infections in FY24. Areas of focus to decrease C. Diff are twofold. First, hospital wide education on C. Diff screening, testing and prevention. Second, deployment of an enterprise-wide hand hygiene program have been implemented. (Timeline for improvement: we are currently meeting our targets and focused on maintaining)

b. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q4 (0.062) is significantly improved from Q1 (0.356) and is lower (better) than target (0.166). There have been eleven CAUTI year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and no more than one per month in August 2024 through June 2024. There were zero CAUTI's enterprise wide in January, March, May and June of 2024. Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. This intervention is likely contributing the improved performance in the fourth quarter of FY24. (Timeline for improvement: we are currently meeting our targets and focused on maintaining)

c. **Central Line Associated Blood Stream Infection (CLABSI).** The rate of CLABSI for the fourth quarter (0.000) and year to date (0.057) are favorable to target (0.150). There have been three CLABSIs year to date. This time in FY23 there were eight CLABSIs. Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management of hemodyalsis catheters. In FY23 the majority of CLABSIs were related to hemodyalsis catheters. (Timeline for improvement: we are currently meeting our targets and focused on maintaining)

d. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 Q4 nvHAP rate (0.083) improved from Q1 (0.125). However, we did not meet the nvHAP target and ended the year at (0.092) and is above target of (0.080). Two key interventions, mobilizing our patients out of bed, and having regular oral care are in place. Both practices are contributing to the successful decrease in nvHAP infections affecting our patients. We ended the year with 27 cases of nvHAP as against a target of 23 cases. The quality manager and team have increased rounding focused on oral care and in the moment education of staff and patients about the importance of preventing nvHAP. (Timeline for improvement: we will continue to monitor nvHAP and continue best practices to reduce the incidence. Our prediction is that we should see improvement in Q1/Q2 of FY 2025)

2. **Surgical Site Infection (SSI).** The rate of surgical site infections for FY24 Q4 (0.413) is unfavorable to target (0.369). FYTD rate of (0.475) is unfavorable to target. Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. Initiatives launched the previous FY have resulted in a significant decrease of total knee replacement (TKR) infections. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures. We have noticed an increase in SSIs in abdominal hysterectomies and biliary procedures this FY. We have instituted a task force to identify any opportunities in processes to address this increase. (Timeline for improvement: We anticipate that our SSI rate will go down by Q2/Q3 of FY 2025. This is a major focus for the organization and we will devote significant resources to understand and implement any changes needed)

B. TIMELY

1. **Lab STAT Troponin Turnaround Time for Emergency Department (received to verification).** [1]The goal is to have 90% of results back within (40 minutes). Performance in Q4 FY24 (92.4%) is favorable to target (90.0%) . This improvement was subsequent to our identifying an issue with the analyzer and correcting the issue. FYTD was (86.8%) unfavorable to target of 90%. (Timeline for improvement: We are focused on sustaining the improvements deployed. We are confident that the measures implemented which resulted in improvement in Q4 will continue to sustain)

2. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q4 (81.0%) and YTD (79.0%) are unfavorable to target (84%). FY 24 Q4 results are improved and closer to target than prior quarters. The root cause of the delays relates to the suboptimal performance of the 'night hawk' radiology vendor who performs readings for the hospitals after hours. A transition to the new nighttime partner took effect February 13, 2024. (Timeline for improvement: We anticipate improvement in the Turnaround times by Q2 2025)

C. EFFECTIVE

1. Risk Adjusted Readmission Index. Performance through May YTD (1.12) is unfavorable to target (1.0). El Camino Health remains committed to ensuring timely follow-up care for patients under SVMD primary care providers, after they are discharged from the hospital. We are also partnering with our colleagues at the County as well as Palo Alto Medical Foundation to get timely appointments for patients who are discharged from the hospital.

In addition, our Post-Acute Network Integrated Care team has also implemented a process to identify high-risk patients and coordinate their care with our Preferred Aligned Network (PAN) providers, including home health care services and skilled nursing facilities. The goal is to ensure timely follow-up appointments with patients' primary care providers after they are discharged from a PAN provider, thereby reducing the risk of readmissions back to the hospital.

Furthermore, we have introduced other initiatives to lower readmissions, including a philanthropy-sponsored program by the ECH Foundation. This program provides free Naltrexone (Vivitrol) Long-Acting Injectable (LAI), a drug that reduces patients' dependency on opioids and alcohol. This initiative targets substance-related readmissions and went live on April 10th. (Timeline for improvement: We anticipate more accurate, and lower Readmission Index when we transition to our new Clinical Data Base partner in Q1 of FY25. There will be a learning curve when we make the change to understand the documentation nuances needed to optimize the accuracy of the denominator "expected readmission")

2. Risk Adjusted Mortality Index. Performance for FY24Q4 (1.23) and YTD (1.12) are unfavorable to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality. (Timeline for improvement: We anticipate more accurate, and lower Mortality Index when we transition to our new Clinical Data Base partner in Q1 of FY25.

There will be a learning curve when we make the change to understand the documentation nuances needed to optimize the accuracy of the denominator "expected mortality")

3. Sepsis Mortality Index. Performance for FY24Q4 (1.25) and YTD (1.22) is unfavorable to target (1.0). Patients often arrive in the ED in Septic Shock. We are working to increase Social Work and/or Palliative Care support in the ED for goals of care discussions. Pursue hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change internally was that the sepsis coordinators provide concurrent sepsis bundle compliance to ED physicians and staff in the real time. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program. (Timeline for improvement: The GIP program is planned for go-Live in Q1 of FY25. With a robust program, there will be a trickle-down impact on driving earlier referral for Palliative Care consultation. This alone, Palliative care consult" increases the expected risk of mortality 6-fold)

4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV. FY24Q4 performance through April of 2024 (29.5%) is unfavorable to target of 23.9%. Contributing factors to the increase is the patient population in this quarter which had a greater number of patients of advanced maternal age, and with medical co-morbidities which increases their risk of C-section. The MCH team shares data quarterly with the medical staff regarding individual physician NTSV rates. The introduction of a NTSV check list had a positive impact on decreasing c/s rate initially after roll out in Q2. What has been most impactful is the bi-weekly review by a multidisciplinary team of nurses, midwives, and physicians to review the indication for every single NTSV. When an opportunity for improvement is identified, MCH leaders reach out to the provider with feedback. (Timeline for improvement: We will not achieve target for YTD based on the Q1 and Q3 rates. Goal for improvement is to achieve target in the fourth quarter of FY24)

D. EFFICIENT

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD (1.18) is unfavorable to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams are optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:
   - Within Epic a centralized care plan was created that pulls together important information about the patients care plan. This tool increased efficiency and allows the care team to obtain pertinent information in a timely way. Additionally, interdisciplinary team members can track internal and external delays which will offer insight into the primary reasons for delays in patient throughput.
   - Since the initiation of Multidisciplinary rounds (MDR) in December 2023, there have been significant improvements in LOS within the pilot program for patients who stay in nursing unit 2C. The data indicates a noteworthy decrease of -1.1 days in LOS (as of 04/24/2024) for these patients. Given the successful demonstration, the MDR process was expanded to the nursing unit on 3C. In addition, the plan is to roll out the MDR process to 3 additional units in Q1 2025.

- We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements. (Timeline for improvement: We anticipate improvement due to the changes implemented by Q3 of 2025)

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q4 performance (155 minutes) and YTD (155 minutes) is favorable to the target of 165 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

E. EQUITABLE

1. Homeless discharge documentation of providing appropriate clothes. In Q4 of FY24, documentation indicating that weather-appropriate clothing was provided to homeless patients prior to discharge improved from 64.9% to 81% (FYTD 66.2%). The Health Equity Department is collaborating with Patient Access Services, Clinical Documentation, the HIM Department, and the ED nursing clinical team. This partnership aims to enhance the accurate identification of our homeless population and address inefficiencies in our EMR system, which currently hinder consistent documentation of adherence to our homeless discharge policy.

2. Quality Council Health Equity Item Included in Process Improvement Efforts (% of departments). With the return of our Health Equity manager from a medical leave, the health equity team has been able to coach and support departments to include at least one improvement measure viewed through an equity lens. For the fourth quarter of FY2024 six of six departments (100%) reported on a health equity measure during their annual performance improvement report at the monthly Quality Council meeting. This measure aligns with Join Commission and CMS requirements to engage leadership and clinical management staff in health equity initiatives.

3. Sepsis Bundle Compliance by Race. We continue to track and learn from the practice of segregating some of our quality measures by race, while simultaneously enhancing the accuracy of the race data we collect from our patients at registration. The reliability of the 'race' data provided by our patients needs to be improved before we can extract meaningful insights about sepsis bundle compliance across different racial groups. In collaboration, the Health Equity Department and the Quality Data Management Department have developed a race and ethnicity algorithm that enables accurate and consistent segregation of clinical outcomes based on these critical demographic data. Furthermore, in partnership with the Sepsis Quality Team, we have established the first-of-its-kind Health Equity Sepsis Bundle Compliance Dashboard. This tool allows us to accurately identify gaps and plan for initiating process improvement project in specific groups.

F. PATIENT CENTERED

1. Inpatient HCAHPS Likelihood to Recommend. For the month of June (83.4) and FY24YTD (81.9) performance has exceeded the target of 76.4. This holds true for both the LG and MV campuses. We continue to rank in the top decile in the Bay Area. These increases were due to strong scores in our Key Drivers, that is Nurse Communication and Staff Worked Together (teamwork). We are continuing to upgrade our RN call system on both campuses leading to better responsiveness. We are on track to exceed this target for FY24.

2. Inpatient Maternal Child Health-HCAHPS Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend". For Q4 (81.4) and FY24YTD (82.) performance exceeded target of .75. We continue to perform in the top decile in the Bay Area and 87% nationally. Our new facility in Mountain View has rave reviews from our patients and families.

3. ED Likelihood to Recommend Top Box Rating of "Yes, Definitely Likely to Recommend". The overall ED top box score exceeded target (71.7) Q4 FY24 (75.6) and exceeding target (71.7) for fiscal year to date.

4. El Camino Health Medical Network: Likelihood to Recommend Care Provider Top Box Rating of "Yes, Definitely likely to Recommend". Our ECHMN Clinics exceeded target for the month of June (84.3) and YTD (81.3). We continue to work with our primary care clinics on access and scheduling (the organization is recruiting as fast as they can!).

Attachments:

1. STEEEP Dashboard through Q4 of FY2024

El Camino Health

FY24 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric		Past Performance				Baseline	Target	Current Performance				
			FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FY 23	FY 24	FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4	FYTD
Safe Care	HAC Index 2.0 Score		1.358	1.451	1.238	0.861	1.238	**1.201**	1.130	1.367	0.966	0.444	**0.985**
Safe Care	HAC Component: Cdiff Weighted (25%) Rate (per 10,000 Patient Days)		0.627	1.165	0.874	0.629	0.830	**0.805**	0.649	1.019	0.680	0.300	**0.669**
Safe Care	HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)		0.136	0.162	0.218	0.177	0.171	**0.166**	0.356	0.192	0.058	0.062	**0.167**
Safe Care	HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)		0.511	0.000	0.080	0.000	0.154	**0.150**	0.000	0.075	0.147	0.000	**0.057**
Safe Care	HAC Component: nvHAP Weighted (25%) Rate (per 1000 Patient Days)		0.084	0.124	0.066	0.055	0.082	**0.080**	0.125	0.081	0.080	0.083	**0.092**
Safe Care	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		0.314	0.552	0.196	0.463	0.380	**0.369**	0.564	0.350	0.578	0.413	**0.475**
Timely	Lab STAT Troponin TAT for ED (received to verification)		93.8%	88.8%	70.9%	78.0%	82.7%	**90.0%**	84.2%	81.3%	88.7%	92.4%	**86.8%**
Timely	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		78.4%	78.3%	78.3%	77.0%	78.0%	**84.0%**	76.5%	76.9%	81.4%	81.0%	**79.1%**
Effective	Risk Adjusted Readmissions Index		1.05	1.18	1.05	1.09	1.07	**1.00**	1.14	1.12	1.14	1.08* (Apr-May 24)	**1.12* (July-May 24)**
Effective	Risk Adjusted Mortality Index		1.03	1.14	1.19	1.14	1.13	**1.00**	1.00	1.14	1.10	1.23	**1.12**
Effective	Risk Adjusted Sepsis Mortality Index		1.02	1.37	1.26	1.15	1.21	**1.00**	1.07	1.33	1.22	1.25	**1.22**
Effective	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	26.4%	**23.9%**	26.4%	22.7%	23.0%	29.5%* (Apr 24)	**24.6%* (July-Apr 24)**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	1.20	1.17	1.18	**1.20**
Efficient	Median Time from ED Arrival to ED Departure (Enterprise)		174 min	167 min	168 min	164 min	168 min	**165 min**	157 min	154 min	152 min	155 min	**155 min**
Equitable	Homeless Discharge Clothing Documentation Compliance		----	----	----	----	----	**100.0%**	50.5% (176/348)	64.9% (257/396)	73.1% (242/331)	81.0%* (200/247) (Apr-May 24)	**66.2%* (875/1322) (July-May 24)**
Equitable	Quality Council Health Equity Item Included in PI efforts (% of depts)		----	----	----	----	----	**50.0%**	0.0% (0/6)	33.3% (4/12)	100.0% (11/11)	100.0% (6/6)	**60.0% (21/35)**
Equitable	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	73.7% (28/38)	84.9% (28/33)	82.6%* (19/23) (Jan-Feb 24)	N/A	**79.8%* (75/94) (July-Feb)**
Equitable	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	72.2% (13/18)	78.3% (18/23)	100.0%* (3/3) (Jan-Feb 24)	N/A	**77.3%* (34/44) (July-Feb)**
Equitable	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	84.6% (88/104)	84.7% (72/85)	87.8%* (43/49) (Jan-Feb 24)	N/A	**85.3%* (203/238) (July-Feb)**
Equitable	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	66.6% (10/15)	72.7% (8/11)	33.3%* (2/6) (Jan-Feb 24)	N/A	**62.5%* (20/32) (July-Feb)**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		79.9	78.8	76.6	78.4	78.5	**76.4**	84.0	80.3	79.9	83.4	**81.9**
Patient-centered	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	74.5	74.3	75.6	**75.5**
Patient-centered	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	83.7	83.2	81.4	**82.0**

Updated: 07/16/24

STEEEP: Safe Care, Timely, Effective, Efficient, Equitable, Patient-Centered

Legend:
- **Green: At or exceeding target**
- **Yellow: Missed target by 5% or less**
- **Red: Missed target by > 5%**
- **White: No target**

El Camino Health

Quality Domain	Metric		Metric Definition
Safe Care	HAC Index 2.0 Score		For FY24, the HAC (hospital-acquired condition) Index is an internally developed composite measure that tracks hospital-level performance improvement related to (4) key inpatient safety events. The elements of the composite are weighted as noted: Clostridium difficile infections (C-Diff) 35%, Catheter Associated Urinary Tract Infection (CAUTI) 15%,Central Line Associated Blood Stream Infection (CLABSI) 15%, and non-ventilator hospital-acquired pneumonia (nvHAP) 35%.
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)		1) Based on NHSN defined criteria: inclusions: Inpatients, Peri-Op, Behavioral Health; exclusions: Rehab, NICU, outpatients, ED patients 2) All positive C.diff Toxin/antigen lab tests that result on or after the patient's 4th day of hospitalization 3) Latency: C-Diff infections may be identified up to 30 days, thus previously reported results may change.
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)		1) Based on NHSN defined criteria 2) Exclusions : ED & OP
	HAC Component: nvHAP Weighted (35%) Rate (per 1000 Patient Days)		≥ 3 days hospitalization & Not receiving mechanical ventilation. Evidence of order or procedure code for chest X-ray or computerized tomography of the chest. Administration of selected antimicrobials (e-Table 3) not previously administered in past 2 days and continued for ≥3 days (changes in antibiotics permitted during the 3 day period so long as each new agent was not used in the preceding 2 days). More detailed and specific definition can be provided.
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		1) Based on NHSN defined criteria 2) Inclusions: Surgical cases categorized with either a "clean wound class" or "clean-contaminated wound class" 3) Exclusions: surgical cases with a wound class of "contaminated" or "dirty". 4) SSIs that are classified: "deep –incisional" and "organ-space" are reportable. 5) Latency: SSIs may be identified up to 90 days following surgery, thus previously reported results may change.
Timely	Lab STAT Troponin TAT for ED (received to verification)		A metric that assists with ED through-put and timely diagnosis of cardiac injury. The measurement begins with a time stamp of the specimen being received in the clinical laboratory and ends with a time stamp of the Troponin result being released to EPIC.
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		Imaging TAT Criteria : TAT from Exam END to Exam Finalized, Routine orders only. Qualified exam won't include the exams that Prelim or ED Wet Read exists. On Target as defined as ED - <= 45 min. Over Target is defined as ED > 45 min. ED encounters
Effective	Risk Adjusted Readmissions Index		1) An inpatient admission of the same patient to the same facility within 30D of a prior admission, regardless of cause (All Cause). 2) Based upon Premier's Care Sciences Standard Practice risk-adjustment + CMS' All-Cause 30D readmission methodology (excludes cases CMS deems 'planned'). 3) Numerator inclusions: Patient Type = Inpatient 4) NOTE: Excludes cases discharged from (1) hospital, then readmitted to the other hospital w/in 30D.
	Risk Adjusted Mortality Index		1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice.
	Risk Adjusted Sepsis Mortality Index		1) Numerator inclusions: Patient Type = Inpatient, Prin or 2nd diagnosis of sepsis & age 18+ yrs 2) Numerator exclusions: LOS > 120 days, patients transferred to ECH from another hospital, MDC = 14 (OB)
	PC-02 NTSV C-Section		1) Numerator: Patients with cesarean births 2) Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation
Efficient	Length of Stay O/E		1) Based upon Premier's Care Sciences Standard Practice RA for expected risk used by O/E ratio. 2) Criteria: inclusion: Patient Type = Inpatient; exclusions: Patient Type = Rehab, Psychiatric or Hospice.
	Median Time from ED Arrival to ED Departure (Enterprise)		ED Arrival to ED Departure (TAT-D - Direct Discharge): This metric is the median arrival to patient discharged time from ED. This metric excludes Inpatients, Outpatients, Observation Patients, and Hospital Outpatient Surgery Patients who arrive via the ED. Time stamp is used for this calculation: ED Arrival - Patient Arrived in ED (50) (ADT_ARRIVAL_DTTM in Clarity "F_ED_ENCOUNTERS" table) ED Departure Time - "ED_Departure_DTTM" in Clarity "F_ED_ENCOUNTERS" table
Equitable	Homeless Discharge Clothing Documentation Compliance		EMTALA - Homeless Discharge Navigator. Specifically for Clothing documented and compliance. Epic data source.
	Quality Council Health Equity Item Included in PI efforts (% of depts)		Departments that present a Health Equity (HE) -related item during Quality Council presentation / total departments presented
	Sepsis Bundle Compliance by Race	Asian	Sample of patients age >18 years, presenting in the Emergency Dept or In-patient unit with Severe Sepsis/Septic Shock (Suspected or known infection, 2+SIRS, 1 new organ dysfunction). Retrospective or concurrent chart reviews identified from one or more of the following: Emergency Room work up/differential, admitting diagnosis, Sepsis Alert, safety reporting system, EHR surveillance, iCare reporting, ICD-10 discharge code. Time of Presentation(TOP): time at which all criteria for severe sepsis are present, OR provider documentation of severe sepsis, whichever is earliest. Race is as defined of patient registration input, collected & documented in Epic.
	Sepsis Bundle Compliance by Race	Hispanic	
	Sepsis Bundle Compliance by Race	White	
	Sepsis Bundle Compliance by Race	Others	
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		1) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. 2) Inclusions: Inpatient nursing units; excludes: MBU. 3) Data run criteria, 'Top Box, Received Date, and Adjusted'
	ED - Likelihood to Recommend (PG)		ED Likelihood to Recommend - PressGaney data (not part of HCAHPS) Data run criteria, 'Top Box, Received Date, and Adjusted'
	MCH - HCAHPS Likelihood to Recommend		Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Mother Baby Units only. Data run criteria, 'Top Box, Received Date, and Adjusted'

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Director
From: Shreyas Mallur, M.D, Chief Quality Officer
Date: August 14, 2024
Subject: Quality Deep Dive Topic: Mortality Rate and Index

Purpose: Review the current state of Mortality measures at El Camino Health and performance improvement initiatives to reduce the Mortality rate and Index.

Background: The rise in the mortality index at El Camino has been a cause for concern and various assumptions made as to the reasons why this was so. We used benchmarked data to analyze trends and present future course of action to reduce the mortality index at El Camino.

Assessment: Based on data analysis, here is a summary of the findings for current state:

- Overall mortality index is higher than in FY 2021. The mortality index has stayed stable over the last two Financial Years; however, it continues to be above our expected target.
- On publicly reported data, we are doing better than the national average, however there is room for improvement compared to the best performing health systems in the country.
- Significant decrease to zero in GIP care transitions and opportunities to discharge to hospice when converted to comfort care code status (hospice facility capacity, staffing, family/caregiver ability to care for patient at home).

List of Attachments:

1. PRESENTATION: Mortality data and performance analysis.

Improving Patient Outcomes: A Mortality Review

Shreyas Mallur, M.D
Chief Quality Officer

Agenda

- Overview
- ECH Comparison
- Drivers at ECH
- Management Intervention

Hybrid Hospital Wide Mortality (HWM) Comparisons

FY2023 (July 1, 2022 - June 30, 2023)

Standardized Mortality Ratio

California: 0.92
El Camino Health: 0.80

ECH Among NATIONAL

of Hospitals that Performed Better than National Rate
60 (5.3%)

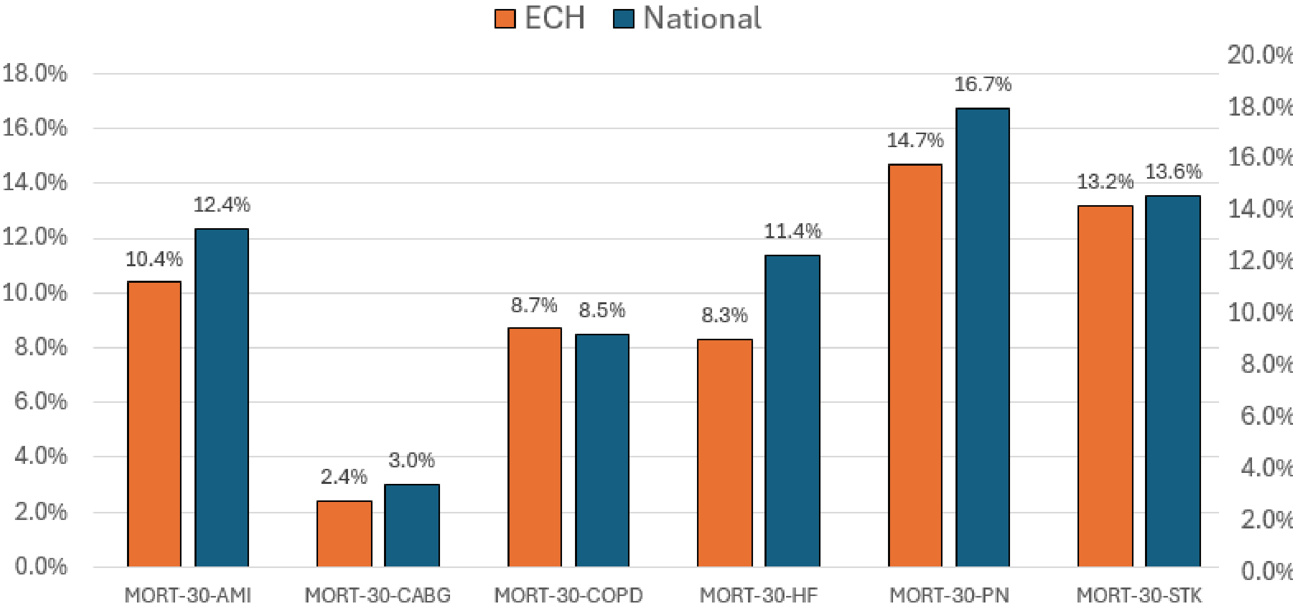
ECH Among STATE

of Hospitals that Performed Better than National Rate
6 (9.2%)

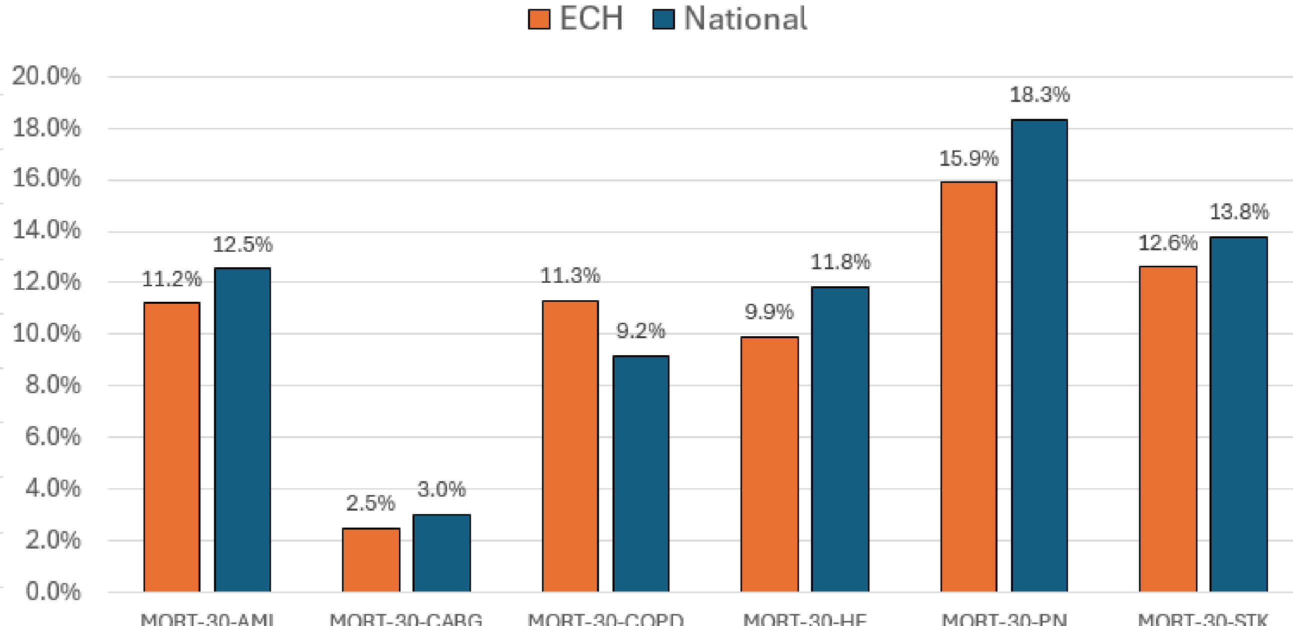
El Camino Health®

CMS Hospital Comparison Data

2023



2024



Lower is better

El Camino Health

Mortality Index

A low index represents a higher number of saved lives

$$\text{Mortality Index} = \frac{Observed\ Mortality}{Expected\ Mortality} = OE\ Ratio$$

Index < 1

Less patients expired compared to what was expected.

- Exceptional quality of care
- Excellence clinical documentation
- Correct level of care

Index = 1

The number of patients that expired was **correctly reflected**

- The number of deaths was expected

Index > 1

The number of expired patients is **higher than the severity of the case**.

- Suboptimal documentation
- Incorrect level of care
- Combination of both above

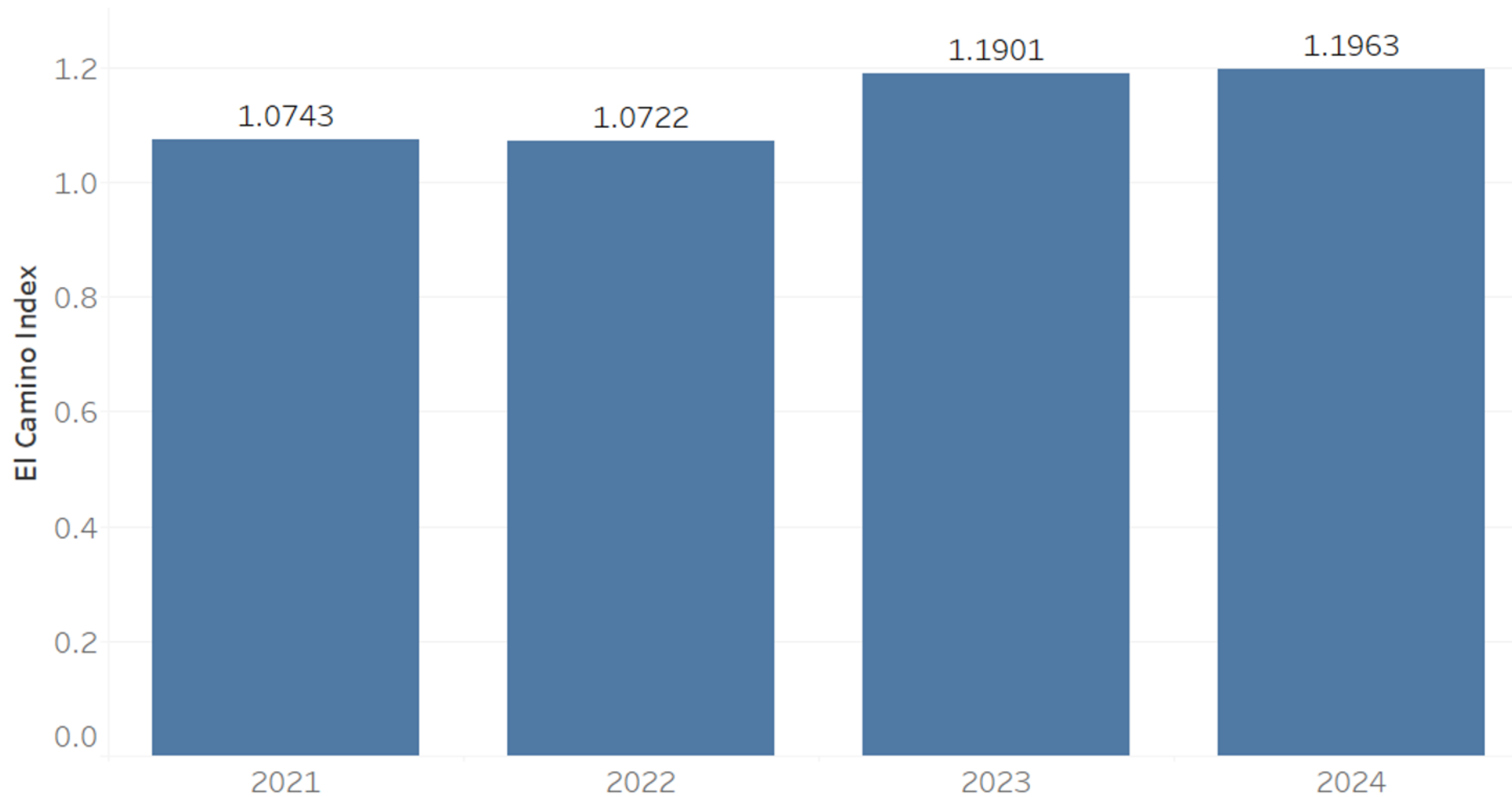
Impact of Documentation

Same patient, different level of coding detail and accuracy

CMS Expected Mortality = 50%	CMS Expected Mortality = 12%
87-year-old female with:	**87-year-old female with:**
○ Acute on chronic systolic heart failure	○ Heart failure
○ End stage kidney disease	○ End stage kidney disease
○ Covid-19 Pneumonia	○ Covid
○ Chronic iron deficient anemia	○ Anemia
○ Moderate malnutrition	○ Malnutrition
Risk of Mortality: High	**Risk of Mortality: Low**

El Camino Hospital Performance

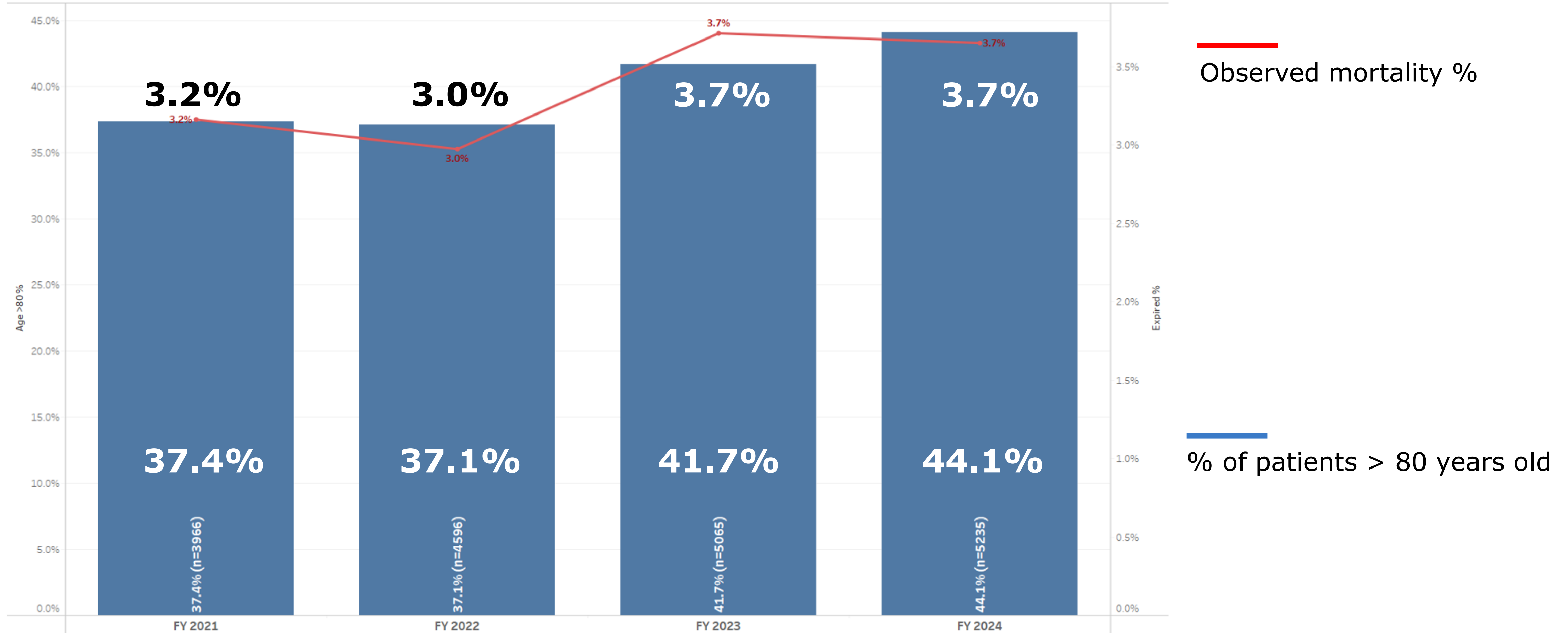
By Year & Index **(Data Period: January 2021 – June 2024)**



El Camino Health

El Camino Hospital Performance

Patients who are >80 years of age vs. mortality



El Camino Health

Management Intervention

Managing the Expected Mortality in Observed/Expected index

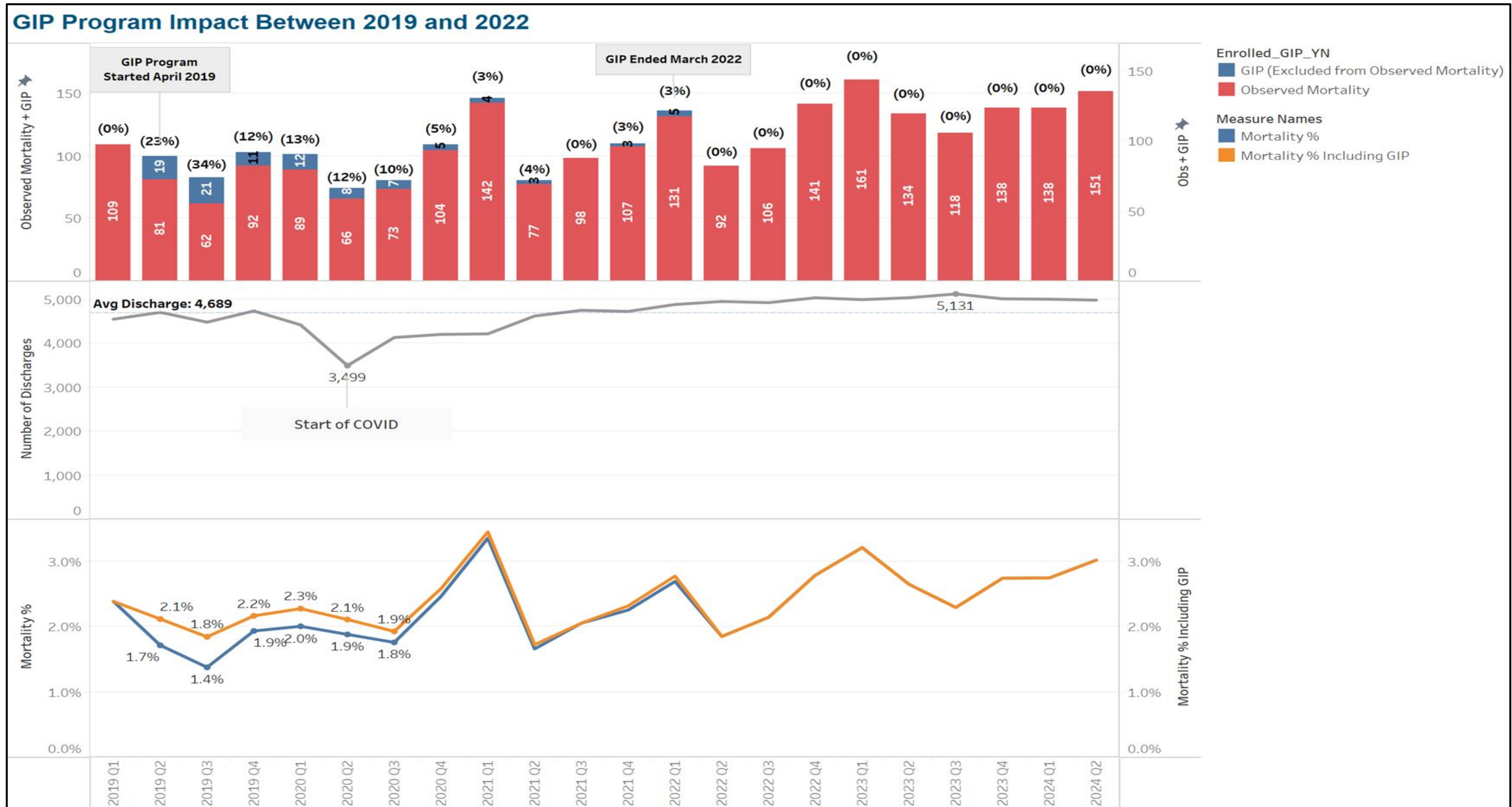
- Palliative Care/GIP
- CDI and Coding (Accurate documentation to reflect true nature of complexity)
- Best Practices from organizations with low mortality index

Managing the Observed Mortality in Observed/Expected index

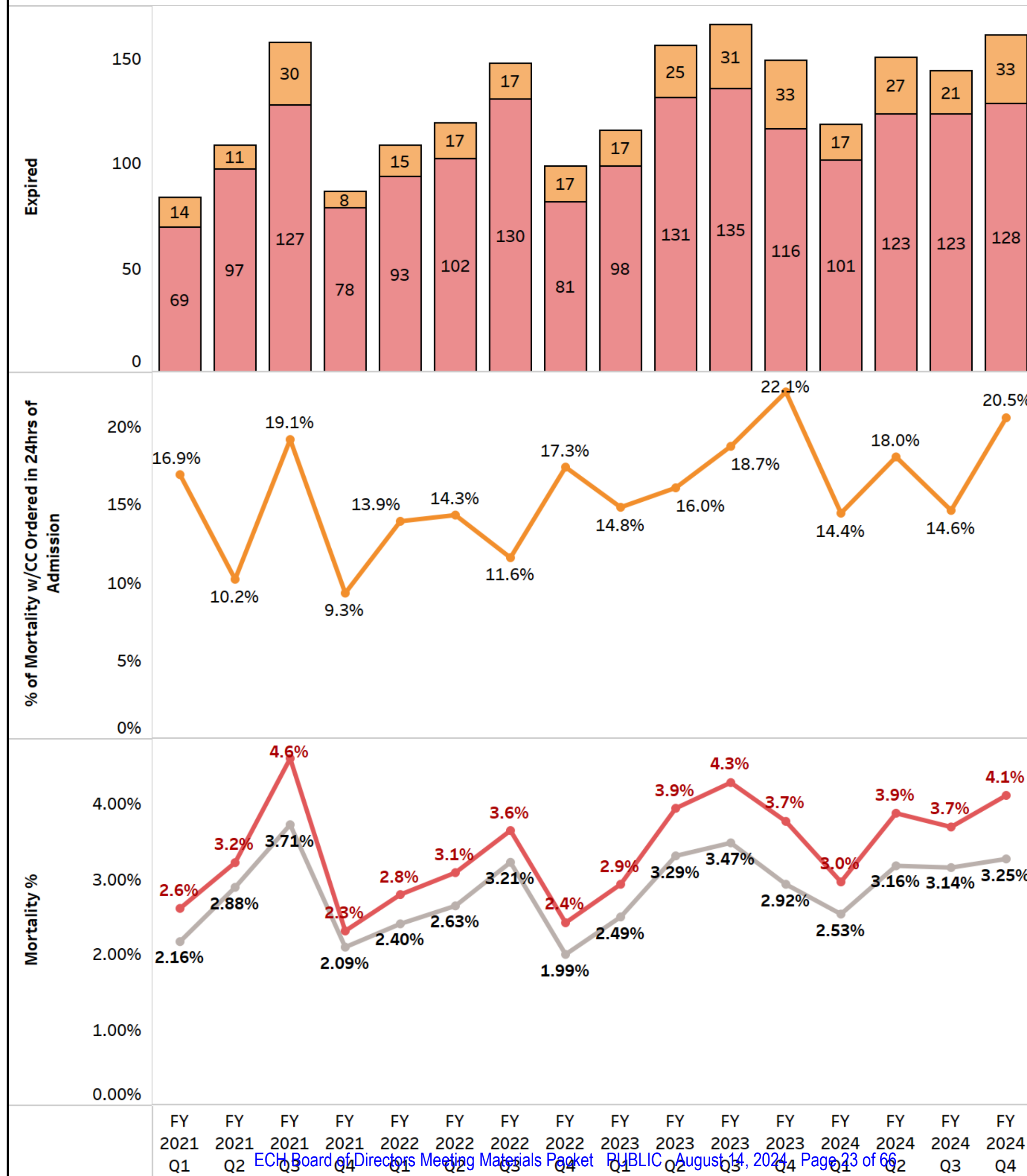
- Standardize care and reduce practice variation –leverage Medical Director and Medical Staff Leadership
- Focus on Sepsis and specific high-risk populations
- Mortality reviews/Peer review
- Utilize Data and Analytics to identify trends early, intervene early.
- Network with high performing organizations (through our partnership with database vendor)

APPENDIX

General Inpatient (GIP) Program Impact



ECH Mortality Analysis



El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Theresa Fuentes, Chief Legal Officer
Date: August 14, 2024
Subject: ECH Board Policy Update

Recommendation(s):

To recommend approval of El Camino Hospital Board Committee Governance Policy.

Summary:

El Camino Hospital Board Committee Governance Policy

The Committee Governance Policy is a new policy that was created to establish consistency across the Board committees regarding term, appointment, removal, and membership on Committees, and attendance and meeting expectations. Committee Charters will be updated to cite this new policy.

The Committee Governance Policy was reviewed and recommended for Board approval at the March 12, 2024, Governance Committee meeting. The Governance Committee recommended that the terms for committee members be updated to three years. At the April 23, 2024, El Camino Hospital Board meeting, the Board recommended that the three-year terms be staggered to maintain continuity and ease recruitment efforts, and to bring the policy back to a future meeting.

Edits have been made consistent with the Board's request to provide for three-year staggered terms. The new edits are reflected in the attached redline. The attached Committee Governance Policy was reviewed and recommended for Board approval at the June 3, 2024, Governance Committee meeting.

This policy will streamline and provide efficiencies for the Board as the reappointment process for members will only need to be completed on staggered terms rather than yearly for all members. It will also ensure transparent, accountable Committee operations, subject to periodic review for relevance and operational efficiency. This policy complements bylaws and charters by offering consistency and a more detailed and flexible framework for committee operations. It contributes to organizational effectiveness, alignment with strategic goals, and enhanced governance.

Policy	Changes	Effective Date
El Camino Hospital Board Committee Governance Policy	NEW POLICY. For best governance practices to ensure consistency around the governance of committees.	After ECHB approval – August 14, 2024

List of Attachments:

1. DRAFT REDLINED El Camino Hospital Board Committee Governance Policy
2. CLEAN El Camino Hospital Board Committee Governance Policy

El Camino Health

TITLE:	El Camino Hospital Board Committee Governance Policy
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August XX, 2024

Coverage:
All Members of the El Camino Hospital Board of Directors ("Board") and Board Advisory Committees ("Committees"). The Governance Committee shall review this policy at least every three (3) years to ensure that it remains relevant and appropriate.

Authority:
The Board has established the following standing Advisory Committees pursuant to Article 7.6 of the El Camino Hospital Bylaws: Compliance and Audit Committee; Executive Compensation Committee; Finance Committee, Governance Committee, Investment Committee; and Quality, Patient Care, and Patient Experience Committee. The Committees have the authority granted to them per the Hospital Bylaws, the Committee Charter, and majority action of the Board. Committees may study, advise and make recommendations to the Board on matters within the committee's area of responsibility as stated in the Committee Charter. The authority of committees is limited to advisory recommendations except in responsibilities directly delegated by the Board. Committees may provide recommendations for the Board to consider, which recommendations may be considered, adopted, amended or rejected by the Board in the Board's sole discretion. Committees shall have no authority to take action or otherwise render decisions that are binding upon the Board or staff except as otherwise stated in the Bylaws, the Committee's Charter, or majority action of the Board. To the extent of any conflict with the Committee Charter, this policy controls.

Membership:
Each committee shall have the membership as stated in the Committee Charter but must be composed of at least two members of the Board ("Director Members"), as well as people who are not members of the Board ("Community Members"). Director membership on any single Committee shall not constitute a quorum of either Board or Healthcare District Board membership. The Chair of a committee is its presiding officer. In the absence of the Chair, the Vice-Chair (or if no Vice-Chair, any member of the Committee as determined by the Chair or the Board) shall perform the duties of the Chair.

Appointment and Removal:
The Board Chair (or Board Chair-elect in Board officer election years) shall appoint the Director Members and Committee Chairs, subject to approval of the Board. Community Members shall be appointed by the Committee, subject to approval of the Board. All Board Chair appointments shall be reviewed by the Governance Committee before submission to the Board.

Committee Chairs may appoint and remove a Vice-Chair at the Committee Chair's discretion. However, if the Committee Chair is not a Director Member, a Vice Chair must be appointed who is a Director, in which case the Director Vice-Chair shall be appointed the same as any other Director Member.

The Board has the authority to remove Director Members and Community Members at any time either with or without the Committee's recommendation, in the Board's sole discretion.

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August XX, 2024

Term

Director Members ~~and Chairs shall serve Members of the committee, excluding Directors and Chairs, ,~~ and Community Members serve a term of *three* full or partial fiscal years depending on date of appointment and eligibility to serve. Director and Community Members shall be divided into three appointment categories, as nearly equal in number as possible, as follows: (a) Class 1, the initial term of which shall expire June 30, 2025, and subsequent terms shall be three years each; (b) Class 2, the initial term of which shall expire June 30, 2026, and subsequent terms shall be three years each; (c) Class 3, the initial term of which shall expire June 30, 2027, and subsequent terms shall be three years each.~~,~~ Each class shall hold committee membership until successors are appointed.

Committee Chair and Vice Chair appointments shall be reviewed annually by the Board Chair (or Chair-Elect). Chair and Vice Chair appointments may be changed at any time without effecting the term of that person's membership on the Committee.~~.~~

Director Members, Community Members, Chairs, and Vice Chairs may serve consecutive terms.

If a community member wishes to vacate a position, the committee member shall submit a written resignation letter addressed to the Chair of the Committee and the Chair of the Board, with a copy to the CEO and Governance Services.

Attendance:

Committee members are expected to attend in person and meaningfully participate in all committee meetings absent extenuating circumstances. Remote virtual participation is generally only allowed for just cause or emergency situations such as physical or family medical emergency, childcare, illness, disability, or Board or Committee related travel. Remote virtual participation must comply with the requirements of the Ralph M. Brown Act. Committee members may be removed from the Committee for repeated failure to satisfy attendance requirements.

If a member is physically not present ~~absent or virtual~~ for more than two meetings in a calendar year, the Committee Chair shall contact that member and remind the member of this policy. If the member continues ~~to be absent or virtual~~ to ~~not~~ be physically absent despite the warning, the Committee shall consider a recommendation to the Board for removal.

Meetings:

All Committees shall have a Committee Charter approved by the Board.

Committee meetings shall be open to the public except for items permitted to be discussed in closed session and held in accordance with the provisions of the Ralph M. Brown Act. At least 72 hours before a committee meeting, Governance Services shall post an agenda containing a brief, general description

DRAFT

of each item of business to be discussed at the committee meeting. The posting shall be accessible to the public.

The minutes of each committee meeting, including any recommendation of a committee, shall include a summary of the information presented and the recommended actions. ECHB staff will prepare minutes of each meeting. Draft minutes will be provided to the committee at the next available committee meeting for committee member review and approval. Once approved, minutes will be made a part of the Board's permanent records.

A majority of the members of each committee shall constitute a quorum for the transaction of business.

Only members of the committee are entitled to make, second or vote on any motion or other action of the committee. Each committee member shall be entitled to one vote on all matters considered by the committee. A simple majority vote of the members of the Committee shall designate approval of a motion.

All committee communications must go through the designated committee Chair.

The specific committees and their respective responsibilities are as stated in the Charter for each Committee.

DRAFT

El Camino Health

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August XX, 2024

Coverage:
All Members of the El Camino Hospital Board of Directors ("Board") and Board Advisory Committees ("Committees"). The Governance Committee shall review this policy at least every three (3) years to ensure that it remains relevant and appropriate.

Authority:
The Board has established the following standing Advisory Committees pursuant to Article 7.6 of the El Camino Hospital Bylaws: Compliance and Audit Committee; Executive Compensation Committee; Finance Committee, Governance Committee, Investment Committee; and Quality, Patient Care, and Patient Experience Committee. The Committees have the authority granted to them per the Hospital Bylaws, the Committee Charter, and majority action of the Board. Committees may study, advise and make recommendations to the Board on matters within the committee's area of responsibility as stated in the Committee Charter. The authority of committees is limited to advisory recommendations except in responsibilities directly delegated by the Board. Committees may provide recommendations for the Board to consider, which recommendations may be considered, adopted, amended or rejected by the Board in the Board's sole discretion. Committees shall have no authority to take action or otherwise render decisions that are binding upon the Board or staff except as otherwise stated in the Bylaws, the Committee's Charter, or majority action of the Board. To the extent of any conflict with the Committee Charter, this policy controls.

Membership:
Each committee shall have the membership as stated in the Committee Charter but must be composed of at least two members of the Board ("Director Members"), as well as people who are not members of the Board ("Community Members"). Director membership on any single Committee shall not constitute a quorum of either Board or Healthcare District Board membership. The Chair of a committee is its presiding officer. In the absence of the Chair, the Vice-Chair (or if no Vice-Chair, any member of the Committee as determined by the Chair or the Board) shall perform the duties of the Chair.

Appointment and Removal:
The Board Chair (or Board Chair-elect in Board officer election years) shall appoint the Director Members and Committee Chairs, subject to approval of the Board. Community Members shall be appointed by the Committee, subject to approval of the Board. All Board Chair appointments shall be reviewed by the Governance Committee before submission to the Board.

Committee Chairs may appoint and remove a Vice-Chair at the Committee Chair's discretion. However, if the Committee Chair is not a Director Member, a Vice Chair must be appointed who is a Director, in which case the Director Vice-Chair shall be appointed the same as any other Director Member.

The Board has the authority to remove Director Members and Community Members at any time either with or without the Committee's recommendation, in the Board's sole discretion.

DRAFT

El Camino Health

TITLE:	El Camino Hospital Board Committee Governance Policy
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August XX, 2024

Term
Director Members and Community Members serve a term of *three* full or partial fiscal years depending on date of appointment and eligibility to serve. Director and Community Members shall be divided into three appointment categories, as nearly equal in number as possible, as follows: (a) Class 1, the initial term of which shall expire June 30, 2025, and subsequent terms shall be three years each; (b) Class 2, the initial term of which shall expire June 30, 2026, and subsequent terms shall be three years each; (c) Class 3, the initial term of which shall expire June 30, 2027, and subsequent terms shall be three years each. Each class shall hold committee membership until successors are appointed.

Committee Chair and Vice Chair appointments shall be reviewed annually by the Board Chair (or Chair-Elect). Chair and Vice Chair appointments may be changed at any time without effecting the term of that person's membership on the Committee.

Director Members, Community Members, Chairs, and Vice Chairs may serve consecutive terms.

If a community member wishes to vacate a position, the committee member shall submit a written resignation letter addressed to the Chair of the Committee and the Chair of the Board, with a copy to the CEO and Governance Services.

Attendance:

Committee members are expected to attend in person and meaningfully participate in all committee meetings absent extenuating circumstances. Remote virtual participation is generally only allowed for just cause or emergency situations such as physical or family medical emergency, childcare, illness, disability, or Board or Committee related travel. Remote virtual participation must comply with the requirements of the Ralph M. Brown Act. Committee members may be removed from the Committee for repeated failure to satisfy attendance requirements.

If a member is physically not present for more than two meetings in a calendar year, the Committee Chair shall contact that member and remind the member of this policy. If the member continues to be physically absent despite the warning, the Committee shall consider a recommendation to the Board for removal.

Meetings:

All Committees shall have a Committee Charter approved by the Board.

Committee meetings shall be open to the public except for items permitted to be discussed in closed session and held in accordance with the provisions of the Ralph M. Brown Act. At least 72 hours before a committee meeting, Governance Services shall post an agenda containing a brief, general description of each item of business to be discussed at the committee meeting. The posting shall be accessible to the public.

CLEAN

TITLE:	**El Camino Hospital Board Committee Governance Policy**
CATEGORY:	Administrative
FIRST APPROVAL:	ECHB August XX, 2024

The minutes of each committee meeting, including any recommendation of a committee, shall include a summary of the information presented and the recommended actions. ECHB staff will prepare minutes of each meeting. Draft minutes will be provided to the committee at the next available committee meeting for committee member review and approval. Once approved, minutes will be made a part of the Board's permanent records.

A majority of the members of each committee shall constitute a quorum for the transaction of business.

Only members of the committee are entitled to make, second or vote on any motion or other action of the committee. Each committee member shall be entitled to one vote on all matters considered by the committee. A simple majority vote of the members of the Committee shall designate approval of a motion.

All committee communications must go through the designated committee Chair.

The specific committees and their respective responsibilities are as stated in the Charter for each Committee.

CLEAN

El Camino Health

BOARD OF DIRECTORS
Policies for Review
August 14, 2024

Department	Document Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
HIMS	1. MyCare Access	Revised	Policy	1. Tabled on June 12th; updated # of days per Board recommendation.	• HIM Leadership • ePolicy • MEC > Board > Publish
Emergency Dept	1. Emergency Department – Patient Disaster Surge Plan (Mountain View)	Revised	Plan	1. Minor update	• UPC | ED Physicians • Emergency Mgmt • ePolicy • MEC > Board > Publish
Environment of Care	1. Injury and Illness Prevention Plan (IIPP) – Safety Program Crosswalk	None	Plan	1. None	• Central Safety • PESC • ePolicy • MEC > Board > Publish
Care Coordination	1. Scope of Service – Care Coordination	Revised	Scope of Svc	1. Updated Sections: Types and ages of the Patients Served; Assessment Methods; Scope and Complexity of Services Offered; Staffing; Level of Service Provided.	• Med Dir • ePolicy • MEC > Board > Publish

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I AUGUST 14, 2024

FINANCE:

- **Period 12 – June 2024**
  - **Total Operating Revenue**: $120.0M
    - ($11.5M) / (8.8%) vs. budget
    - $0.7M / 0.1% higher than the same period last year
  - **Operating EBIDA**: $26.0M
    - $6.4M / 32.6% vs. budget
  - **Net Income**: $43.3M
    - $28.6M / 195.8% vs. budget
- **Pre-Audit FYE 2024 (As of 6/30/24)**
  - **Total Operating Revenue**: $1,553.6M
    - $3.8M / 0.25% vs. budget
    - $114.2M / 7.9% higher than FYE 2023
  - **Operating EBIDA**: $252.3M
    - $18.7M / 8.0% vs. budget
    - Consistent with FYE 2023
  - **Net Income**: $313.4M
    - $143.7M / 84.7% vs. budget
    - $30.6M / 10.4% higher than FYE 2023

NURSING: El Camino Health Care Coordination team and other key stakeholders developed **a new method for conducting multidisciplinary rounds (MDR)** using a lean methodology. The length of stay was reduced by 0.5 days at MV during a pilot. This enhanced MDR is now being implemented to all the other units in MV in the first quarter of FY25.

HUMAN RESOURCES: SEIU-UHW and El Camino Hospital reached **a 4-year tentative agreement** on 7/26/24. The union voted to ratify the contract on 7/31 and 8/1/24.

INFORMATION SERVICES: ECH joins the **top 25% Epic organizations which have achieved Gold Stars Level 9**, an annual designation measuring the adoption of best features and practices available in Epic platform. **The Engage intranet app** is now enabled for mobile access. **Epic Secure Chat** is our new, robust texting solution integrated with our Epic EMR.

CORPORATE HEALTH: The Chinese Health Initiative (CHI) started **a new session of the 4-month Diabetes Prevention Series**. The South Asian Heart Center engaged 380 new and prior participants and completed ~700 consultations.

FOUNDATION: In FY24, The Foundation raised ~$9.1M, which **exceeds the ~$7.9M goal**. **The 28th Annual El Camino Heritage Golf Tournament** will be held at Palo Alto Hills Golf & Country Club on Monday, October 21, 2024. The planning has begun, and the proceeds will benefit a new program to provide psychological support to cancer patient and their families. **Hope to Health**, the Foundation's women's giving circle, is being revitalized.

A14a. DRAFT 2024-06-12 ECHB Minutes (Open) vf

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, June 12, 2024

El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

Board Members Present
Bob Rebitzer, Chair **
Jack Po, MD, Ph.D., Vice-Chair
Lanhee Chen, JD, PhD
Wayne Doiguchi
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
John Zoglin

Board Members Absent
Peter Fung, MD
Julia E. Miller, Secretary/Treasurer

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO
Theresa Fuentes, CLO
Omar Chughtai, CGO
Deb Muro, CIO
Tracey Lewis Taylor, COO
Mark Adams, **MD**, CMO
Shreyas Mallur, **MD**, ACMO
Christine Cunningham, Chief Experience and Performance Improvement Officer
Diane Wigglesworth, Compliance/Privacy Officer
Shahab Dadjou, President, ECHMN

Others Present (cont.)
Ed Braxton, Director, Total Rewards
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology
Prithvi Legha, **MD**, MV Chief of Staff
Steven Xanthopoulos, MD

***via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:36 p.m. by Vice Chair Jack Po. Vice Chair Po reviewed the logistics for the meeting. Directors Chen, Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, and Zoglin were present constituting a quorum.	**The meeting was called to order at *5:36 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	No AB-2449 requests were received by the members of the Board.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Vice Chair Po asked the Board if any member had a conflict of interest with any items on the agenda. None were reported.	
4. PUBLIC COMMUNICATION	Vice Chair Po invited the members of the public to address the Board. No members of the public were present.	
5. MEDICAL STAFF VERBAL REPORT	Dr. Legha provided a verbal medical staff report to the Board. Dr. Legha shared his experience during his tenure as Chief of Staff and introduced Dr. Steven Xanthopoulos, who will succeed as Mountain View Campus Chief of Staff for the next two years. The Board thanked Dr. Legha for his service and commitment to going above and beyond for the betterment of the staff and El Camino Health.	
6. RECEIVE QUALITY COMMITTEE REPORT	Dr. Mallur and Dr. Somersille presented the Quality Committee Report. Dr. Somersille provided an overview of the recent discussion on equitable health, presented by Quality Committee Vice Chair Melora Simon. Ms. Simon's	**Actions:** *Staff to coordinate a briefing from Ms. Simon regarding CalAIM, along*

	presentation highlighted strategies to promote equitable health within the community. Dr. Somersille also discussed the key components of the CalAIM (California Advancing and Innovating Medi-Cal) program. She outlined how El Camino Health could leverage the resources offered by CalAIM to enhance care for Medi-Cal patients, emphasizing the importance of integrating social determinants of health into the hospital's community benefits initiatives. The report stressed the necessity of incorporating social determinants of health into the framework of community benefits to improve patient outcomes and health equity. Director Ting commented on mortality rate, highlighting the overall mortality rates observed over the past five years. He emphasized the need for a comprehensive analysis to understand the reasons behind the shifts in these metrics, aiming to improve overall health outcomes.	*with the appropriate members from Community Benefits.* *Staff to provide an in-depth, root-cause analysis of overall observed mortality rates at the September board meeting.*
7. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:54 pm. **Movant**: Ting **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Fung, Miller **Recused**: None	***Recessed to closed session at 5:54 p.m.***
8. AGENDA ITEM 17: CLOSED SESSION REPORT OUT	The open session was reconvened at **7:58 p.m.** by Chair Rebitzer. Agenda Items 8-16 were addressed in closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report was approved by a unanimous vote of all Directors present (Directors Chen, Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin).	***Reconvened Open Session at 7:58 p.m.***

DRAFT

9. AGENDA ITEM 18: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. The following items were removed for further discussion: Item G - FY25 Implementation Strategy Report and Community Benefit Plan as Reviewed and Recommended for Approval by the Finance Committee Item J - FY25 Master Calendar as Reviewed and Approved by the Governance Committee Item K - FY25 Committee Goals as Reviewed and Recommended for Approval by the Governance Committee Item P - FY25 Operating and Capital Budget Item N - Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee – specifically the MyCare policy	
	Motion: To approve the consent calendar items with the removal of Items G, J, K, P, and N. **Movant:** Zoglin **Second:** Watters **Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Miller **Recused**: None	***Consent Calendar Items A-F, H, I, L, M, O were approved.*** ***Prior Open Minutes, Prior Closed Minutes, VP-Chief Marketing and Communications Officer, Resolution 2024-04, FY25 Performance Incentive Goals, Signature Authority Policy, Respiratory Care Services Renewal Agreement, Call Panel Renewal Agreement, FY25 Committee Pacing Plans, FY25 Committee and Liaisons Appointments, QIPS Plan (formerly known as QAPI)***
	For item G), Director Zoglin questioned the allocation of funding to the El Camino Health Foundation and asked about the scale and flow of decision-making. Mr. Woods and Mr. Bohorquez addressed his comments. For item P), Director Zoglin raised concerns about the process, procedure, and duration of board reviews of the budget before approval. Mr. Bohorquez answered, and a discussion ensued. The Board requested that Mr. Bohorquez and Director Watters review the concerns raised about the Budget Review process. For item J), Director Zoglin inquired as to the pacing and date selections of the Master Calendar. Staff explained that	***Action: Director Watters and Mr. Bohorquez to amend current budget process to create additional opportunities for the Board to discuss budget.***

	dates are moved to be considerate of observed holidays and any conflicting dates for the Board and Committees. For item K), Director Somersille noted that the committee goal number 4 for the Quality Committee needed to be revised to remove "… *as facilitated by the Director of Governance*." For item N) in the policies Director Zoglin raised concern about the access of records timing for expired patients addressed in the MyCare Policy. He shared from personal experience that thirty (30) days is not enough time for family to access necessary medical records and asked if there were a way to extend the timeframe. Staff agreed to review the matter and bring the policy back for approval at a future meeting..	***Staff to revise MyCare policy and present for approval at the next Hospital Board meeting.***
	Motion: To approve the consent calendar item G) FY25 Implementation Strategy Report **Movant:** Somersille **Second:** Po **Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Miller **Recused**: None	***FY25 Implementation Strategy Report was approved.***
	Motion: To approve the consent calendar item P) FY25 Operating and Capital Budget **Movant:** Po **Second:** Watters **Ayes**: Doiguchi, Po, Rebitzer, Ting, Watters **Noes**: Somersille, Zoglin **Abstentions**: None **Absent**: Chen, Fung, Miller **Recused**: None	***FY25 Operating and Capital Budget was approved.***
	Motion: To approve the consent calendar item J) FY25 Master Calendar as Reviewed and Approved by the Governance Committee **Movant:** Po **Second:** Watters **Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Miller	***FY25 Master Calendar was approved.***

DRAFT

	Recused: None **Motion:** To approve the consent calendar item K) FY25 Committee Goals as Reviewed and Recommended for Approval by the Governance Committee with the requested revision. **Movant:** Somersille **Second:** Po **Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Miller **Recused**: None **Motion:** To approve the consent calendar item N) Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee minus the MyCare policy **Movant:** Po **Second:** Zoglin **Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Miller **Recused**: None	***FY25 Committee Goals were approved with requested revision.*** ***Policies, Plans, and Scopes of Service – minus MyCare policy – were approved.***
10. AGENDA ITEM 19: CEO REPORT	Mr. Woods provided a CEO report acknowledging a favorable total operating revenue for April 2024. Mr. Woods continued to highlight Newsweek's recognition of El Camino Health as one of the 2024 Best Maternity Hospitals. He continued to note the Mountain View Campus implantation of a state-of-the-art CT scanner. Finally, Mr. Woods shared that the Hospital's Auxiliary recorded 3,561 volunteer hours for April bringing the combined hours for FY24 to 38,148.	
11. AGENDA ITEM 20: BOARD ANNOUNCEMENTS	There were no announcements from the Board.	
12. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 8:17 pm **Movant:** Somersille **Second:** Doiguchi **Ayes**: Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Miller **Recused**: None	***Meeting adjourned at 8:17 p.m.***

DRAFT

DRAFT

Attest as to the approval of the preceding minutes by the Board of Directors of El Camino Hospital:

____

John Zoglin, Secretary/Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: Tracy Fowler, Director, Governance Services
Reviewed by Legal: Theresa Fuentes, Chief Legal Officer

DRAFT

A14b. DRAFT 2024-06-12 ECHB Minutes (Closed) vf

El Camino Health

CONFIDENTIAL

Minutes of the Closed Session of the
El Camino Hospital Board of Directors
Wednesday, June 12, 2024

El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

Board Members Present
Bob Rebitzer, Chair **
Jack Po, MD, Ph.D., Vice-Chair
Lanhee Chen, JD, PhD
Wayne Doiguchi
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
John Zoglin

Board Members Absent
Peter Fung, MD
Julia E. Miller, Secretary/Treasurer

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO
Theresa Fuentes, CLO
Omar Chughtai, CGO
Deb Muro, CIO
Tracey Lewis Taylor, COO
Mark Adams, **MD**, CMO
Shreyas Mallur, **MD**, ACMO
Christine Cunningham, Chief Experience and Performance Improvement Officer
Diane Wigglesworth, Compliance/Privacy Officer
Shahab Dadjou, President, ECHMN

Others Present (cont.)
Ed Braxton, Director, Total Rewards
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology

***via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. **CALL TO ORDER**	Chair Rebitzer called the closed-session meeting of the El Camino Hospital Board of Directors to order at 5:54 p.m. A quorum was present.	***Called to order at 5:54 pm.***
2. **AGENDA ITEM 8: ENTERPRISE RISK MANAGEMENT**	Mr. Bohorquez and Ms. Wigglesworth provided the Enterprise Risk Management Update. Ms. Wigglesworth covered movement in legal and regulatory claims within the risk assessment scoring tool. Ms. Wigglesworth explained the rationale for the movements of the risk assessments and how the Compliance and Audit Committee held a robust discussion on the continuous risk associated with IT security. The Board inquired regarding the risk scoring for the strategic plan given certain developments within the market.	***Actions**: Staff to reassess the scoring of Enterprise Level of Risk, specifically concerning the Strategic Plan.*
3. **AGENDA ITEM 9: FY25 OPERATING AND CAPITAL BUDGET**	The Board discussed the process and procedures for the review and approval of the Operating and Capital Budgets year to year. Mr. Bohorquez shared that the FY25 meets all the targets established during the annual update of the 5-year financial and capital plan as presented by management to the joint Finance & Investment Committees in February 2024. Mr.	***Actions:** Mr. Bohorquez and Director Watters to review and discuss the current review and approval processes of the Operating and Capital Budget*

CONFIDENTIAL - DRAFT

	Bohorquez highlighted the key budget drivers and identified funding and investment priorities for the Enterprise.	
4. AGENDA ITEM 10: LOS GATOS CAMPUS DEVELOPMENT	Mr. Woods provided the Los Gatos Campus Development process. Mr. Chughtai continued to discuss the current state of the redevelopment, a review of next steps, and options available to pursue growth within the market.	
5. AGENDA ITEM 11: FY25 ORGANIZATIONAL STRATEGIC MILESTONES	Mr. Woods shared the FY25 Organizational Strategic Milestones. The Board discussed the strategic targets included and how to address desired improvements in Likelihood to Recommend.	
6. AGENDA ITEM 12: APPROVE CREDENTIALING AND PRIVILEGING REPORT	**Motion:** To approve the Credentialing and Privileging report **Movant:** Somersille **Second:** Po **Ayes**: Chen, Doiguchi, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Fung, Miller **Recused**: None	
7. AGENDA ITEM 13: FINANCE COMMITTEE ITEMS	Dr. Adams provided an overview of the included Finance Committee items. The Board did not have any discussion points for any of the included Finance Committee items.	
8. AGENDA ITEM 14: EXECUTIVE COMPENSATION COMMITTEE ITEMS	Mr. Woods presented the Executive Compensation Committee Items. The Board discussed the proposed FY2025 Organizational Performance Goals. Mr. Woods shared that the methodology for the goals is to create goals that people all throughout the organization could align themselves to. Staff, except for Mr. Woods, exited at 7:33 pm for the duration of the second part of the discussion regarding the FY25 Executive Individual Incentive Goals.	
9. AGENDA ITEM 15: EXECUTIVE SESSION	The Board of Directors continued into Executive Session. Staff, excluding Mr. Woods, remained out of the room. The staff returned at 7:58 p.m.	
10. AGENDA ITEM 16: RECONVENE TO OPEN SESSION	**Motion:** To reconvene to open session at 7:04 pm. **Movant:** Miller **Second:** Doiguchi **Ayes**: Chen, Doiguchi, Po, Rebitzer, Somersille,	***Reconvened to Open Session at 7:04 pm***

CONFIDENTIAL - DRAFT

DRAFT

	Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Fung, Miller **Recused**: None	

Attest as to the approval of the preceding minutes by the Board of Directors of El Camino Hospital:

____
John Zoglin, Secretary/ Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: Tracy Fowler, Director, Governance Services
Reviewed by Legal: Theresa Fuentes, Chief Legal Officer

CONFIDENTIAL - DRAFT

CONFIDENTIAL

A14c1. MyCare Access-History-Redlined

Status Pending PolicyStat ID 16147608

Origination	12/2016	Owner	Kristina Underhill: Manager HIM Ops
Last Approved	N/A	Area	HIM
Effective	Upon Approval	Document Types	Policy
Last Revised	07/2024		
Next Review	3 years after approval		

MyCare Access

COPY

COVERAGE:

El Camino Hospital staff

PURPOSE:

All patient information is considered confidential. Information that identifies or potentially identifies a patient, or information about a specific patient, will not be disclosed unless authorized by law or by the patient / legal guardian.

This procedure ensures confidentiality of patient information and allows for limited information to be accessed by the patient, patient's legal representative or designated patient proxy via myCare.

REFERENCE:

- California Hospital Association Consent Manual, 2021

PROCEDURE:

A. **Patients Requesting myCare Access:**
   1. By default, patients who are registered at El Camino Hospital receive a myCare activation code upon discharge. This information is located on the patients After Visit Summary (AVS).
   2. The auto-generated activation code expires 14 days from the date of discharge or service.

3. Patient may request an activation code via the myCare self sign-up page.
4. Patients can also call the Health Information Management (HIM) Department or contact myCare Help via email to request an activation code.
5. If the patient contacts the HIM Department, the following will occur:
    a. An HIM team member will verify patient demographic information which includes patient name, date of birth, last four digits of the social security number and additional information if needed.
    b. Once the patient's identity has been verified, an activation code is generated and sent to the patient via email, text or USPS.

B. **Requesting Adult Proxy Access of Minor Patient:**
1. Parent, legal guardian or conservator can request Proxy access to a minor's chart by completing a myCare Child Proxy access form.
    a. Exception: Mother of minor child born at El Camino Hospital as of November 2018, will automatically be given proxy access via EHR.
2. El Camino Hospital will validate the parent, legal guardian or conservator relationship of the minor patient.
3. Once validated and approved, a myCare account will be created for proxy use.
4. Limited access is granted based on the minor's age due to state and federal patient privacy regulations.
    a. Minors 0 -11 years of age: Proxy will be able to view general medical record information, schedule appointments and send a message to the provider.
    b. Minors 12 – 17 years of age: Proxy will be able to schedule appointments and send a message to the provider Proxy access of a minor patient will terminate when the minor patient turns 18 years of age.

C. **Requesting Adult Proxy Access of Adult Patient:**
1. A patient 18 years of age and older can designate a proxy by completing a myCare Adult proxy form and a myCare Adult proxy release of protected health information authorization.
2. El Camino hospital will validate the patient's request and authorization.
3. Once validated and approved, a myCare account will be created for proxy use.
4. The Authorization for Release of Protected Health Information for myCare proxy access is valid until revoked by the patient or El Camino Hospital

D. **Patients Requesting a Password Reset or Re-activation of their myCare Account:**
1. Patients will undergo the same verification process as a new patient requesting access.
2. Once the patients identity has been verified, a temporary password will be generated and provided to patient and/or account will be re-activated.

COPY

E. **Patients Requesting a Deactivation of their myCare Account:**

1. Patients will undergo the same verification process as a new patient Requesting access.
2. Once patient's identity has been verified, the account will be deactivated and a notation entered regarding the deactivation request.

F. **Expired Patients**

1. Once a patient medical record is marked as expired/deceased, the patient's myCare account access will be de-activated.
2. Any active proxy user access will remain active for ~~30~~90 days post patient expiratiion in a read-only format
3. Users with proxy access can request deactivation prior to the ~~30~~90 days by calling the HIM Department for assistance
4. No additional proxy accounts will be created once patient has expired.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

COPY

Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	Pending
HIM Leadership	Kristina Underhill: Manager HIM Ops	07/2024
	Kristina Underhill: Manager HIM Ops	07/2024

History

Draft saved by Underhill, Kristina: Manager HIM Ops on 7/2/2024, 7:20PM EDT

Edited by Underhill, Kristina: Manager HIM Ops on 7/2/2024, 7:20PM EDT

> Based off recommendations to extend the proxy access to expired patient accounts, the update changes from 30 to 90 days. Approved by CFO, HIM and LMR committee

Last Approved by Underhill, Kristina: Manager HIM Ops on 7/2/2024, 7:20PM EDT

Last Approved by Underhill, Kristina: Manager HIM Ops on 7/2/2024, 7:21PM EDT

Comment by Santos, Patrick: Policy and Procedure Coordinator on 7/10/2024, 4:51PM EDT

> Reviewed at ePolicy 2/24/23; minor change as requested by the Board.

COPY

A14c2. Emergency Department - Patient Disaster Surge Plan -Mountain View-Redlined

Status **Pending** PolicyStat ID **15076473**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	3 years after approval
Owner	Jumana Baluom: Clinical Manager
Area	Emergency Department
Document Types	Plan

Emergency Department - Patient Disaster Surge Plan (Mountain View)

COPY

COVERAGE:

All El Camino Hospital ~~Emergency Department (ED)~~ Staff

PURPOSE:

The purpose of the ED Patient Disaster Surge Plan is to enhance preparedness in the Mountain View emergency department during a patient surge or temporary increase in demand for services while providing safe and timely care for walk-in and ambulance patients.

The goals of the ED patient surge management plan are to:

- Maintain Patient Safety
  - Prioritize the high acuity patients
  - Improve patient access to safe and timely care
  - Re-assess patients in the waiting room as needed
- Communication & Teamwork
  - Charge & Leader rounds with escalated response through standard work flow
  - Request additional staff to facilitate surge plan
  - Communicate effectively & professionally to colleagues
  - Communicate delays to patients &/or families

- Commitment & consistency in following the standard process:
    - Use NEDOCS – National Emergency Department Overcrowding Scale
    - Increase space capacity using alternate care areas and ED hallway beds
    - Management of Inpatient Boarding patients in ED (move ED admit holds to appropriate inpatient beds)

PROCEDURE:

A. Monitor ED overcrowding through Leader Rounding and complex and determine if meets surge criteria.
    1. Surge Criteria - NEDOCS score (National Emergency Department Overcrowding Study)
        a. Black (>180) Internal disaster = Command Center activated
        b. Red (141 – 180) Severely Overcrowded = ED surge
        c. Yellow (61-140) Busy
        d. Green (0 – 60) Normal

B. Once the surge criteria above is met in the department (Red or Black status), the charge nurse should consider activation of the patient surge contingency plan and the following steps should occur:
    1. Leadership Huddle: Charge Nurse, Lead Provider, ED Manager and Assistant Hospital Manager will discuss ED Status & decide on immediate deployment of needed resources.
    2. The Charge Nurse will notify the Medical Director who will determine Provider resources and attempt to increase provider staffing to cover alternate care areas if able to open them.
    3. RN Staffing (ED staffer or central staffing will be notified to attempt to increase ED staffing).
        a. Charge RN will assign nurses and open additional areas depending on patient acuity, and department need and staff availability

C. Triage Process:
    1. As patients arrive, the Triage Nurse will perform a quick triage to determine a patient's level of acuity. Critical patients will be reported to the Charge RN, who will assign a room and delegate appropriate staff.
    2. The Triage RN will initiate Initiation of Care (IOC) orders if provider is not available to TIP in a timely manner.
    3. In times of a surge, the Charge RN may assign a second or third Triage Nurse, as staffing permits.
    4. The screener nurse may also assist in triage. They may also help with vital signs and point of care (POC) tasks.
    5. As staffing allows, at least one ED tech will be assigned to the waiting room to

COPY

obtain vital signs. ED tech will reassess waiting room patient vital signs as. Needed or as instructed by provider/nurses.

D. Screener Nurse:

1. The Screener Nurse will greet patients on arrival and determine any immediate needs. If the patient is critical they will notify the Charge RN and facilitate getting the patient to the appropriate location with the appropriate resources.
2. The Screener Nurse will also request EKGs via Vocera and ensure they are completed (goal within ten minutes of arrival).
3. The Screener Nurse will assist with triage and facilitating care.
4. The Screener Nurse will obtain vital signs and help with POC tasks as ordered.

E. Front End Process / Roles:

1. The POC RN (Point of Care Registered Nurse) is the nurse who facilitates the testing and treatment of patients arriving from Triage. The primary responsibility of the POC RN is to facilitate radiology procedures and the collection of blood, urine and swabs. The POC RN may administer medications that do not require patient monitoring.
2. Front Resource RN (FRN) is the nurse who assists in moving lower acuity patients through the department. They help with ensuring tasks are complete, reevaluating patient status, notifying providers to reevaluate patients discharging and moving patients to the appropriate area within the department. If staffing allows, the Charge RN may assign multiple FRNs. Their primary role is to manage waiting room patients, hallway patients and provide care in the recliner area. These RNs may also help triage as needed.

F. RME (rooms 21 - 24)

1. Patients in the RME Area should ideally be ESI 3, 4 or 5 patients who require fewer resources. This zone may be used for higher acuity patients if the department requires additional beds and would be a regular zone if alternate care areas are open for lower acuity patients. This RN may help with triage, as needed.

G. Alternate Care Areas: (Hallway beds, Radiology Overflow Area (ROA) and ED express care area.

The patient will be triaged by the Triage RN then a medical screening is done by the Provider. The Provider and Triage RN will determine those patients who are appropriate for alternate care areas.

1. Hallway beds in ED – USE FIRST
   a. Overflow area used for lower acuity patients. Line gurneys in available hall space and use screens/dividers for privacy.
   b. May accommodate multiple patients depending on bed availability.
   c. This role is staffed with ED nurses and the Charge RN may pull from breaks, PIT, FRN as staffing permits.
   d. Contact the Environmental Services Supervisor for additional gurneys.
2. Radiology Overflow Area (ROA) – USE SECOND (located next to CT in IR area)

COPY

a. Overflow area used for lower acuity patients
b. Open when hallway beds are utilized and full. Must have adequate staffing.
c. No waiting area available. Patients assigned to this area will wait in the main WR.
d. Staffed with RNs, ED tech and a dedicated provider.
e. Supplies:
    i. WOW with soft ID printer and scanner.
    ii. Portable otoscope and ophthalmoscope
    iii. Alternate care area Supply cart w/ key
    iv. Suture cart
f. Place comment in Epic indicating patient appropriate for ROA. Place patient in appropriate area on ED track board.

3. ED Express Care area (ECA) – USE THIRD (located in Sobrato)
    a. Overflow area used for lower acuity patients.
    b. Open when hallway beds are utilized and full. Must have adequate staffing.
    c. This area has its own waiting area so patients can be brought over and wait for an available spot.
    d. Staffed with RNs, ED tech and a dedicated provider.
    e. Supplies:
        i. WOW with soft ID printer
        ii. Alternate care area supply cart w/ key
        iii. Two vital sign machines
        iv. Two oxygen tanks
        v. Suture cart
        vi. Broslow cart
    f. Place comment in Epic indicating patient appropriate for ED Express Care. Place patient in appropriate area on ED track board.

H. Fast Track Area:
1. Management will attempt to move as many patients out of the ED to the appropriate floors as possible.
2. ED admit holds would be relocated to Fast Track area and report will be given to assigned nurse.
3. Charge/AHM will notify Staffing Office of need for additional staff (i.e. PCR).
4. Fast Track rooms 1 – 10 may be used for med/surg, telemetry and PCU inpatient boarding patients if the ED is holding admitted patients.
5. In a surge situation, PCR staff may manage this area to free up ED staff to manage

COPY

other areas that are ED specific.

6. The assistant hospital manager may pull the Rapid Response RN and/or ADT RN to facilitate moving and settling these patients in a timely manner.

I. PIT RN (Resource Nurse):

1. The PIT RN is responsible for assisting the charge RN in managing throughput in the department. Duties include but are not limited to: transporting patients, rooming patients into care areas and initiating their care, assisting/caring for critically ill patients, assisting with breaks, cleaning rooms, and intaking ambulance patients. The PIT nurse is also expected to assist the Triage nurse as needed. These nurses may also be deployed to the alternate care areas as directed by the Charge RN.

J. Additional available NON-ED staff: (both CNAs and RNs)

If float staff are available and allocated to the ED, they can be used for a variety of non ED tasks within their scope of practice.

1. PCR RNs to staff FT if needed for boarding patients.
2. Assist with vital signs including reassessing waiting room patients.
3. Assist primary RN in alternate care areas as needed.
4. Answer phones and call lights.
5. Clean dirty rooms.
6. Round on patients and help with meeting patient needs, i.e. Blankets, food, bathroom.
7. Transport patients to ancillary areas and units.
8. Restock supplies, blanket warmers.
9. Other tasks as assigned by Charge RN.

K. SPECIFIC RESPIRATORY ILLNESS MANAGEMENT

1. Initiated if large amount of surge patients present with respiratory complaints.
2. Screener to assist in masking ALL patients & visitors entering the ED.
3. Staff to mask as per Santa Clara County requirement when caring for patients who present with respiratory symptoms.
4. Place available Isolation towers & Droplet Precaution signs throughout department.
5. Utilize red/green cards on ED room entryway/door.

COPY

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	06/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2024
Emergency Management Committee	Bryan Plett: Mgr Environmental Hlth&Safety	05/2024
UPC | ED Physicians	Jumana Baluom: Clinical Manager	05/2024

History

Created by Santos, Patrick: Policy and Procedure Coordinator on 1/19/2024, 4:11PM EST

> Starting approval process

Last Approved by Baluom, Jumana: Clinical Manager on 5/14/2024, 1:23PM EDT

> no changes

Last Approved by Plett, Bryan: Mgr Environmental Hlth&Safety on 5/28/2024, 11:03AM EDT

> Approved via email by Emergency Management Committee on 05.27.2024

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/17/2024, 2:22PM EDT

> Per ePolicy recommendation to update Coverage section: All ECH Staff

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/17/2024, 3:26PM EDT

> ePolicy 6/14/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 6/28/2024, 11:24AM EDT

COPY

MEC 6/27/24

COPY

A14c3. Injury and Illness Prevention Plan -IIPP- - Safety Program Crosswalk

Status Pending PolicyStat ID 13281707

Origination	02/2007	Owner	Matthew Scannell: Director Safety & Security Services
Last Approved	N/A	Area	Environment of Care
Effective	Upon Approval	Document Types	Plan
Last Revised	02/2020		
Next Review	3 years after approval		

Injury and Illness Prevention Plan (IIPP) - Safety Program Crosswalk

COPY

COVERAGE:

All El Camino Hospital staff

PURPOSE:

El Camino Hospital's Safety Program complies with the Occupational Safety and Health Administration (OSHA) Injury and Illness Prevention Program (IIPP). The hospital policies and procedures are formatted differently from the IIPP layout. This table notes which ECH policies correspond to each element of the OSHA IIPP:

IIPP Elements	ECH Policy
(a) Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum:	
(1) Identify the person or persons with authority and responsibility for implementing the Program.	Hospital Safety Officer Designation and Responsibilities
(2) Include a system for ensuring that employees comply with safe and healthy work practices. Substantial compliance with this provision includes recognition of employees who follow safe and healthful work practices, training and retraining programs, disciplinary actions, or any	Responsibility for Safety - Department Safety Coordinator Responsibility for Safety - Employee Responsibility for Safety – Management

IIPP Elements	ECH Policy
other such means that ensures employee compliance with safe and healthful work practices.	Training - Safety Education Requirements
(3) Include a system for communicating with employees in a form readily understandable by all affected employees on matters relating to occupational safety and health, including provisions designed to encourage employees to inform the employer of hazards at the worksite without fear of reprisal. Substantial compliance with this provision includes meetings, training programs, posting, written communications, a system of anonymous notification by employees about hazards, labor/management safety and health committees, or any other means that ensures communication with employees.	Training - Safety Education Requirements Training - Safety Education Documentation
(4) Include procedures for identifying and evaluating work place hazards including scheduled periodic inspections to identify unsafe conditions and work practices. Inspections shall be made to identify and evaluate hazards.	Safety - Reporting Safety Hazards Safety – Facility Maintenance and Access Safety - Environmental Monitoring Safety - Safety Rounds (Environmental Tours)
(5) Include a procedure to investigate occupational injury or occupational illness.	Safety - Accident, Incident, and Exposure Investigation Guidelines Safety - Record Keeping Requirements
(6) Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard:	Safety – Facility Maintenance and Access Safety - Reporting Safety Hazards
(7) Provide training and instruction:	Training - Safety Education Requirements Training - Safety Education Documentation
(b) Records of the steps taken to implement and maintain the Program shall include:	
(1) Records of scheduled and periodic inspections required by subsection (a)(4) to identify unsafe conditions and work practices, including person(s) conducting the inspection, the unsafe conditions and work practices that have been identified and action taken to correct the identified unsafe conditions and work practices. These records shall be maintained for at least one (1) year; and	Safety - Record Keeping Requirements
(2) Documentation of safety and health training required by subsection (a)(7) for each employee, including employee name or other identifier, training dates, type(s) of training,	Training - Safety Education Documentation

COPY

IIPP Elements	ECH Policy
and training providers. This documentation shall be maintained for at least one (1) year.	
(c) Employers who elect to use a labor/management safety and health committee to comply with the communication requirements of subsection (a)(3) of this section shall be presumed to be in substantial compliance with subsection (a)(3) if the committee:	
(1) Meets regularly, but not less than quarterly;	Central Safety Committee Charter
(2) Prepares and makes available to the affected employees, written records of the safety and health issues discussed at the committee meetings and, maintained for review by the Division upon request. The committee meeting records shall be maintained for at least one (1) year;	Central Safety Committee Charter
(3) Reviews results of the periodic, scheduled worksite inspections;	Central Safety Committee Charter
(4) Reviews investigations of occupational accidents and causes of incidents resulting in occupational injury, occupational illness, or exposure to hazardous substances and, where appropriate, submits suggestions to management for the prevention of future incidents;	Central Safety Committee Charter
(5) Reviews investigations of alleged hazardous conditions brought to the attention of any committee member. When determined necessary by the committee, the committee may conduct its own inspection and investigation to assist in remedial solutions;	Central Safety Committee Charter
(6) Submits recommendations to assist in the evaluation of employee safety suggestions; and	Central Safety Committee Charter
(7) Upon request from the Division, verifies abatement action taken by the employer to abate citations issued by the Division.	

COPY

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending

MEC	Michael Coston: Director Quality and Public Reporting [PS]	06/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	04/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	04/2024

History

Sent for re-approval by Peck, Daniel: Mgr Environmental Hlth&Safety on 3/8/2023, 6:02PM EST

> No changes.

Last Approved by Peck, Daniel: Mgr Environmental Hlth&Safety on 3/8/2023, 6:02PM EST

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 3/30/2023, 4:12PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 4/3/2023, 3:32PM EDT

Responsibilities transferred to new account by Santos, Patrick: Policy and Procedure Coordinator on 4/14/2023, 12:55PM EDT

> The previous owner's account (*Daniel Peck: Mgr Environmental Hlth&Safety*) was deactivated, so all of their responsibilities were transferred to *Matthew Scannell: Director Safety & Security Services*.

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 6/5/2023, 3:21PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 6/8/2023, 4:15PM EDT

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 6/28/2023, 2:21PM EDT

Last Approved by Scannell, Matthew: Director Safety & Security Services on 4/18/2024, 4:59PM EDT

Last Approved by Madrid, Delfina: Quality Data Analyst on 4/29/2024, 1:18PM EDT

> Approved by PESC 4/24/24

COPY

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 5/3/2024, 2:18PM EDT

> Updated doc type to Plan; this isn't a procedure

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/17/2024, 3:38PM EDT

> ePolicy 6/14/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 6/28/2024, 11:22AM EDT

> MEC 6/27/24

COPY

A14c4. Scope of Service - Care Coordination-Redlined

Status Pending PolicyStat ID 15783692

Origination	09/2015	Owner	Carolyn Bogard: Director Care Coordination
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval	Document Types	Scope of Service
Last Revised	06/2024		
Next Review	3 years after approval		

Scope of Service - Care Coordination

COPY

Types and ages of the Patients Served

The Care Coordination Department serves patients of all ages. When a patient is admitted to the hospital, a ~~care coordinator~~case manager is assigned to the patient.

Assessment Methods

The ~~care coordinator~~case manager's assessment is based on review of documentation and input from the health care team and includes the following: assessment of appropriateness of admission and continued stay, physical and psychosocial issues, social support systems, cultural/spiritual identity, financial resources and liabilities/responsibilities, expected length of stay, optimum health expectations, and community reintegration potential.

Scope and Complexity of Services Offered

Care Coordination is an interdisciplinary process involving the timely coordination of health care services to meet an individual's specific needs and to promote quality care and cost-effective outcomes. The Care Coordination ~~includes~~department provides case management, ~~discharge planning,~~ social work and utilization review services ~~and utilization review~~.

Appropriateness, Necessity and Timeliness of Services

Case finding occurs through assignments, screening, and direct referrals. Case Managers and Medical Social Workers are assigned to patients on a daily basis, geographically, by nursing unit. Social service

referrals can be made by any member of patient care team. Care Coordination process focuses on safe and realistic discharge planning to reduce readmission rate and decrease length of stay.

Staffing

Care Coordination staffing includes: Director, Clinical Manager, Social Work Manager, Utilization Management Supervisor, Case Managers, Medical Social Workers, and support staff.

Care Coordination staff is available every day from approximately 8:00 am until 4:30 pm. A ~~care coordinator~~case manager is scheduled for PM shift in Emergency Department. Staffing is adjusted daily based on patient census. After hours the shift supervisors are available to assist nursing staff with discharge planning, utilization and social issues.

Level of Service Provided

Every patient admitted to the hospital will ~~receive~~be screened for risk factors that put them at risk for poor care transitions. The care coordination ~~services. The~~process provides for continuity of care ~~coordination process provides for continuity of care~~ and referral to post hospital services, aimed at improving or maintaining the patient's health status. The care coordination process may also include facilitating multidisciplinary patient care conferences, which include the patient and family, attending physicians, clinical nurses and other support specialty personnel as appropriate. Utilization review process assesses the appropriateness of admission.

COPY

Standards of Practice

Care coordination services are governed by the California Health and Safety Code via regulations as outlined in Title 22. The department also follows standards set forth by The Joint Commission. Specific practices are described in the Care Coordination Department Policies and Procedures.

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the electronic version prevails.

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	06/2024

ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2024
Department Medical Director or Director for non-clinical Departments	Carolyn Bogard: Director Care Coordination	05/2024
	Carolyn Bogard: Director Care Coordination	05/2024

History

Draft saved by Bogard, Carolyn: Director Care Coordination on 5/7/2024, 12:28PM EDT

Edited by Bogard, Carolyn: Director Care Coordination on 5/7/2024, 12:29PM EDT

> Updated language from care coordinator to case manager. Document updated to reflect current department structure.

Last Approved by Bogard, Carolyn: Director Care Coordination on 5/7/2024, 12:30PM EDT

Last Approved by Bogard, Carolyn: Director Care Coordination on 5/7/2024, 12:30PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/7/2024, 1:14PM EDT

> Updated doc type

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/17/2024, 3:16PM EDT

> ePolicy 6/14/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 6/28/2024, 11:22AM EDT

> MEC 6/27/24

COPY