AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, May 8, 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: 971 9057 2423# No participant code. Just press #.**

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

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

MISSION: To heal, relieve suffering, and advance wellness.

VALUE PROPOSITION STATEMENT: Setting the Standard for the best healthcare experience in the Bay Area by delivering dependable clinical excellence in a caring, convenient way

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**AB 2449 – REMOTE PARTICIPATION**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 – 5:31**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:31 – 5:32**
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	**5:32 – 5:33**
5	**ECHB SPOTLIGHT RECOGNITION – Teri Eyre** Adopt Resolution 2024-02	Bob Rebitzer, Board Chair	Motion Required	**5:33 – 5:40**
6	**QUALITY FOCUSED REVIEW** - Receive STEEEP Dashboard Update	Carol Somersille, MD Quality Committee Chair Shreyas Mallur, MD Associate Chief Medical Officer Lyn Garrett, Senior Director, Quality	Discussion	**5:40 – 6:10**

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
7	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required	**6:10 – 6:11**
8	*Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs*: **QUARTERLY FINANCE AND STRATEGIC MARKET SHARE UPDATE**	Carlos Bohorquez, Chief Financial Officer	Discussion	**6:12 – 6:42**
9	*Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*: **APPROVE CREDENTIALING AND PRIVILEGING REPORT**	Mark Adams, MD, CMO	Motion Required	**6:42 – 6:45**
10	*Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:* **EXECUTIVE SESSION**	Bob Rebitzer, Board Chair	Discussion	**6:45 – 6:50**
11	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**6:50 – 6:51**
12	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	**6:51 – 6:52**
13	**CONSENT CALENDAR ITEMS:** *Items removed from the Consent Calendar will be considered at the end of the regular agenda.* a. Approve Hospital Board Open Session Minutes (04/23/2024) b. Approve Minutes of the Closed Session of the Hospital Board (04/23/2024) c. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee d. Receive FY24 ECHB Pacing Plan e. Receive report from Chief Legal Officer providing update regarding Board committee responsibilities as related to ECHMN, charter revisions, and governance policy f. Approve QAPI as Reviewed and Recommended for Approval by the Quality Committee	Bob Rebitzer, Board Chair	Motion Required	**6:52 – 6:55**
14	**BOARD OFFICER ELECTIONS** **Candidates**: Board Chair: Bob Rebitzer Vice-Chair: Jack Po Secretary/Treasurer: Julia Miller, John Zoglin Adopt Resolution 2024-03	Bob Rebitzer, Board Chair	Motion Required	**6:55 – 7:15**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
15	**CEO REPORT**	Dan Woods, Chief Executive Officer	Discussion	**7:20 – 7:25**
16	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:25 – 7:29**
17	**ADJOURNMENT** **APPENDIX**	Bob Rebitzer, Board Chair	Motion Required	**7:30**

Next ECHB Regular Meetings: June 12, 2024

El Camino Hospital Board

RESOLUTION 2024 – 02

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE AND SUPPORT

WHEREAS, the Board of Directors of El Camino Hospital values and wishes to recognize the contribution of individuals who enhance the experience of the hospital's patients, their families, the community and the staff, as well as individuals who in their efforts exemplify El Camino Health's mission and values.

WHEREAS, the Board honors and recognizes Teri Eyre for her service to the El Camino Hospital Executive Compensation Committee over the past 12 years.

WHEREAS, the Board acknowledges Teri Eyre for her commitment to providing expert guidance related to executive compensation to our board and executives as a member of the El Camino Hospital Executive Compensation Committee.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously recognize, thank, and pay tribute to:

Teri Eyre

FOR YOUR COMMITMENT AND DEDICATION TO THE EL CAMINO HOSPITAL EXECUTIVE COMPENSATION COMMITTEE.

IN WITNESS THEREOF, I have hereunto set my hand this **8TH DAY OF MAY, 2024.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee J. Chen, JD, PhD
Julia E. Miller
Carol A. Somersille, MD, FACOG
John L. Zoglin
Wayne Doiguchi
Jack Po, MD
George O. Ting, MD
Peter C. Fung, MD
Bob Rebitzer
Don Watters

Julia E. Miller
Secretary/Treasurer
El Camino Hospital Board of Directors

El Camino Health

El Camino Health

El Camino Health Board of Directors
Board Meeting Memo

To: El Camino Hospital Board of Directors
From: Shreyas Mallur, MD and Associate Chief Medical Officer
Date: May 8, 2024
Subject: STEEEP Dashboard through March 2024

Purpose:

To update the El Camino Hospital Board of Directors on quality, safety, and experience measure performance through March 2024 (unless otherwise noted). This memo will describe performance from the STEEEP Dashboard.

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.

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 March (**0.904**) and Fiscal Year-To-Date (**1.158**) we are **favorable** to target of (1.201).

   a. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (**0.680**) for the third quarter and year to date (**0.784**) are **favorable** to target (0.805). There have been 25 hospital acquired infections in FY24. For the month of February, we had zero hospital on-set C. Diff cases. 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.

b. **Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q3 (**0.058**) 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 through March 2024. There were zero CAUTI's enterprise wide in January and March 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 third quarter of FY24.

c. **Central Line Associated Blood Stream Infection (CLABSI)**. The rate of CLABSI for third quarter (**0.147**) and year to date (**0.077**) 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.

d. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 Q3 nvHAP rate (**0.080**) improved from Q1 (**0.125**) and is at target (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. There was one nvHAP in the month of March 2024. 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.

2. **Surgical Site Infection**. The rate of surgical site infections for FY24 Q3 (**0.551**) is **unfavorable** to target (0.369). Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. These initiatives have decreased surgical site infections for TKR surgeries. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures.

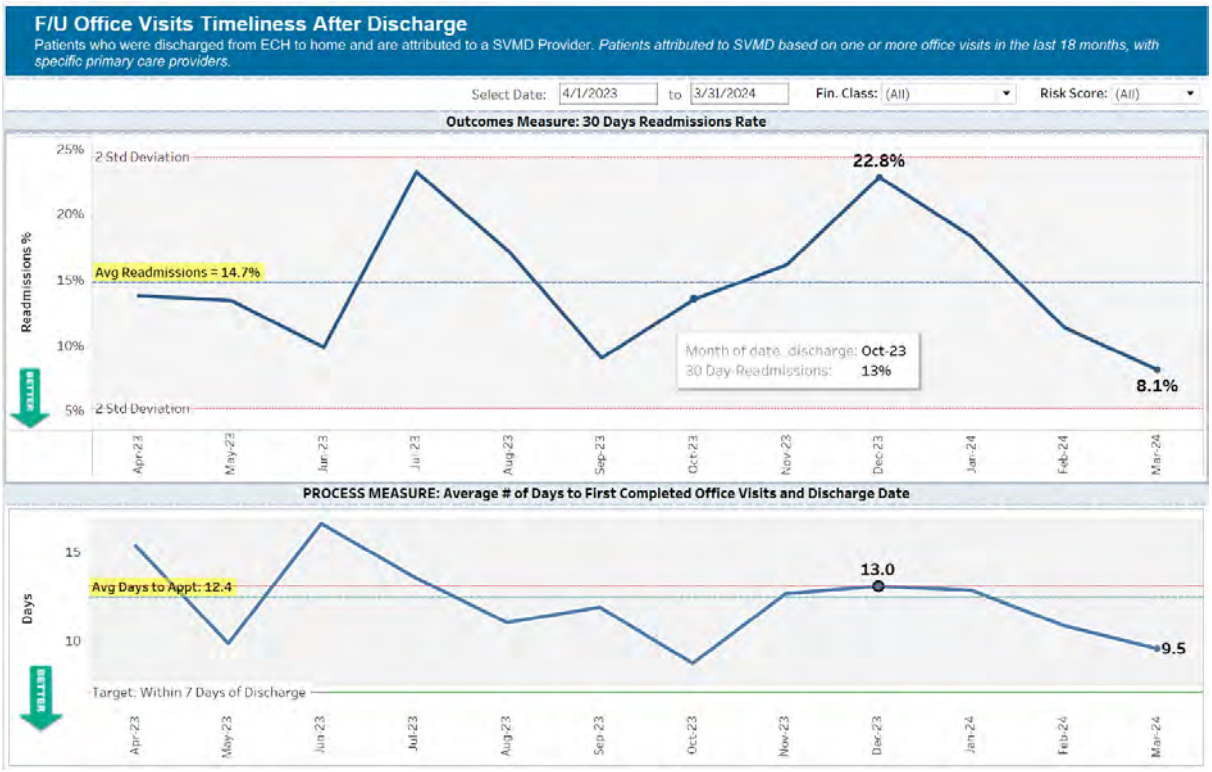
B. Timely

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 Q3 FY24 (**88.7%**) is unfavorable to target but improved from prior quarters. Below is a detailed analysis of gaps and corrective actions to improve our performance. Root causes of not meeting this target include: 1) Need for repeat troponin due to erroneous results, 2) Specimen integrity – specimens not fully clotted, 3) Critical calls. Key actions to improve include: 1) Daily monitoring of chemistry TAT, 2) Weekly meetings with vendor to address instrumentation issues, and 3) updating the critical call threshold with Heart and Vascular

2. **Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q3 (**81.4%**) and YTD (**78.4%**) are **unfavorable** to target (84%). FY 24 Q3 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. Within 3-months of this transition, we anticipate a significant improvement (decrease) in reading times.

C. Effective

1. **Risk Adjusted Readmission Index.** Performance through February 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. Recent data on "F/U Office Visits Timeliness After Discharge" indicates a significant improvement, with the readmission rate decreasing to 8.1% in March from over 22% in December. Additionally, the average time to the first completed appointment after discharge has decreased from 13 days to 9 days in March, correlating well with the decrease in readmissions. This improvement underscores the benefits of an integrated approach, providing a smooth transition between inpatient and ambulatory care for our patients who seek care at ECH.



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.

2. **Risk Adjusted Mortality Index.** Performance for FY24Q3 (**1.09**) and YTD (**1.08**) are **unfavorable** to target (1.00). Mortality index tracks, and for this time frame, is driven by sepsis mortality.

3. **Sepsis Mortality Index.** Performance for FY24Q3 (1.17) and YTD (1.21) 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, hospice when appropriate for patients in the ED to go home, or if admitted then to a robust GIP program. A recent process change now has sepsis coordinators providing concurrent sepsis bundle compliance to ED physicians and staff in 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.

4. **4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV).** The FY24Q3 performance (**28.3%**) is **unfavorable** to target of 23.9%. The MCH team shares data quarterly with the medical staff regarding individual physician NTSV rates. There are more details for this metric in the Core Measures memo.

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 (**1.20**) 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 have the opportunity to 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 will expand to the nursing unit on 3C. This expansion aims to replicate the positive

outcomes observed in the initial phase, optimizing patient care and efficiency in discharging patients.

- 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.

2. **Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q3 performance (**152 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 Q3 of FY24, documentation indicating that weather-appropriate clothing was provided to homeless patients prior to discharge improved from 64.9% to 73.1% (FYTD 62.8%). 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 third quarter of FY2024 eleven of eleven 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

STEEEP Dashboards through March 2024
May 8, 2024

1. **Inpatient HCAHPS Likelihood to Recommend**. For the month of March (**81.8**) and FY24YTD (**81.4**) 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. For our Mountain View Campus, we saw substantial increases in 3C and 4A unites (green after four months of red) and a noticeable increase in our LG Med Surg Unit. 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 the month of March (**88.6**) and FY24YTD **(82.2**) performance exceeded target of 75. Our Mother/Baby units exceeded their enterprise targets for the month of March on both campuses with Los Gatos achieving a **top box score of 100.0!** 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 did not achieve target (71.7) for the month of March (**70.7**), however, as an enterprise, (**75.5**) we are exceeding target 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 did not achieve their target (81.3) for the month of March (**80.8**). Year to date (**82**), ECHMN is exceeding target. We did exceed our target in the areas of Specialty Care and Urgent Care, but not in primary care. We continue to work with our primary care clinics on access and scheduling (the organization is recruiting as fast as they can!). Also, during the month of March was the welcoming of the new USNC (Urology) clinics and our staff spent a lot of time partnering with USNC to provide patient experience focused onboarding.

Attachments:

1. STEEEP Dashboard through Q3 of FY2024

BOARD OF DIRECTORS
Policies for Review
May 8, 2024

Department	Document Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
Foundation	1. Scope of Service - El Camino Health Foundation	Revised	Scope of Svc	1. Updated Sections: Purpose, Scope and Complexity of Services Offered, Staffing, Level of Services Provided, Standard of Practice	• President of Foundation • ePolicy • MEC
Human Resource	2. HR – Aerosol Transmissible Disease (ATD) Exposure Control Plan	Revised	Plan	2. Updated Sections: References, Procedure	• HR Leadership | CHRO • ePolicy • MEC

El Camino Hospital Board												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/9	9/13	10/11	11/8	12/6	JAN	2/7	3/13	4/23	5/8	6/12
STANDARD												
Public Communication		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports (Informational and Consent item, unless requested)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Consent Approvals		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Session		✓	✓	✓	✓	✓		✓	✓		✓	✓
CEO Report		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
COMPLIANCE												
Annual Corporate Compliance Summary					✓							
EXECUTIVE PERFORMANCE												
CEO Assessment Results Discussion			✓									
CEO Performance Evaluation & Compensation				✓								
Executive Incentive Approvals				✓								
FINANCE												
Financials		✓		✓				✓			✓	
Budget Review & Approval												✓
MEDICAL NETWORK												
Bi-Annual Report			✓						✓			
STRATEGY												
Strategy Update, Strategic Vision					✓			✓		✓		
Board Retreat										✓		
QUALITY												
Quality Committee Focused Review			✓		✓			✓			✓	
Medical Staff Report			✓		✓				✓			✓
GOVERNANCE												
Board Self-Assessment & Action Plan												
ECHB Officer Elections (Bi-annual)										✓	✓	
Director, Committee Member, and/or Chair Appointments					✓							✓
Committee Charter Review												✓

Last Update: 03/13/2024

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: May 8, 2024
Subject: Update regarding Board committee responsibilities as relates to ECHMN, charter revisions, and governance policy

Recommendation(s):

To provide the El Camino Hospital Board of Directors ("Board") with a proposed timeline to address the questions that have arisen with respect to Board committee responsibilities as it relates to the El Camino Health Medical Network (ECHMN), charter revisions, and governance policy.

Summary:

For reference, attached is a chart showing the organizational structure for the Hospital and ECHMN. Within this organizational structure, certain information can be shared with the Board committees for purposes of ensuring enterprise standards of care and service and compliance with required reporting and shared services, as specified in the Operating and Administrative Services Agreements. Questions have arisen from various Board and committee members regarding what information should be shared within this structure, what responsibilities the Board committees currently have or should have, and what, if any, modifications should be made to Board committee charters to reflect the desired outcome.

In addition, a new El Camino Hospital Board Committee Governance Policy has been drafted and was approved by the Governance Committee. At the April 2024 Board of Directors meeting, the Board requested additional review of the proposed three-year term for committee members, and the possibility of staggering those terms. The administration would like to bring this policy and questions back to the Governance Committee along with edits to the Charters, for consideration at the June 2024 Governance Committee meeting.

Report:

The administration will conduct a review of each committee's current responsibilities and charter language as it pertains to ECHMN and will present recommendations at the next Governance Committee meeting in June 2024. Thereafter, recommendations and proposed charter revisions will be presented to each of the committees at their next available meeting that falls after the June 2024 Governance Committee meeting. Since no meetings are held in July, most of the committee reviews will be conducted in August 2024. After committee review, the final documents will be presented to the Board for approval at the next available Board meeting. For committees that meet in August, the next available Board meeting will be September 2024.

Attachment: Hospital and Medical Network Organizational Structure April 2024

Hospital and Medical Network Organizational Structure
April 2024

El Camino Healthcare District

ECHD Sole member of Hospital

El Camino Hospital MV & LG

Nonprofit 501(c)(3) Corp.

Doing business as (d/b/a) El Camino Health

El Camino Hospital Board of Directors

Hospital Board Advisory Committees:
- Compliance and Audit
- Executive Compensation
- Finance
- Governance
- Investment
- Quality, Patient Care, and Patient Experience

Operating Agreement
between Hospital and SVMD

Hospital Sole member of SVMD

Silicon Valley Medical Development, LLC
Limited Liability Corporation
H&S code 1206(g) clinics

d/b/a El Camino Health

d/b/a El Camino Health Medical Network

*Business of SVMD is responsibility of SVMD Board of Managers, except sole power reserved by Hospital:
- Approval of SVMD's Annual Budget
- Unbudgeted expenditures exceeding $1M; capital expenditures exceeding $5M
- Appointment to Board of Managers
- Selection of auditor to perform audits of SVMD
- Transfer, sale, merger, or disposition of assets
- Amendment of Operating Agreement

SVMD Board of Managers

SVMD Board Advisory Committees:
- Compliance
- Quality

*SVMD reports to Hospital Board:
- Semi-annually on performance to strategic metrics
- Quarterly to Hospital Quality Committee
- Quarterly to Hospital Compliance Committee

Members:
- Bob Rebitzer, Chair
- Mark Adams
- Holly Beeman, MD
- Carlos Bohorquez
- Shahab Dadjou
- Peter Fung, MD
- Shabnam Husain, MD
- George Ting, MD
- Dan Woods

Administrative Services Agreement

*Services provided by Hospital to SVMD:
- Procurement - equipment, inventory, and supplies
- Patient Experience Support
- Accounting, Payor, and Revenue Cycle Support
- IT support
- Facilities and leasing support
- Marketing and communications support
- Legal and Compliance support
- Transitional Executive staffing

Professional Services Agreement	Professional Services Agreement	Professional Services Agreement	Professional Services Agreement
San Jose Medical Group	USNC	El Camino Medical Associates	Vituity (Urgent Care)

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: May 8, 2024
Subject: Election of Officers

Recommendation: Adopt Resolution 2024-03 appointing officers of El Camino Hospital, including the Chairperson, Vice-Chairperson, Secretary/Treasurer, Chief Executive Officer, and Chief Financial Officer.

Election Process for Board Director Officers: All directors who are interested in running for Chairperson, Vice-Chairperson, or Secretary/Treasurer stated their interest to the Chief Executive Officer on or prior to May 1, 2023. Those individuals are listed below. Position Statements are not required. As agreed at the April 23, 2024, Board meeting, the process will be as follows, consistent with prior years and existing policy:

- The names of directors who have stated their interest to the CEO by May 1, 2024, and the position in which they are interested, are identified on the meeting agenda. The candidates are as follows: CHAIRPERSON: Bob Rebitzer; VICE-CHAIRPERSON: Jack Po; SECRETARY/TREASURER: Julia Miller and John Zoglin.

- Each candidate will provide a brief verbal statement (10 minutes) regarding their interest, and their priorities and goals if elected to the position.

- The Board will ask any questions of the candidates.

- If there is only one candidate for a position, the board shall consider a motion to elect that candidate.

- If there is more than one candidate for a position, the balloting process will be as stated in Section 7 of the attached Nomination and Selection Procedures dated 5/11/22.

List of Attachments:

1. Resolution 2024-03 appointing officers of El Camino Hospital
2. Nomination and Selection Procedures dated 5/11/22

DRAFT RESOLUTION 2024-03

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL APPOINTING OFFICERS OF EL CAMINO HOSPITAL

WHEREAS, Article VIII of the Amended and Restated Bylaws of El Camino Hospital ("Corporation") provides that the officers of the Corporation shall consist of the Chairperson, the Vice Chairperson, the Secretary and Treasurer, and such other persons who are specifically designated as officers by the Board;

WHEREAS, on May 8, 2024, the Board of Directors conducted elections for the offices of Chairperson, Vice Chairperson, and Secretary and Treasurer, for a two-year term commencing July 1, 2024;

WHEREAS, the Chief Executive Officer and Chief Financial Officer are employees of the Corporation and are appointed officers as long as they hold their positions;

NOW, THEREFORE, BE IT RESOLVED, that the following persons are appointed to the offices indicated next to their names to serve until their successor(s) shall be duly elected or appointed, unless the officer resigns, is removed from office, or is otherwise disqualified from serving as an officer of the corporation, to take their respective offices as of July 1, 2024, except in the case of the Chief Executive Officer and the Chief Financial Officer, who have and shall retain their offices throughout their employment with the Corporation:

Office	**Name**
Chief Executive Officer	Dan Woods
Chief Financial Officer	Carlos Bohorquez
Chairperson	
Vice-Chairperson	
Secretary and Treasurer	

RESOLVED FURTHER, that the officers of the corporation are, and each acting alone is, hereby authorized to do and perform any and all such acts within their authority, including execution of any and all documents and certificates, as such officers shall deem necessary and advisable, to carry out the purposes and intent of the foregoing resolutions.

RESOLVED FURTHER, that any actions taken by such officers prior to the date of the foregoing resolutions adopted hereby are within their authority conferred thereby and are hereby ratified, confirmed, and approved as the acts and deeds of the corporation.

DULY PASSED AND ADOPTED at a Regular Meeting held on the 8th day of May 2024 by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

By: _____
Julia E. Miller Secretary/Treasurer
El Camino Hospital Board of Directors

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT | MAY 8, 2024

GROWTH: **Two new surgery centers** have been added to our care network. Here are some additional service line specific highlights;

- **Women's**: Recognized by Santa Clara County Department of Public Health for collaboration in advancing perinatal equity. Received $50,000 Foundation donor gift to initiate a mental health support program.
- **Neurosciences**: The Peter C. Fung MD stroke center continues to deliver cutting-edge treatments to patients as evident using Woven EndoBridge to embolize an aneurysm.
- **Orthopedics & Spine**: Passed the 3,000-case milestone for patient-reported outcomes for total joint replacement surgery as we continuously improve our treatments and contribute to advancing the science.

MEDICAL STAFF: El Camino Health's cutting-edge **electrophysiology (EP) program** was recently highlighted in the April issue of *EP Lab Digest*.

NURSING: **National Nurses Week** is May 6th-12th. Please use the card at your seat to **scan the QR code** and view the **nursing annual report**, which we produce each year for Nurses Week. Our nursing leaders shared the results of a landmark study, **Magnet4Europe**, in Belgium to highlight the importance of improving providers' mental health, wellbeing and working environment.

FOUNDATION: The Foundation has **raised over $8.0M**, which is 81% of the FY24 fundraising goal. The Foundation hosted an open house on April 27th to celebrate ASPIRE's new clinic in Los Gatos, showcasing our program and staff. El Camino Health Foundation also began an **8-month engagement with an outside consulting agency** to perform a comprehensive review of best practices, market benchmarking, and potential for a large-scale capital campaign.

HUMAN RESOURCES: El Camino Health **Intern Program** hosted two high school students from Mountain View Los Altos High School District's AVID Program, providing learning opportunities for potential career paths. The Talent Development team participated in Mountain View Los Altos High School District's **AVID Program's 6th Annual Mock Career Fair**. SEIU Negotiations began on April 29.

INFORMATION SERVICES: El Camino Health is the **first hospital in Northern California** to implement **WoundVision**, a thermal imaging technology to identify and reduce hospital acquired pressure injuries. **Virtual visits** continue to improve patient access and satisfaction. To ensure resiliency during a cyber event, the Disaster Recovery Team completed a **Disaster Recovery Rehearsal** to safeguard patient data.

CORPORATE HEALTH: In recognition of **May – Mental Awareness Month**, Concern provided a comprehensive awareness campaign to our 250 employer groups to promote our services. The **Chinese Health Initiative (CHI)** organized a series of community events to promote culturally competent **end-of-life care, parenting, nutrition, and CHI services**. The South Asian Heart Center engaged 434 new and prior participants and completed 811 consultations.

AUXILIARY: The Auxiliary donated **3,829 volunteer hours for the month of March**. This brings our combined hours for FY24 to 34,562.

A06b. STEEEP FY24Q3 for Board vFinal

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	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	**1.158**
	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	**0.784**
	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	**0.202**
	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	**0.077**
	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	**0.095**
	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	0.551	**0.484**
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%	**84.8%**
	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%	**78.4%**
Effective	Risk Adjusted Readmissions Index		1.05	1.18	1.05	1.09	1.09	**1.00**	1.14	1.12	1.12* (Jan-Feb 24)	**1.13* (July-Feb 24)**
	Risk Adjusted Mortality Index		1.03	1.14	1.19	1.14	1.13	**1.00**	1.00	1.14	1.09	**1.08**
	Risk Adjusted Sepsis Mortality Index		1.02	1.37	1.26	1.15	1.20	**1.00**	1.07	1.33	1.17	**1.21**
	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	27.0%	**23.9%**	26.4%	22.7%	28.3%	**25.1%**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	1.19	1.24	**1.20**
	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**
Equitable	Homeless Discharge Clothing Documentation Compliance		----	----	----	----	----	**100.0%**	50.5% (176/348)	64.9% (257/396)	73.1% (242/331)	**62.8% (675/1075)**
	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)	**51.7% (15/29)**
	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	73.7% (28/38)	84.9% (28/33)	82.6%* (19/23) (Jan-Feb 24)	**79.8%* (75/94) (July-Feb)**
	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	72.2% (13/18)	78.3% (18/23)	100.0%* (3/3) (Jan-Feb 24)	**77.3%* (34/44) (July-Feb)**
	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	84.6% (88/104)	84.7% (72/85)	87.8%* (43/49) (Jan-Feb 24)	**85.3%* (203/238) (July-Feb)**
	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	66.6% (10/15)	72.7% (8/11)	33.3%* (2/6) (Jan-Feb 24)	**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	**81.4**
	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	74.5	74.3	**75.5**
	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	83.7	83.2	**82.2**

Updated: 04/22/24

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'

A13a. DRAFT 2024-04-23 ECHB Minutes (Open)

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Tuesday, April 23, 2024

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

Board Members Present
Jack Po, MD, Ph.D., Vice-Chair
Julia E. Miller, Secretary/Treasurer
Lanhee Chen, JD, PhD *(at 5:06 pm)*
Wayne Doiguchi
Peter Fung, MD *(at 5:25 pm)*
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
John Zoglin

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Theresa Fuentes, CLO
Omar Chughtai, CGO
Shreyas Mallur, MD, ACMO
Deb Muro, CIO
Andreu Reall, VP of Strategy
Ryan Kim, Chief of Staff

Others Present (cont.)
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology
Bob Miller, Chair, Executive Compensation Committee
Brooks Nelson, Chair, Investment Committee
Heidi O'Brien, Mercer

Board Members Absent
Bob Rebitzer, Chair

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 4:31 p.m. by Vice Chair Jack Po. Vice Chair Po reviewed the logistics for the meeting. Directors Doiguchi, Miller, Po, Somersille, Ting, Watters, and Zoglin were present constituting a quorum. Director Peter Fung joined the meeting at 5:25 p.m. Director Lanhee Chen joined the meeting at 5:06 p.m..	**The meeting was called to order at *4:31 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 commented during the allotted time.	

5. CONSENT CALENDAR	The consent calendar was presented to the Board for approval and a request was made by Director Zoglin to remove item (d) for discussion. **Motion:** To approve the consent calendar items minus item d) "*Approve new ECHB Committee Governance Policy as reviewed and recommended for approval by the Governance Committee"* **Movant:** Miller **Second:** Watters **Ayes**: Doiguchi, Miller, Po, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Rebitzer **Recused**: None With respect to item (d), Director Zoglin inquired about the term limits for the ECHB Committee Governance policy. Director Zoglin suggested staggering terms to maintain continuity and ease recruitment efforts. Vice Chair Po and Director Miller agreed with Director Zoglin's points regarding staggering terms and asked for staff to come back with an updated version at the next meeting.	***Consent calendar items a, b, c, and e were approved. Items f, g, and h were received. Item d was tabled for discussion at the next Board meeting.*** ***ECHB Committee Governance Policy to come back to the next meeting.***
6. BOARD OFFICER ELECTIONS PROCEDURE	Vice Chair Po provided an overview of the Board Officer Elections procedure. Director Zoglin inquired whether the practice of informing the board about interested candidates for Board Officer positions is still followed. Upon further discussion, the Board agreed to move the deadline for declaration of interest in serving as a Board Officer to May 1st.	***Staff to send an email to the Board letting them know who has expressed interest in serving as an officer.***
7. CEO REPORT	Mr. Woods provided a CEO report including recognition for Cheryl Reinking, CNO, who was representing El Camino Health at the Magnet4Europe conference. Mr. Woods thanked the Board for their attendance at the 57th Employee Service Awards. Mr. Woods also introduced Ryan Kim, Chief of Staff.	
8. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at **4:47 pm**. **Movant**: Ting **Second**: Doiguchi	***Recessed to closed session at 4:47 p.m.***

	Ayes: Doiguchi, Miller, Po, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Rebitzer **Recused**: None	
9. AGENDA ITEM 12: CLOSED SESSION REPORT OUT	The open session was reconvened at **8:03 p.m.** by Vice Chair Po. Agenda Items 8-11 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 Doiguchi, Miller, Po, Somersille, Ting, Watters, Zoglin).	***Reconvened Open Session at 8:03 p.m.***
10. AGENDA ITEM 13: BOARD ANNOUNCEMENTS	There were no announcements from the Board.	
11. AGENDA ITEM 14: ADJOURNMENT	**Motion:** To adjourn at 8:04 pm **Movant:** Miller **Second:** Watters **Ayes**: Doiguchi, Fung, Miller, Po, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Rebitzer **Recused**: None	***Meeting adjourned at 8:04 p.m.***

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

_____

Julia Miller, Secretary/Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: 04/30/2024 – Tracy Fowler, Director, Governance Services
Reviewed by Legal: 04/30/2024 – Theresa Fuentes, Chief Legal Officer

A13b. DRAFT 2024-04-23 ECHB Minutes (Closed)

El Camino Health

CONFIDENTIAL

Minutes of the Closed Session of the
El Camino Hospital Board of Directors
Tuesday, April 23, 2024

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

Board Members Present
Jack Po, MD, Ph.D., Vice-Chair
Julia E. Miller, Secretary/Treasurer
Lanhee Chen, JD, PhD *(at 5:06 pm)*
Wayne Doiguchi
Peter Fung, MD *(at 5:25 pm)*
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
John Zoglin

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Theresa Fuentes, CLO
Omar Chughtai, CGO
Shreyas Mallur, MD, ACMO
Deb Muro, CIO
Andreu Reall, VP of Strategy
Ryan Kim, Chief of Staff

Others Present (cont.)
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology
Bob Miller, Chair, Executive Compensation Committee
Brooks Nelson, Chair, Investment Committee
Heidi O'Brien, Mercer

Board Members Absent
Bob Rebitzer, Chair

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER	Vice Chair Po called the closed-session meeting of the El Camino Hospital Board of Directors to order at 4:47 p.m. A quorum was present. Director Chen arrived at 5:06 pm. Director Fung arrived at 5:25 pm.	***Called to order at 4:47 pm.***
2. AGENDA ITEM 9: APPROVE CREDENTIALING AND PRIVILEGING REPORT	Dr. Mallur gave an overview of the Credentialing and Privileging report. Dr. Mallur responded to numerous questions from the Board regarding resignations listed in the report, core privileges, and the structure of the Credentialing Committee. **Motion:** To approve the Credentialing and Privileging report **Movant:** Ting **Second:** Watters **Ayes**: Doiguchi, Miller, Po, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Fung, Rebitzer **Recused**: None	***Credentialing and Privileging report was approved.***
3. AGENDA ITEM 10: BOARD STRATEGY SESSION	Vice Chair Po opened the strategy discussion out of the original agenda order. The discussion opened with a marketplace overview of competitors and their current stances in the market. Mr. Woods shared a high-level overview of the challenges that El Camino Health faces with the evolving market.	

	The Board discussed the challenges presented and expressed a continued emphasis on supportive environments for physicians and maintaining a high standard of quality patient care.	
4. AGENDA ITEM 10A: FINE TUNING OUR STRATEGY	Director Watters shared a presentation on El Camino Health Medical Network ("ECHMN") and the financial impact that ECHMN has on the Hospital system. Director Watters provided his account of the value of the medical network and how his position has evolved through a thorough analysis of the data. He provided specific metrics and figures to display the benefits of the partnership. Director Chen shared a presentation that highlighted significant changes in the healthcare landscape over the past 15 years, driven by policy and regulatory shifts. Director Chen discussed the ongoing challenges in healthcare economics, consolidation pressures, competition for healthcare dollars, and the influence of populist policies on future regulatory directions. Vice Chair Po presented the evolution of machine learning technology over the past decade and its impact on various industries, including healthcare. He shared an overview of possible applications of machine learning in healthcare while providing reasoning for the need for robust data governance infrastructure and integration for the successful implementation of AI in healthcare systems.	***Staff to pace the ECHMN value report with a similar methodology each year***
5. AGENDA ITEM 10B: 2027 PERFORMANCE MILESTONES	Mr. Woods presented the current organization status against the FY27 Performance Milestones. He noted that the nature of the goal setting is intended to be dynamic and adjustable due to market trends and various shifting market dynamics. The Board discussed physician alignment, resource expansion, high-performing organization metrics, and accountability for goal setting. The Board reviewed the current FY27 strategic milestones and offered input in the perceived order of importance for the milestones, based on the shared data and explained marketplace shifts.	***Staff to review and revise the strategic plan for FY 25 goals based on market dynamics and external factors discussed in the meeting***
6. AGENDA ITEM 10C: BEST PRACTICES FOR SETTING AND EVALUATING ENTERPRISE GOALS	The Board discussed the need to focus on ensuring that goals are clearly defined and prioritized based on their strategic importance. Ms. O'Brien and Mr. Miller emphasized the need to differentiate between critical goals and less important ones to avoid spreading efforts too thin. Mr. Miller emphasized	

	that management should be able to set goals that maintain current high performance, not set aspirational goals, and be held accountable for these high-performance deriving goals for FY25 and beyond.	
7. AGENDA ITEM 11: RECONVENE TO OPEN SESSION	**Motion:** To reconvene to open session at 8:03 pm. **Movant:** Watters **Second:** Miller **Ayes**: Doiguchi, Fung, Miller, Po, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Rebitzer **Recused**: None	***Reconvened to Open Session at 8:03 pm***

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

_____
Julia Miller, Secretary/ Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: 04/30/2024 – Tracy Fowler, Director, Governance Services
Reviewed by Legal: 04/30/2024 – Theresa Fuentes, Chief Legal Officer

A13c1. Scope of Service - El Camino Health Foundation-History-Changes

Status **Pending** PolicyStat ID **15374574**

Origination	10/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	3 years after approval
Owner	Andrew Cope: President Foundation
Area	Scopes of Service
Document Types	Scope of Service/ADT

Scope of Service - El Camino Health Foundation

PURPOSE

The El Camino ~~Hospital~~Health Foundation (ECHF) is the philanthropic arm of El Camino ~~Hospital Governed~~Health (ECH) governed by a 13-member ~~Foundation~~ECHF Board of Directors, the ~~Foundation~~ECHF Board also includes two liaison representatives from the Hospital Board and Auxiliary who both serve as ex-officio, non-voting members. The ECHF Board meets six times per year and is supported by ~~five~~three working ~~Foundation~~ECHF committees and three special event committees. Its mission is to advance the health of our community through philanthropy and foster innovation while supporting patient and family centered care. Funds raised are used specifically to benefit approved funding priorities of ~~El Camino Hospital~~ECH.

Scope and Complexity of Services Offered

~~The ECH Foundation~~ECHF is a full-service fundraising department that focuses on identifying, cultivating, asking and stewarding charitable gifts. ~~The Foundation~~ECHF accepts donations from individuals, corporations, small businesses and foundations. Primary solicitation programs include:

- Employee giving campaign
- ~~Board-based e~~E-message and direct mail appeals
- Three signature annual fundraising events including a golf tournament, ~~one gala~~a spring event, and a women's luncheon
- Grants and sponsorships
- Major gifts program securing gifts of $10,000 and above
- Planned giving program with focus on Legacy Society membership

Funds received are either restricted or unrestricted. ~~The Foundation~~ECHF manages ~~97 restricted~~11 endowed funds, ~~23~~108 restricted funds and 63 board-designated ~~funds and 10 endowment~~ funds. Unrestricted funds requested for use are pre-approved by ECH leadership and are allocated through the ~~Foundation's~~ECHF Allocations Committee process for amounts under $50, ~~with~~000 and final approval agreed upon by the ~~Foundation~~ECHF Board of Directors ~~and ECH leadership~~for amounts of $50,000 plus. Once approved a new board-designated fund is created to manage payouts.

Staffing

The ~~Foundation~~ECHF leadership team includes a President, Associate Vice President, Director of Foundation Operations, Special Events Manager, Donor Relations Manager, Annual Giving Officer and ~~Senior Philanthropy Officer~~Administrative Supervisor. Additional ECHF staff include ~~56~~ FTE: ~~(2) database administrators,~~ (1) ~~coordinator for annual giving,~~Program Manager for Prospect Research (1) ~~events administrative assistant and~~Program Manager for Data Health and Analytics, (1) ~~executive assistant~~Program Manager for Gift Accounting, (1) Program Manager for Annual Giving, (1) Events Administrative Assistant and (1) Foundation Administrative Assistant. ~~As well~~Additionally, a cadre of volunteers ~~is~~are frequently used for special event execution and mailing projects.

Level of Service Provided

The ~~Foundation~~ECHF provides services under ~~hospital~~ECH and divisional policy and procedure guidelines.

Standard of Practice

Where applicable, ~~The Foundation~~ECHF is governed by state and federal guidelines, codes of ethics used in philanthropy, and Joint Commission on Accreditation of Healthcare Organizations requirements.

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]	04/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	04/2024

President of Foundation	Andrew Cope: President Foundation	03/2024
	Andrew Cope: President Foundation	03/2024

History

Sent for re-approval by Cope, Andrew: President Foundation on 3/5/2024, 1:13PM EST

Last Approved by Cope, Andrew: President Foundation on 3/26/2024, 5:58PM EDT

> No changes since establishment.

Last Approved by Cope, Andrew: President Foundation on 3/26/2024, 5:59PM EDT

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 4/9/2024, 12:52PM EDT

> Updated using word version provided by Andrew Cope.

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 4/15/2024, 2:30PM EDT

> ePolicy recommendation to update title

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 4/15/2024, 2:31PM EDT

> ePolicy 4/12/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 4/26/2024, 10:47AM EDT

> MEC 4/25/24

A13c2. HR - Aerosol Transmissible Disease -ATD- Exposure Control Plan-History-Changes

Status **Pending** PolicyStat ID **15269799**

Origination	06/2011
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2024
Next Review	3 years after approval

Owner	Michael Rea: Mgr Emp Wellness & Health Svcs
Area	Employee Wellness & Health
Document Types	Plan

HR – Aerosol Transmissible Disease (ATD) Exposure Control Plan

COVERAGE:

This plan applies to all job classifications including employees, physicians, volunteers and contractors in inpatient and outpatient services where an occupational exposure to an aerosol transmissible disease could occur.

PURPOSE:

El Camino Hospital has implemented an Aerosol Transmissible Disease (ATD) Exposure Control Plan to minimize the risk of transmission of ATDs to healthcare workers. This plan shall comply with the California Occupational Safety & Health Administration (Cal/OSHA) ATD Standard CCR Tittle 8 Sec 5199.

STATEMENT:

It is the policy of El Camino Hospital to provide its employees with a safe work environment. The purpose of this plan is to minimize employee exposure to infectious and hazardous agents in the workplace through the proper use of respirators during an influenza pandemic or other infectious respiratory disease scenario in which respiratory protection is required.

DEFINITIONS:

- **Aerosol Transmissible Disease (ATD)** – A disease that can be transmitted by either 1) inhaling particles/droplets; or 2) direct contact between particles/droplets and mucous membranes in the respiratory tract or eyes.

- **Airborne Isolation** – Infection control procedures designed to reduce the risk of transmission of airborne infectious pathogens and apply to patients known or suspected to be infected with pathogens that can be transmitted by the airborne route.
- **Droplet Precautions** – Infection control procedures designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.
- **Exposure Incident** – An event in which an employee has been exposed to an individual who is a case or suspected case of a reportable ATD, the exposure occurred without the benefit of applicable exposure controls required by this plan, and it reasonably appears from the circumstances of the exposure the transmission of disease is sufficiently likely to require medical evaluation.
- **Healthcare Worker (HCW)** – A person that has the potential for exposure to infectious diseases through shared air space or contact with persons with infectious disease while doing paid or unpaid work in healthcare settings. Refer to attachment "Job Classifications with Reasonably Anticipated Risk of Exposure".
- **High Hazard Procedures** – Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing a laboratory aerosol transmissible pathogen (ATP-L) in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens.
- **Latent TB Infection (LTBI)** – Infection with *M. tuberculosis* in which bacteria are present in the body, but are inactive. Persons who have LTBI but who do not have TB disease are asymptomatic, do not feel sick and cannot spread TB to other persons. They typically react positive to TB tests.
- **M. Tuberculosis** – *Mycobacterium tuberculosis* – The scientific name of the bacterium that causes tuberculosis.
- **Occupational Exposure** – Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATDs, ATP or ATP-Ls if protective measures are not in place.
- **Respirator** – A device which has met the requirements of 42 CFR Part 84, has been designed to protect the wearer from inhalation of harmful atmospheres, and has been approved by NIOSH for the purpose for which it is used.
- **Surge Control Measures** – The use of procedures, engineering controls and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an ATD, such as persistent cough.
- **Surge** – A rapid expansion beyond normal services to meet the increased demand for qualified personnel, medical care, equipment and public health services in the event of an epidemic.
- **COVID-19** – A respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019. The virus spreads mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes or talks. Some people who are infected may not have symptoms.

REFERENCES:

- ~~Cal/OSHA California Code of Regulations, Title 8 Section 5199. *Aerosol Transmissible Disease.* http://www.dir.ca.gov/Title8/5199.html~~
- ~~Centers for Disease Control and Prevention (2009). *Interim guidance on infection control measures for 2009 H1N1 influenza in healthcare settings, including protection of healthcare personnel*. Retrieved January 15, 2010 from: http://www.cdc.gov/h1n1flu/~~
- ~~NIOSH Respiratory Protection Program (http://www.cdc.gov/niosh/topics/respirators/)~~
- ~~*Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employers*, OSHA 3328-05, 2007~~
- ~~*Reusability of Facemasks during an Influenza Pandemic: Facing the Flu*, National Academy of Science, 2006.~~
- ~~US Department of Health and Human Services, 1999, OSHA Technical Manual: Respiratory.~~

  ~~Protection 29 CFR 1910.134 http://www.osha.gov/SLTC/etools/respiratory/oshafiles/otherdocs.html)~~
- ~~Centers for Disease Control and Prevention (2021) Coronavirus Disease 2019 (COVID-19) https://www.cdc.gov/dotw/covid-19/~~

- State of California Department of Industrial Relations Cal/OSHA. California Code of Regulations, Title 8 Section 5199. *Aerosol Transmissible Disease*. Available at: http://www.dir.ca.gov/Title8/5199.html. Accessed April 11, 2024.
- Centers for Disease Control and Prevention. *CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings.* Available at: https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Accessed April 11, 2024.
- Centers for Disease Control and Prevention The National Institute for Occupational Safety and Health (NIOSH). *Respirators*. Available at: https://www.cdc.gov/niosh/topics/respirators/. Accessed April 11, 2024.
- US Department of Labor Occupational Safety and Health Administration. Respiratory Protection. 29 CFR § 1910.134. Available at: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134. Accessed April 11, 2024.

PROCEDURE:

El Camino Hospital must provide all required safeguards, including personal protective equipment, respirators, training and medical services, at no cost to the employee, at a reasonable time and place for the employee, and during employee's working hours.

A. **Program Administration**
   The Employee Wellness and Health Services Manager and the Hospital Safety Officer are responsible for the administration of the ATD Exposure Control Plan. (See Central Safety Committee Membership for the names).

Title	Telephone
Employee Wellness & Health Services Manager	650-940-7021
Hospital Safety Officer	650-988-7569

Title	Telephone
Employee Wellness & Health Services Manager	650-940-7021
Hospital Safety Officer	650-988-7569

These individuals have the authority to act on any and all matters relating to the operation and administration of the ATD Exposure Control Plan. All employees, operating departments, and service departments will cooperate to the fullest extent. The Employee Wellness and Health Services Manager is referred to as the Respiratory Protection Program Administrator. They will also be responsible for monitoring the ongoing and changing needs for respiratory protection.

B. **Risk Assessment**

A yearly risk assessment shall be performed by the Central Safety Committee. The risk assessment consists of the identification of developing ATD threats or new technologies or measures effective for control of ATD. The yearly risk assessment consists of the following steps:

1. Review the local, community profile of ATD diseases including the epidemiologic surveillance data in collaboration with the Santa Clara Health Department and the California State Department of Public Health. At times, this geographic range may be extended to state, national and international data sources.
2. Review the availability of vaccinations to ATD as it may apply to HCW categories.
3. Review HCW job categories included in the Respiratory Protection Program.
4. Review HCW job categories included in the TB Surveillance Program and frequency of testing.
5. Review the episodes of occupational exposure to ATDs
    a. Identify hospital areas with an increased risk for occupational exposure (if any)
    b. Review job categories of HCW involved with occupational exposures
    c. Review aerosol transmissible pathogens (ATP) involved with occupational exposure
6. Determine the types of environmental controls needed other than airborne infection isolation rooms such as work practice and/or PPE.

C. **Roles & Responsibilities:**

1. **Respiratory Protection Program Administrator (RPPA)**
   The Respiratory Protection Program Administrator is responsible for administering the ATD respiratory protection program. Duties of the RPPA include:

a. Identify work areas, processes, or tasks that require respiratory protection. For this model plan, this means identifying patient care areas and other circumstances likely to present an Airborne Transmissible Disease (ATD) infection risk.

b. Monitor Cal/OSHA policy and standards for changes and make changes to ECH ATD Exposure Control Plan.

c. In collaboration with the Safety Officer Select respiratory protection products.

d. Monitor respirator use to ensure that respirators are used in accordance with their certification.

e. Conduct post-offer TB screening according to current guidelines, as well as assurance of other ATD vaccines or titers (MMR, Varicella, Tdap, influenza) for ECH employees.

f. Conduct annual occupational TB Surveillance Program.

g. Distribute and ensure completion of the medical clearance respiratory questionnaire.

h. Arrange for and/or conduct training and fit testing.

i. Annually review the implementation of the plan in collaboration with the Safety Officer.

j. Provide immunizations and post exposure medications to employees as required by this plan.

k. Provide medical clearance for fit testing.

2. **Managers**

a. Each department manager is responsible for incorporating the relevant aspects of the ATD Exposure Control Plan into department/unit policies/ procedures, and shall have the responsibility for ensuring implementation of the ATD Exposure Control Plan including the enforcement of employee work practice controls and respiratory protection procedures.

b. Be familiar with the hazards in the area in which they work.

c. Be familiar with the types of respirators used in their areas.

d. Ensure employees receive training and medical evaluations.

e. Assist with enforcing annual retraining and/or fit testing.

f. Notifying the RPPA with problems with respirator use, or changes in work processes that would impact airborne contaminant levels.

g. Ensure proper storage and maintenance of all respirators.

h. Assist with staff post exposure follow up processes.

i. Monitor compliance of employees with post exposure follow up and annual surveillance screening: document non-compliance, re-educate and apply progressive discipline to non-compliant employees.

3. **Staff**
   It is the responsibility of all staff to have an awareness of respiratory protection requirements for their work areas (see attachment *Job Classifications with Reasonably Anticipated Risk of Exposure*). Employees are also responsible for wearing the appropriate respiratory protective equipment according to proper instructions and for maintaining the equipment in a clean and operable condition. Employees should:
   a. Participate in all training.
   b. Maintain equipment.
   c. Report malfunctions or concerns.
   d. Notify EWHS of any changes in facial structure (i.e. weight loss or gain, facial hair, etc.) if required to use N95 respirators.
   e. Ensure compliance with respiratory protection by visitors.
   f. Have the opportunity to review and comment on the ATD Exposure Plan annually. Staff may communicate opinions via written documentation to EWHS or Safety Officer.

4. **Infection Prevention Registered Nurse**
   a. Initiate ATD post-exposure process and consulting with clinical area managers in generating a list of employees with potential exposures. The tracking tool will be sent by the managers to EWHS.
   b. Communicate with the Santa Clara TB Control when appropriate.
   c. Provide consultation in all aspects of this plan.

5. **Central Services**
   a. Ensure that there is an adequate supply of personal protective equipment and other equipment necessary to minimize employee exposure in normal operations and foreseeable emergencies.
   b. Ensure proper storage and maintenance of respiratory protection equipment.

D. **Identifying Work Hazards**

1. **High Hazard Procedures**
   a. High hazard procedures are procedures performed on a person who is a case or suspected case of an aerosol transmissible disease in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. According to the CDC, such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of high risk medications, and pulmonary function testing. High hazard procedures also include, but are not limited to; autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens (see attachment Aerosol-Generating Procedures).

b. High hazard procedures shall be conducted in airborne infection isolation rooms. Persons not performing the procedures shall be excluded from the area, unless they use the respiratory and personal protective equipment required for employees performing these procedures.

c. The hospital shall provide a powered air purifying respirator (PAPR) with a high efficiency particulate air (HEPA) filter(s), or a respirator providing equivalent or greater protection (than N95). PAPR use is **required** for employees who perform high hazard procedures on airborne infectious disease confirmed or suspected cases, unless ECH determines that this use would interfere with the successful performance of the required task or tasks such as emergency intubation.

E. **Work Practice Controls**

1. **Visual Alerts**

a. Visual alerts will be posted at the entrance to inpatient and outpatient facilities instructing patients and visitors to inform healthcare personnel of symptoms of a respiratory illness when they first register for care. (See attachment Respiratory Etiquette).

b. Inform individuals entering the facility of the source control practices implemented by El Camino Hospital.

2. **Respiratory Etiquette**

a. EWHS and Infection Prevention shall implement written source control procedures. (See attachment Respiratory Etiquette).

b. The procedures shall include methods to manage exposure incidences from airborne transmissible disease (ATD), precautionary removal period of contagious employee, and routine infection control and isolation practices for typical work situations.

c. During an outbreak of a new virus type or pandemic flu, infection control guidance may change as the situation unfolds based on available epidemiological data. In these situations, it will be the responsibility of the RPPA to keep current with CDC and OSHA recommendation.

d. In the case of an outbreak the program will be adjusted and employees will be kept informed as changes occur.

3. **Initiating Airborne Precautions**

a. Confirmed or suspected ATD patients must be promptly identified, masked and transferred to an appropriate AIIR.

b. Patients will only leave the room when medically necessary.

c. Patients with confirmed or suspected communicable ATD must wear a surgical mask over the nose & mouth during transport.

d. Please refer to Infection Prevention Standard Precautions, Droplet Precautions and Airborne Precautions Procedures.

4. **Engineering Controls**
    a. El Camino Hospital shall use feasible engineering and work practice controls to minimize employee exposures to airborne transmissible pathogens (ATPs).
    b. Where engineering and work practice controls do not provide sufficient protection (e.g., when an employee enters an airborne infection isolation room or area) ECH shall provide, and ensure that employees uses personal protective equipment, and shall provide respiratory protection in accordance with Cal/OSHA subsection (g) 5199 to control exposures to airborne infectious pathogen (AirIPs).
    c. During an alert period, priority for respirator use should be given to healthcare personnel performing aerosol-generating procedures (see attachment Aerosol-Generating Procedures).
    d. When feasible, it is preferred that staff who have not been immunized against the specific agent be given priority for respirators over immunized staff when conducting aerosolizing procedures on patients who are known to be infected with the agent involved in the infectious disease alert period and during times of limited supply (CDC, 2009).
5. **Vaccinations**
    a. El Camino Hospital shall make available to all health care workers with occupational exposure all vaccinations recommended by Cal/OSHA subsection(h) 5199 and/or the California Department of Public Health (CDPH) Immunization Branch
    b. These vaccinations shall be provided by EWHS at a reasonable time and place for the employee.
    c. ~~EWHS will notify department managers regarding employees who have not completed the recommended vaccination series and are not considered immune.~~
    d. In the event El Camino Hospital cannot implement these procedures because of the lack of availability of vaccine, EWHS shall document efforts made to obtain the vaccine in a timely manner and inform employees of the status of the vaccine availability, including when the vaccine is likely to become available. ECH shall check on the availability of the vaccine at least every 60-calendar days and inform employees when the vaccine becomes available (Cal/OSHA 5199).

e.

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	Two doses
Tetanus, Diphtheria & Acellular Pertussis (Tdap)	One dose annually
Varicella-Zoster	Two doses
COVID-19	Two doses and booster

6. **Respirator PPE Selection**
    a. The respirators selected will be used for respiratory protection from potentially airborne infectious diseases; they do not provide protection from chemical exposure.
    b. When working around hazardous chemicals, fumes, mists or dusts, see the El Camino Hospital Chemical Exposure Respiratory Protection Program.
    c. Through normal working situations employees may be asked to have contact with patients who could be infected with a potentially airborne infectious agent such as Tuberculosis (see attachment Aerosol Transmissible Diseases-Pathogens).
    d. Only respirators approved by the National Institute for Occupational Safety and Health (NIOSH) will be selected and used.
    e. Respirators approved for use at this facility:
        i. El Camino Hospital has adopted the use of Powered Air Purifying Respirators (PAPRs) for most areas of the hospital. For those areas where respiratory protection is needed and where PAPRs are not acceptable due to the need to preserve a sterile field the use of an N95 respirator is required.
        ii. Half Mask "Elastomer" face piece air-purifying respirator is available for patient contact/care.
        iii. In times of a shortage of PAPRs, priority for PAPR use shall be given to healthcare personnel performing aerosol-generating procedures (see Attachment Aerosol-Generating Procedures).

Respiratory Protection Equipment
Respirators: A device which has met the requirements of 42 CFR Part 8, has been designed to protect the wearer for inhalation of harmful atmospheres and has been approved by NIOSH for the purpose for which it is used..

PAPR (Powered Air Purifying Respirator): A respirator that provides cleaned air to the inside of a light-weight hood, purifying the air by means of a battery powered blower which pulls the air through a filter cartridge. PAPRs are the first choice of respirator at ECH and as required by OSHA for certain high risk procedures.	 
N95 Respirators: "N95" refers to respirators designed for non-oil based respiratory hazards which have an efficiency of at least 95% (stopping 95% of particles). N95 respirators are required in certain departments/ job classifications where PAPRs are not allowed to preserve the sterile field.	
Half Mask "Elastomer" Air Purifying Respirator: These re-usable respirators are sometimes called "half-face" or "half-mask" respirators since they cover just the nose and	

mouth. They have removable cartridges that filter out dust, chemicals and other aerosolized contaminants.	

7. **Personal Protective Equipment Respiratory Protection:**

   a. **Training**

   EWHS will evaluate which PPE is appropriate for personnel based on the job description. Hands on PAPR training is provided and documented as part of the post offer EWHS visit followed by annual HealthStream Module refresher training. These are treated as competencies with records being maintained in HealthStream. When an N95 is needed, as part of the post offer EWHS visit and annually thereafter, EWHS will perform a Qualitative Fit test to determine which brand/ size N-95 respirator will best protect the employee. EWHS will maintain all N-95 training and fit testing records for compliance purposes.
   (See attachment Fit Testing Training Guide & N95 Fit Test Procedures)
   Training will include, but is not limited, to the following topics:

   I. Identifying hazards, potential exposure to these hazards, and health effects of hazards.
   II. PAPR: Equipment, inspection, donning, removal, trouble shooting and cleaning & storage procedures.
   III. N95 Respirator: fit, improper fit, usage, limitations, and capabilities for maintenance, usage, cleaning, and storage. Inspecting, donning, removal, and trouble shooting.
   IV. Explaining respirator program (policies, procedures, Cal/OSHA standard, resources).

   b. **Medical Clearance**

   I. EWHS will determine individual medical clearance by a medical questionnaire and/or medical evaluation.
   II. A mandatory medical evaluation questionnaire (specified in Section 5144(c) OSHA) is used by the OHN/ OHNP in EWHS.
   III. The medical questionnaire is filed in the employee's employee health record.
   IV. If the OHN/OHNP deems it necessary, the employee will receive medical evaluation. The purpose of the medical evaluation is to determine if the employee is physically and psychologically able to perform the assigned work while wearing the respiratory protective equipment.
   V. Employees who are required to wear respirators must be medically cleared before being permitted to wear a respirator on

the job.

VI. Employees are not permitted to wear respirators until receiving medical clearance

VII. All examinations and questionnaires are to remain confidential between the employee and Employee Wellness & Health Services.

VIII. The medical evaluation procedures are as follows:

- The medical evaluation will be conducted using the questionnaire provided. EWHS will provide a copy of this questionnaire to all employees requiring medical clearance.
- All covered employees will complete the medical questionnaire
- Employees will be permitted to fill out the questionnaire on company time.
- Employees will be provided with an opportunity to discuss the questionnaire with an EWHS OHN/OHNP.
- Follow-up medical exams will be granted to employees as required by this program, and/or as deemed necessary by the medical practitioner.
- Re-evaluation will be conducted under these circumstances:
  - Employee reports physical symptoms that are related to the ability to use a respirator, (e.g., wheezing, shortness of breath, chest pain, etc.)
  - It is identified that an employee is having a medical problem during respirator use.
  - The healthcare professional performing the evaluation determines an employee needs to be reevaluated.
  - A change occurs in the workplace conditions that may result in an increased physiological burden on the employee

c. **Fit Testing**

Fit Testing is only needed when N95 or half-face respirator use is required.

i. After the initial fit test, fit tests must be completed at least annually or more frequently if there is a change in status of the wearer or if the employer changes model or type of respiratory protection.

ii. The fit testing procedure appears in attachment Fit Testing

Training Guide & N95 Fit Test Procedures. Fit tests are conducted to determine that the respirator fits the user adequately and that a good seal can be obtained. Respirators that do not seal do not offer adequate protection.
Fit tests will be conducted:

- Prior to being allowed to wear any respirator.
- If the facility changes respirator product.
- Employees need to be re-fit tested if there is a 10 pound (or greater) change in weight, a change of facial beard or goatee, recent facial reconstructive surgery, or change in dentures.
- If the employee reports that a respirator that previously passed a fit-test is not providing an adequate fit.
- If the RPPA, OHN/OHNP or other manager notices a change in employee that would require an additional fit-test as Cal/OSHA standards require.

iii. PAPR's do not require fit testing but do require specific training. Hands on PAPR training is provided and documented as part of the post offer EWHS visit followed by an annual HealthStream Module refresher training.

Fit testing will not be performed on employees with facial hair that passes between the respirator seal and the face or interferes with valve function. Such facial hair includes stubble, beards and long sideburns.

d. **Proper Respirator Use:**

i. Employees will use their respirators under conditions specified by this plan and in accordance with the training they receive on the use of the selected model(s).

ii. The respirator shall not be used in a manner for which it is not certified by the National Institute for Occupational Safety and Health (NIOSH) or by its manufacturer.

iii. It is El Camino Hospital policy that employees **do not** bring their own personal protective equipment into ECH for use, and request that employees do not wear PPE in areas where it is not indicated.

iv. If using a half mask reusable respirator, all employees shall conduct positive and negative pressure user seal checks each time they wear a respirator (Please see attachment Respirator Usage Half Mask Reusable Respirator Use & Care for detailed directions).

v. All employees shall leave a potentially contaminated work area if

their respirator is impeding their ability to work. This means employees shall leave the contaminated area:

- If increased breathing resistance of the respirator is noted
- If severe discomfort in wearing the respirator is detected
- Upon illness of the respirator wearer, including: sensation of dizziness, nausea, weakness, breathing difficulty, coughing, sneezing, vomiting, fever and chills.
- To wash face to prevent skin irritation
- Upon malfunction of the respirator such as a reduction in air flow of a PAPR
- Upon detection of leakage of contaminant into the respirator

e. **Cleaning and Disinfecting**

i. PAPRs

- *See attachment MaxAir 710 PAPR Use and Care Instructions*
- *See attachment PAPR Request Process*

ii. Half Mask

- *Please refer to attachments Care of Respiratory Personal Protective Equipment and Half Mask Reusable Respirator Cleaning*.

iii. N95 Respirators

- N95 shall not be re-donned and should be disposed after one use unless procedures for re-donning due to a pandemic situation are implemented (see below)
- Discard if soiled, if breathing becomes more difficult, or if structural integrity is compromised.
- If patient is under Contact Precautions (e.g., MRSA, ESBL, Cdiff), discard the respirator after use with that patient.
- N95 Respirator Re-use (Re-donning)
  The decision to implement the procedure that permit extended use or limited reuse of N95 respirators should be made by the Respiratory Protection Program Administrator in consultation with Infection Prevention, EWHS Medical Director and Environmental Health & Safety.

- Disposable N95 respirators are not designed for re-use. However, concern about potential shortages of N95s during a pandemic has forced consideration of respirator re-use. The CDC recommends using the following steps to reduce contact transmission after donning:
    - Discard N95 respirators following use during aerosol generating procedures.
    - Discard N95 respirators contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.
    - Discard N95 respirators following close contact with, or exit from, the care of any patient co-infected with an infectious disease requiring contact precautions.
    - Consider use of a cleanable face shield (preferred) or a surgical mask over an N95 respirator and/or other steps (e.g., masking patients, use of engineering controls) to reduce surface contamination.
    - Perform hand hygiene with soap and water or an alcohol based hand sanitizer before and after touching or adjusting the respirator (if necessary for comfort or to maintain fit).
    - Discard any respirator that is obviously damaged or becomes hard to breathe through.

f. **Procedures For Communication**

i. Non hospital risk communications
On a regular basis during a non-alert or pandemic period, the focus of respiratory protection shall be source control, training procedures, and dissemination of RPP information to employees. The RPPA will ensure proper communication channels are maintained.

ii. Hospital risk communications
To reduce the likelihood of conflicting or confusing messages

during Alert and Pandemic periods across the healthcare system, El Camino Hospital will coordinate all external media content with the Santa Clara County Public Health Department (SCCPHD) and other area hospitals. The SCCPHD – Public Information Officer (SCCPHD PIO) will take the lead in development of public health and medical risk communication materials for release to the public, business community, schools, and critical infrastructure including healthcare facilities. The hospital Public Information Officer (PIO) shall maintain a close working relationship with the SCCPHD PIO.

g. **Surge Procedures**

i. A Surge is a rapid expansion beyond normal services to meet the increased demand for qualified personnel, medical care, equipment, and public health services in the event of an epidemic, public health emergency, or disaster (see Emergency – Pandemic Influenza Plan policy).

ii. Surge procedures and guidance may change as a situation unfolds, based on available epidemiological data and the Center for Disease Control (CDC). In these situations, it will be the responsibility of the RPPA to keep current and to inform employees of any operational changes.

h. **Recordkeeping**

i. EWHS shall establish and maintain records of the Respiratory Protection Program (RPP) to include annual review of the RPP, employees with occupational exposures, fit-testing training Records of annual review of the RRP shall include the name(s) of the person conducting the review, the dates the review was conducted and completed, the name(s) and work area(s) of employees involved, and a summary of the conclusion.

ii. The record shall be retained for three years.

iii. Records of exposure incidents shall be maintained and made available for as long as employee is employed at El Camino Hospital, plus thirty years. These records shall include: the date of the exposure incident; the names, and any other employee identifiers used in the workplace, of employees who were included in the exposure evaluation; the disease or pathogen to which employees may have been exposed; the name and job title of the person performing the evaluation; the identity of any local health officer and/or physicians or other licensed health care practitioner consulted; the date of the evaluation; and, the date of contact and contact information for any other employer who either notified ECH or was notified by EWHS regarding potential employee exposure.

iv. Records of fit-test training shall include the following: the date(s)

of the training session(s); the contents or a summary of the training session(s); the names and qualifications of persons conducting the training or who are designated to respond to interactive questions; and the names and job titles of all persons attending the training sessions. Training records shall be maintained for three years from the date on which the training occurred.

v. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record shall be retained for three years.

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.

Attachments

Aerosol Transmissible Diseases/Pathogens

Aerosol-Generating Procedures

b64_f972e3de-f0e9-47bf-94fc-97cb4d0494d4

Half-Mask Reusable Respirator Use & Care

Image 02

Job Classifications with Reasonably Anticipated Risk of Exposure

MaxAir MaxAir® 710 PAPR Instructions

MV PAPR Request Process

N95 Respirator Fit Testing Procedures

Respiratory Etiquette

Respiratory Fit Testing Training Guide for Testers

Approval Signatures

Step Description	Approver	Date

Board of Directors	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	04/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	04/2024
HR Leadership and CHRO	Tamara Stafford: Dir Talent Development & EWHS [PS]	04/2024
	Tamara Stafford: Dir Talent Development & EWHS	04/2024
	Michael Rea: Mgr Emp Wellness & Health Svcs	04/2024

History

Draft saved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 12:01PM EST

Edited by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 12:02PM EST

> Remove: "EWHS will notify department managers regarding employees who have not completed the recommended vaccination series and are not considered immune." Remove table of vaccines due to errors and redundancy.

Last Approved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 2/19/2024, 12:02PM EST

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 3/21/2024, 7:55PM EDT

> Reviewed by HR Leadership Team, March 20, 2024

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 3/21/2024, 7:57PM EDT

> Reviewed by HR Leadership Team, March 20, 2024

Draft saved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 4/11/2024, 6:47PM EDT

Edited by Rea, Michael: Mgr Emp Wellness & Health Svcs on 4/11/2024, 6:47PM EDT

> updated references

Last Approved by Rea, Michael: Mgr Emp Wellness & Health Svcs on 4/11/2024, 6:47PM EDT

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 4/11/2024, 7:12PM EDT

> 04/11/24

Last Approved by Stafford, Tamara: Dir Talent Development & EWHS on 4/15/2024, 4:23PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 4/15/2024, 4:23PM EDT

> ePolicy 4/12/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 4/26/2024, 9:59AM EDT

> MEC 4/25/24

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 4/29/2024, 11:11AM EDT

> Discussed w/ Michael Coston over the phone that there hasn't been a Board review from previous version. He agreed that this needs to go to the Board for review. Updating approval workflow.

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 4/29/2024, 11:11AM EDT

A13f. QAPI Plan as Reviewed and Recommended for Approval by the Quality Committee

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
QUALITY COMMITTEE MEETING COVER MEMO

To: Quality, Patient Care and Patient Experience Committee
From: Lyn Garrett, MHA, MS, CPHQ, Senior Quality Director
Date: May 6, 2024
Subject: El Camino Health Quality Improvement and Patient Safety Plan (QAPI) for 2024

Recommendation: Approve Quality Assessment and Performance Improvement Plan (QAPI)

Authority: The Board Quality, Patient Care and Patient Experience Committee is responsible for the oversight of the QAPI program through its periodic review of the program, including, the development of a plan to implement and maintain the QAPI program, the review of the progress of QAPI projects, the determination of annual QAPI projects, and the evaluation of the effectiveness of improvement actions that the hospital has implemented. *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*

Background: The Centers for Medicare and Medicaid Services (CMS) requires hospitals to have a well-designed and well-maintained QAPI program as a condition of participation. CMS requires that a hospital's QAPI program "provides a process by which a hospital can fully examine the quality of care it delivers and implement specific improvement activities and projects on an ongoing basis for all of the services provided by the hospital, while considering the scope and complexity of those services and the patient populations it serves." *(Department of Health and Human Services, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, March 9, 2023)*. The ECH QAPI program is updated annually to reflect, timely, the systems we have in place to identify and correct problematic events, policies or practices to ensure we are effective in improving performance, quality and safety.

Assessment: The El Camino Hospital QAPI plan describes our ability to develop, implement, and maintain an effective, ongoing, hospital-wide, and data-driven quality assessment and performance improvement program, which also includes tracking and monitoring of adverse events and medical errors. A notable enhancement to our FY24 QAPI plan is a focused section (section II) on our Patient Safety Plan and Safety First Mission Zero efforts to eliminate preventable harm.

Other Reviews: Reviewed and approved by the Quality Council, Patient and Employee Safety Committee and the Medical Executive Committee.

Outcome: The Committee will approve the QAPI Plan. There are no changes to the plan to report or review.

List of attachments:

1. Quality Assessment and Performance Improvement Plan with referenced QAPI addendums.

Status **Pending** PolicyStat ID **14285860**

Origination	05/2018
Last Approved	N/A
Effective	Upon Approval
Last Revised	11/2023
Next Review	1 year after approval

Owner	Michael Coston: Director Quality and Public Reporting
Area	Quality
Document Types	Plan

Quality Improvement & Patient Safety Plan (QIPS)

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip and Knee, Hip Fracture, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center, in Joint Replacement for Hip and Knee, Spinal Fusion and as a "baby friendly hospital" by WHO/ UNICEF.

The ECH Medical Staff includes 1100 active, telemedicine, provisional and consultant, 328 affiliate physicians, and 116 independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

El CAMINO HEALTH VISION

To provide consumers in the South Bay with a high quality, locally-oriented health system, across the full care continuum.

El CAMINO HOSPITAL VALUES

Quality: We pursue excellence to deliver evidence-based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

DEFINITIONS:

El Camino Hospital has adopted the Institute of Medicine's (IOM) Quality Framework – STEEEP – as its definition of quality. These six aims for a healthcare system comprise ECH's approach to quality:

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Efficient:** Avoiding wastes, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

SERVICES/PROGRAMS

ECH provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:	Emergency Services	Outpatient Services
Acute Rehabilitation	Basic Emergency	Advanced Care & Diagnostics Center
Cardiac Catheterization		Behavioral Services – Outpatient

Services		
Cardiovascular Surgery		Cancer Center
Intensive & Critical Care Unit		Cardio Pulmonary Wellness Center
Labor and Delivery (L&D)		Endoscopy
Medical/Surgical/Ortho		Infusion Services
Mental Health and Addiction Services (Inpatient Psychiatry)		Interventional Services
Mother/Baby		Occupational Therapy/Physical Therapy
Level II and Level III Neonatal Intensive Care Unit (NICU)		Outpatient Surgical Units
Operating Room (OR)		Pre-admission Service/ Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiation Oncology
Pediatrics		Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI, Breast Health Center, Mobile Imaging)
Post-Anesthesia Care Unit (PACU)		Rehabilitation
Progressive Care Unit (PCU) (Step-down)		Speech Therapy
Telemetry/Stroke		Wound Care Clinic

Section I Quality Improvement Plan

PURPOSE

The Quality Improvement Plan, as equivalent to CMS' Quality Assessment Performance Improvement (QAPI), describes the multidisciplinary, systematic quality improvement framework utilized by El Camino Hospital (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety based on the complexity of the ECH's services/ programs.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.

6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.
12. Respond to external hospital environment or community needs in regards of providing equitable care and positive quality outcomes.

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility and oversight for implementing the Quality Improvement, Patient Safety, and Patient Experience Plan to the hospital administration, medical staff, and its respective governance committees. Refer to Attachment A on Governance Information Flow.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, is responsible for the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting The Joint Commission and College of American Pathology accreditation standards, California Code of Regulations including Title 22, CMS Conditions of Participation and complying with applicable laws and regulations.

Other specific responsibilities with regard to quality improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the

Governing Board.

Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

1. Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered to patients in the hospital;
2. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and make recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
3. Assisting in obtaining and maintenance of accreditation.

Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of three Enterprise departments which are those with constituency at both campuses (including MV & LG). All departments report to an Enterprise Medical Staff Executive Committee. The current departments are; (a complete list of all subspecialties in each department is available from the Medical Staff Office.)

- Medicine to include Radiology, Emergency Medicine, Hospitalists, Psychiatry, Neurology, and Family Medicine
- Surgery to include Pathology, Anesthesia, Orthopedics, Gynecologic Oncology, Otolaryngology, Ophthalmology, Plastic Surgery, Neurosurgery, General Surgery, Urology, Cardio-thoracic surgery, and Vascular Surgery
- Maternal Child Health to include Obstetrics/Gynecology, Pediatrics and Neonatology

Each of these three departments has monthly meetings of their Executive Committees where ongoing quality improvement projects are initiated and progress reported routinely to the Quality Council.

Other specific responsibilities with regard to quality improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A for a graphic depiction of the flow of quality information through committees and to the governing board.

Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes quality improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

1. Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support

activities

2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for quality improvement and safety giving priority to high-volume, high-risk, or problem- prone processes for performance improvement activities and reprioritize these activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's quality performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff are trained in quality and safety improvement approaches and methods and receive education that focuses on safety, quality, and high reliability
7. Continuously measure and assess the effectiveness of quality and safety improvement activities, implement improvements for these activities, and ensure sustainability of improvements made
8. Reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities

Medical Staff, Employees, and Contracted Services

Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, reporting adverse events, and implementing actions to sustain improvements.

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is ~~co-~~chaired by the past chief of staff, their designee, and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY 2023 is reduction of the Hospital Acquired Conditions (HAC) Index, and receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY 23 Quality Council report schedule.

Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and

improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality Department staff serves as internal resources for the development and evaluation of quality improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including, but not limited to; the teams addressing the organizational quality, i.e. ERAS (Enhanced Recovery After Surgery) Team and the NV-HAP (non-ventilator hospital-acquired pneumonia) Team. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments C and D.
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment E for Data Registries in use)
5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
6. Collaborates with the Risk Management and Patient Safety department on efforts to manage and reduce risk through Root Cause, Apparent Cause and Common Cause Analyses as responses to adverse events and near misses and events reported to regulatory agencies
7. Collaborates on performance of failure mode and effectiveness analysis (FMEA) at least every 18 months with Risk Management and Patient Safety
8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
10. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
11. Providing data as requested to external organizations, see data provided in Attachment F
12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix E for current list
13. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data
14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health (CDPH) to improve the quality of care and safety of care provided to our patients.
15. Facilitates identification of health care disparities in the patient population by stratifying quality and safety data

Hospital Services

All ECH departments and service lines participate in the Quality Improvement Plan by establishing mechanisms that continuously and systematically evaluate the quality of specific service care processes and outcomes. Service directors and managers annually review and identify their expected quality and performance improvement efforts based on the findings of their measurement activities. Each clinical and non-clinical service is responsible for and supporting ECH completion of at least one (1) quality and performance improvement project annually that improves patient care, safety, and/or experience and demonstrates cost efficiency.

All clinical contracted services will be reviewed, evaluated, and will demonstrate a quality and performance improvement summary/assessment on an annual basis and presented to the Enterprise Quality Council.

IMPROVING ORGANIZATIONAL PERFORMANCE

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Quality improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. Quality improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(es) to quality improvement. These leaders set priorities for improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives is based upon the following criteria:

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of quality improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.
9. Response to changes not only in the internal, but also in the external environment or the community it serves

Performance Processes

1. **Design**
   The design of processes is in conjunction with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

2. **Measurement**
   ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and finance. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.
   Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:
   a. Consistent with the organization's mission, vision, goals, objectives, and plans;
   b. Meeting the needs of individuals served, staff and others;
   c. Clinically sound and current;
   d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
   e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
   f. Incorporated into the results of performance improvement activities.
   g. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs
      Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:
      a. Establish a performance baseline;
      b. Describe process performance or stability;
      c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
      d. Identify areas for more focused data collection to achieve and sustain improvement.

3. **Analysis**
   Data shall be analyzed on an ongoing basis to identify performance improvement opportunities.

Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.
a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;
d. Blood Utilization to include confirmed transfusion reactions;
e. Other types of safety events identified in the Safety Event Management and Cause Analysis procedure;

Improvement Model and Methodology

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

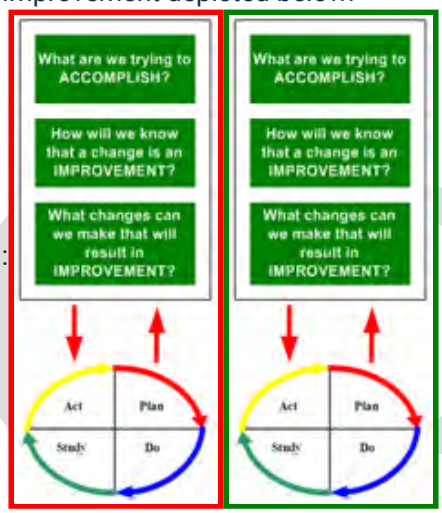
Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other The Plan-Do-Study-Act (PDSA) Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

The model has two parts:

1. ***Three fundamental questions, which can be addressed in any order.***
    - What are we trying to accomplish?
    - How will we know that a change is an improvement?
    - What changes can we make that will result in improvement?
      This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

2. ***The Plan-Do-Study-Act (PDSA) Cycle***
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

Step 1: Plan
Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
Step 2: Do
Try out the test on a small scale. What did we observe that was not a part of our plan?
Step 3: Study
Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
Summarize and reflect on what was learned.
Step 4: Act
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.
In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



3. ***Goal Setting and Auditing Methodology***

   - S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
     The acronym stands for:
     S – Specific
     When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
     Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
     What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
     When – You'll get more specific about this question under the "time-bound" section of

defining S.M.A.R.T. goals, but you should at least set a time frame.
Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

M – Measurable

What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.

A – Achievable

This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.

R – Relevant

Relevance refers to focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.

T – Time-Bound

Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

- Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.
  Measure of Success (MOS) auditing process has specified the following minimums:
  - Sample all cases for a population size of fewer than 30 cases
  - Sample 30 cases for a population size of 30–100 cases
  - Sample 50 cases for a population size of 101–500 cases
  - Sample 70 cases for a population size of more than 500 cases
  - Sample 100 cases for a population greater than 500 cases

To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

Process Improvement and the El Camino Health Operating System

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. High Reliability Organizations deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Process Improvement department has been in existence since 2012, and has adopted the use of Lean methodology and principles as the foundation for our interventions. We also use tools from Six Sigma, Change Management, and PDCA, to support our transformation in becoming a High Reliability Organization. We do this by focusing on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the foundation.

The Process Improvement department provides resources to the organization for problem solving, as well as deploying ECHOS, our El Camino Health Operating System. The dedicated team is comprised of Process Improvement Advisors with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization.

The success of Process Improvement is dependent on robust education and training programs. Our PI Academy, a 90-day project based training program designed to encourage and support all staff to be problem-solvers, is an example of how we engage with front line staff in continuous improvement. We also provide ad hoc training sessions covering Lean/PI tools and methods throughout the enterprise to assist departments with project completion.

The Process Improvement department also has a year-long fellowship program, which has been designed to develop and grow talented, high performing and high potential leaders by providing an accelerated and intensive hands-on learning opportunity with focus on the ECHOS Daily Management and Performance Improvement Systems. Participants leave their current department and join the Performance Improvement team to gain a foundation in core management and improvement system behaviors, methods, and tools to build on their talents. They do this through high-impact assignments that help the organization drive continuous improvement to achieve the highest level outcomes across patient experience, quality, safety, affordability and physician and staff engagement.

ECHOS: El Camino Health Operating System

The El Camino Health Operating System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work, and, includes leader behaviors that support our teams. It is the way that we lead and accomplish work at EL Camino Health. Our True North incorporates our mission, vision and values, and is supported by our True North pillars. ECHOS as our foundation, is built on the Lean principles of respect for people and pursuit of continuous improvement. These concepts, methods and tools, support our overall Daily Management System.

The Daily Management System, with our patients as the focus, has three components which define how we:

1. **Align** the goals of the organization from the Executives to the Front Line with annual *Strategy Deployment*
2. **Engage** our people in daily front line problem solving daily through the *Daily Management System* using Tiered Huddles, Linked Visual Systems, Gemba, Standard Calendar, and Leader Standard Work
3. **Continuously Improve** our processes across departments, using structure and tools that enable both local and large cross-functional processes to be improved and even transformed

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in three areas: quality & safety, service and finance. See below for the Fiscal Year ~~2023~~2024 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the Hospital Acquired Conditions Index, ECH formed ~~five~~four teams to address opportunities with ~~patient falls,~~ Hospital-acquired ~~Pressure Injuries (HAPI), Hospital-acquired~~ Pneumonia (nvHAP), C. Difficile infections, ~~and Surgical Site Infections at the beginning of the fiscal year and who meet bi~~Central Line ~~weekly: Patient Falls Committee, Skin Integrity Committee~~Associated Bloodstream Infection (~~SIC~~CLABSI), ~~Hospital~~and Cather ~~acquired Pneumonia~~Associated Urinary Tract Infection (~~HAP~~CAUTI) ~~team, and Infection Control and Prevention subcommittees for C.Diff and SSI.~~ Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

Fiscal Year 2023 Performance Incentive Goal Dashboard

Pillar	Goal	Measurement Defined			
		FY 22	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.066	1.013	0.986	0.959
Service	Likelihood to Recommend (LTR) – Inpatient	80.8	80.8	81.0	81.3
	LTR – El Camino Health Medical Network	74.5	83.2	83.4	84.1
People	Culture of Safety	N/A	3.99	4.02	4.04
Finance	Operating EBIDA Margin	286.0M	$114.17M	$119.88M	$125.59M

Pillar	Goal	Measurement Defined			
		FY 23	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.453	1.424	1.410	1.395
Service	Likelihood to Recommend (LTR) – Inpatient	78.5	74.7	76.4	78.1
	LTR – El Camino Health Medical Network	82.7	80.0	81.3	82.6
People	Culture of Safety	3.98	3.95	4.00	4.02
Finance	Operating EBIDA Margin	256.9M	$221M	$233M	$245M

HAC Index

FY22 Baseline					
Metric	Num.	Den.	Rate	Weight	Weighted Rate
Falls	153	patient days*	xxx	0.20	0.265
Hospital Acquired Pressure Injury	8		xxx	0.25	0.022
nvHospital Acquired Pneumonia	115		xxx	0.20	0.365
C. Difficile Infection	37		xxx	0.10	0.355
Surgical Site Infection	18	# surgeries	xxx	0.25	0.06
HAC Index				Sum »	1.066

Commitment to Patient Experience

ECH has embraced the concept of an exceptional patient experience as foundational. It is our goal to form trusting partnerships among health care practitioners, staff members, and our patients and families that have been proven to lead to better outcomes and enhance the quality, safety and experience of patients and the health care team. Consequently, ECH solicits and captures feedback from a myriad of sources to ensure that the Patient/Family voice is embedded in all that we do. The comments and insights received through our feedback cards and patient satisfaction surveys are shared on a regular basis with our service lines and departments and used for recognition and improvement efforts. Understanding the experience of our

patients throughout the continuum of care is imperative as we embark on our high reliability journey. In addition to the regular feedback received through these mechanisms, ECH has also engaged prior patients to work collaboratively with our organization. The Patient and Family Advisory Council (PFAC) was established as a mechanism for involving patients and families in shared decision making as we explore performance improvement efforts, policy and program decision-making and other operational processes. The patient and family advisors partner with our various service lines and departments, providing unique perspective and aiding us in achieving the ideal patient experience. They are engaged in reviewing communication to patients and families to ensure messaging is consistent, and easily understood. Also serving as members of hospital committees, our patient and family advisors collaborate and co-design alongside our team members. They provide insights on the services they value and what is important to them as we look closely at our processes.

To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.

SECTION II: Patient Safety Plan

PURPOSE

El Camino Health (ECH) is committed to the health of our community. That means we provide the highest quality, personalized care to everyone who comes through our doors — treating them not simply as a patient, but as a whole person. Fundamental to that care is our culture of Safety First/Mission Zero. In each action, decision and process, we accept nothing less than putting safety first to achieve our mission of zero harm for our patients, visitors and workforce.

El Camino Health uses the diagram above to depict the organization's Mission, Vision and Values and True North Pillars. El Camino Health is on a contuing journey to build a culture of high reliability with a focus on safety to eliminate preventable harm to patients, visitors and our workforce-what we call Safety First/ Mission Zero. El Camino Health uses the following high reliability principles to support patient safety: Preoccupation with Failure, Sensitivity to Operations, Reluctance to Simplify, and Commitment to Resilience and Deference to Expertise. El Camino Health has established leadership expectations found in Attachment H and has also established universal SAFETY skills and behaviors that all of our workforce have been trained to use to eliminate preventable harm (See Attachment I).

The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. The Patient Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing quality and patient safety initiatives.

GUIDING PRINCIPLES

1. We believe that patient safety is at the core of a quality healthcare system.
2. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.
3. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.
4. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.
5. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.

6. We will foster a culture that respects diversity and inclusivity as a shared responsibility promoting access and equity for our workforce and patients.

OBJECTIVES

1. Deliver high quality safe care for every patient.
2. Engage our workforce and patients in safe practices at work at all levels of the organization using SAFETY skills (universal skills).
3. Promote a culture of safety.
4. Build processes that improve our capacity to identify and address patient safety issues.
5. Classify patient safety events and perform cause analysis to better undertand cauess of errors and areas of improvement using the root cause or apparent cause analysis tools as delineated in the Safety Management and Cause Analysis procedure.
6. Educate workforce, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm.
7. Encourage organizational learning about medical/health care errors.
8. Incorporate recognition of patient safety as an integral job responsibility.
9. Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame.
10. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions.
11. Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.
12. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

There are a number of integral and connected structures at El Camino Hospital that address Patient Safety.

Governing Board

The Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Board shall delegate responsibility for implementing this Patient Safety Plan to the medical staff and hospital administration and the committees noted below.

Quality Committee of the Board

The Quality Committee of the Board oversees Patient Safety at the hospital. They review patient safety indicators on an ongoing basis and provide direction and input to senior leadership on patient safety concerns and initiatives. An annual report of the Patient Safety program, which includes a summary of incident reports, regulatory activity and summary of reports made to the Department of Public Health and

actions taken to address patient safety, shall be presented to the Quality Committee of the Board

Enterprise Hospital Committees

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that oversees hospital patient safety related activity. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly.

The **Enterprise Patient and Employee Safety Committee (PESC)** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), Culture of Safety surveys, National Patient Safety Goals, Safety/ Security, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Employee Injuries and the Grievance Committee. (See Attachment G: Patient and Employee Safety Dashboard). It is a multidisciplinary committee with hospital and medical staff representation, and the minutes and dashboard are shared with Quality Council monthly. The PESC is responsible for initiating performance improvement related to patient and employee safety concerns based on identified trends and concerns. Aggregated reports of patient safety events and actions taken to promote patient safety are reported quarterly to the Patient and Employee Safety Committee.

The **Root Cause Analysis (RCA)/Cause Analysis Oversight Steering Committee** is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). This committee is responsible for providing oversight and monitoring of the Cause Analysis program described in Safety Event Management and Cause Analysis procedure. This group is responsible for ensuring that action plans are implemented for root cause analyses and overall effectiveness of the Cause Analysis program. The **Enterprise Patient Safety Oversight Committee (PSOC)** is a hospital senior leadership committee that meets weekly to review new patient safety events and prioritize actions needed for patient safety. Information reviewed is brought forward by Risk and Patient Safety, Medical Staff leadership, Quality and Regulatory leaders. These leaders provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

Patient Safety Department

El Camino Hospital has a Patient Safety Department consisting of a Director of Risk Management and Patient Safety (designated as the Patient Safety Officer), Patient Safety Manager and Patient Safety Specialists. These individuals work closely with members in the Risk Management and Quality Department on implementation of the patient safety program as described below. The Patient Safety Department works across disciplines and with team members across the organization to support and promote patient safety and drive our goal of Zero Preventable Harm.

The scope of the Patient Safety program includes the following but is not limited to:

1. Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
2. Coordination of an annual Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.

3. Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
4. Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
5. Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach and Leader Mentor program as well as development of a Patient Safety Academy.
6. In partnership with Risk Management and Quality, performance of Failure and Effects Mode Analysis (FMEA).
7. In partnership with Risk Management, implementation of performance improvement related to patient safety based on trends or needed risk mitigation.
8. Regulatory follow up needed related to patient safety
9. Promote transparency of errors and mistakes through sharing lessons learned

PATIENT SAFETY PLAN

The mechanism to ensure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines.

1. Incident reporting is a cornerstone of Safety First/Mission Zero and our Culture of Safety. Training is provided to all workforce members upon hire and with refreshers on reporting concerns using ISAFE, the hospital's electronic incident reporting system with the expectation that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/ improvements. The ISAFE system also allows for reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to ensure timely response and follow-up, track and trend feedback themes and inform quality improvement opportunities.
2. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment J) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.
3. As this organization supports the concept that errors occur due to a breakdown in systems and processes and a fair and just culture, workforce members involved in an event with an adverse outcome will be supported by:
    a. A non-punitive approach and without fear of reprisal, as evidenced by the Fair and Just Culture policy.
    b. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
    c. Resources such as Support our Staff (SOS) or EAP should the need exist to provide support for our workforce after an event
    d. Culture of Safety surveys about their willingness to use our safety reporting systems
4. PESC Dashboard and Patient Safety Targets, Refer to Attachment G. The PESC establishes a dashboard annually to monitor patient and employee safety events with desired quality targets based on any available benchmarks and organizational goals.

5. Patient Safety Priorities are based on the following:
    a. Serious Safety Events as identified by the Safety Event Classification team whose process is described in the Safety Event Management and Cause Analysis procedure
    b. Other patient safety events that are not classified as an SSE but raise concerns due to aggregate trend or potential for harm
    c. Information from internal assessments related to patient safety such as tracers
    d. Information from external organizations related to patient safety such as the Joint Commission Sentinel Event Alerts, ISMP
    e. Accreditation and regulatory requirements related to patient safety
    f. Fallouts from PESC dashboard.

Patient Safety Initiatives

• Safety First Mission Zero SAFETY skill program • Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis • Hand Hygiene Audits • Monthly Leader and Executive Rounding using 4C SAFETY skill scripts • New hire and manager Orientation to include SAFETY skill education • HeRO Recognition and Award Program	
Quality Indicators of Patient Safety:	
• Nurse Sensitive Indicators (Medication Safety, Falls) • Healthcare Associated Infections • Surgical site infections • Surgical Safety Checklist	• Pressure Injuries • Transfusion reactions/ blood/blood product administration • Use of Restraints • Employee Safety • Serious Safety Event Rate • Culture of Safety Survey results
Safety Programs:	
• Central Safety Committee • Emergency Preparedness Committee • Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Antimicrobial Stewardship Program • Radiation Safety Committee
Data from Environmental Safety Issues:	

• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

Confidentiality

The Quality Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Quality Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the Quality Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality, Risk Management and Patient Safety Departments and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Chief Quality Officer, Sr. Director, Quality Services Department, Director of Risk Management or Patient Safety or the Compliance Officer.

Annual Evaluation

The Chief Quality Officer or the Sr. Director of Quality Services, and the Director of Risk Management and Patient Safety shall coordinate the annual evaluation of the Quality and Patient Safety program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address both program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.

Modifications will be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Quality Council, Medical Executive Committee, and the Governing Board.

Attachments

Att A Governance Information Flow~~.pdf~~

Att B Quality Council Reporting Calendar (FY~~23 Combined Quality Council Reporting Calendar rev 1.25.22.pdf~~24)

~~Att C Org Goals and Quality FY23.pdf~~

Att C Enterprise Quality, Safety and Experience Dashboard FY24

Att D Board Quality and Safety Dashboard FY~~23.pdf~~24

Att E Abbrev Registries List~~.pdf~~

Att F External Regulatory Compliance Indicators ~~2022.pdf~~2023

Att G Patient and Employee Safety ~~Committee~~ Dashboard FY24

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

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.

Attachments

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY24).pdf

Att C Enterprise Quality, Safety and Experience Dashboard FY24.pdf

Att D STEEEP FY24Q1 for Board

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicator 2023

Att G Patient and Employee Safety Dashboard FY24

Att H Safety First / Mission Zero Leader Skill Toolkit

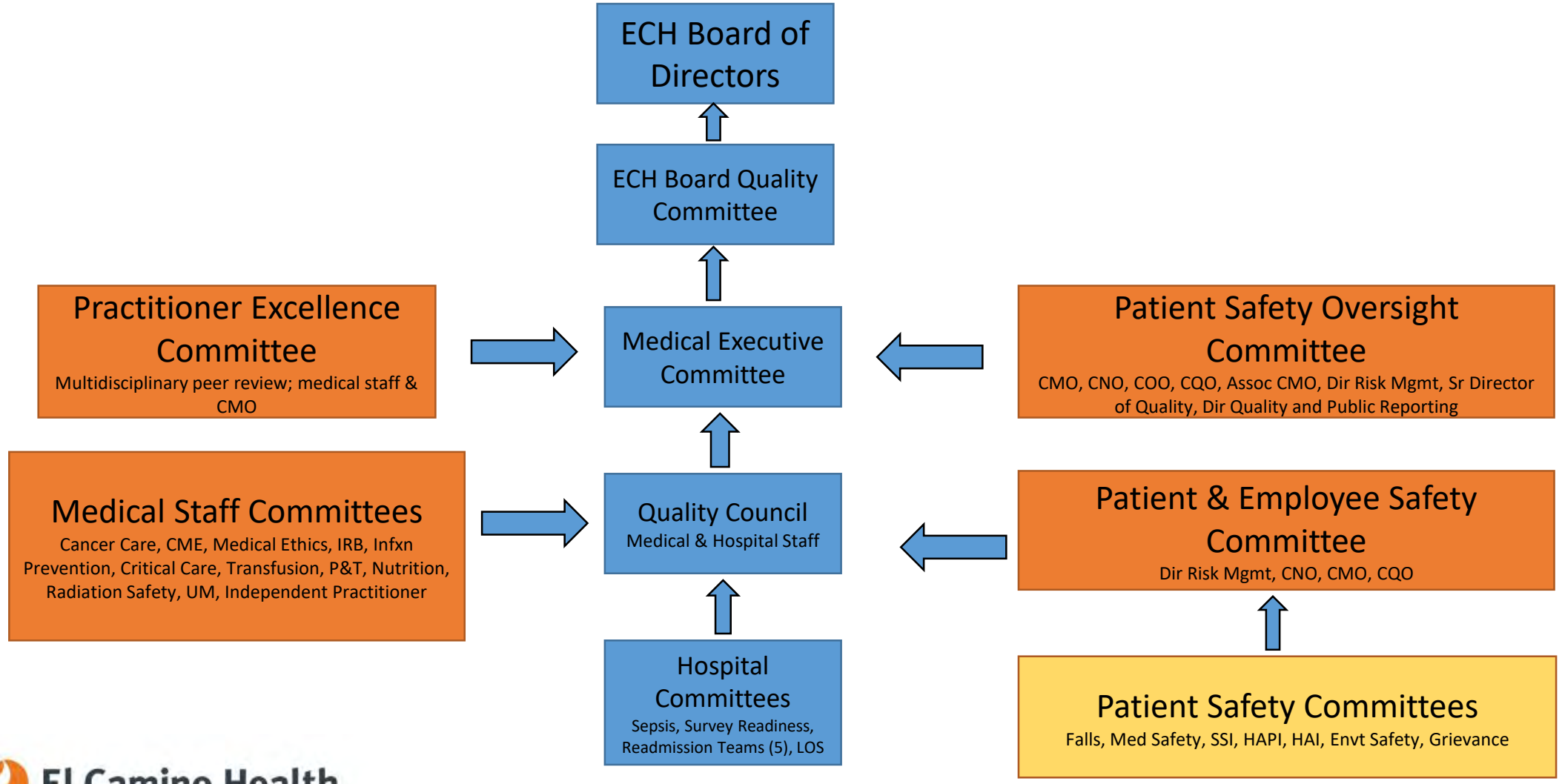
Att I Safety First / Mission Zero Universal Skills Toolkit

Att J HPI Classification Tools for SEC

Approval Signatures

Step Description	Approver	Date
Quality Committee	Michael Coston: Director Quality and Public Reporting	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	02/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2023
Quality Council	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	11/2023
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst [PS]	11/2023
	Heidi Yamat: Director AR&L and Public Reporting	10/2023

Quality Assurance and Performance Improvement—Governance Information Flow FY23



El Camino Health

El Camino Health

FY 24 Quality Council

Annual Performance Improvement Reporting Calendar for

Hospital Departments/Programs/Service Lines

1st Wednesday – 7:00 am to 9:00 am

2023	**July 5, 2023**	**August 2, 2023**	**September 6, 2023**
		• Health Information Management • Orthopedics Service Line • Patient Experience (HCAHPS)	• Antibiotic Stewardship • Nutrition Services • Pharmacy • Heart/Vascular Institute • Quality Improvement & Patient Safety (QIPS) Plan
	October 4, 2023	**November 1, 2023**	**December 6, 2023**
	• MV Emergency Department • LG Emergency Department • ED Physician Service Contract Evaluation • Information Services • Care Coordination	• Cancer Service Line • Human Resources • Maternal Child Health Service Line	• Urology Service Line • Sleep Center • Respiratory Care Services • Spine Service Line
2024	**January 3, 2024**	**February 7, 2024**	**March 6, 2024**
	• Rehab Service • Mental Health & Addiction Service Line • Environmental Services	• Infection Prevention • Acute Dialysis • Critical Care / Intensive Care • Organ Donation/Donor Network	• Sepsis • Acute Rehab • Patient Blood Management
	April 3, 2023	**May 1, 2024**	**June 5, 2024**
	• Imaging Services / Radiology • Contract Services • Sterile Processing • Value Based Purchasing	• Core Measures • CPR • Laboratory & Pathology • Utilization Management	• Palliative Care • MV Peri-Operative Services • LG Peri-Operative Services • Stroke Program

El Camino Health

Annual Reports

- Acute Dialysis
- Acute Rehab
- Antibiotic Stewardship
- Cancer Service Line
- Care Coordination
- Contracted Services
- Core Measure
- CPR
- Critical Care / Intensive Care
- Emergency Dept. (MV & LG)
- Emergency Dept. Physician Services Contract Evaluation
- Environmental Services
- Health Information Management (HIM)
- Heart & Vascular Institute
- Human Resources
- Imaging Services / Radiology
- Infection Prevention
- Information Services
- Laboratory & Pathology
- Maternal Child Health Services Line
- Mental Health & Addiction Service Line
- Nutritional Services
- Organ Donation/Donor Network
- Orthopedic Service Line
- Palliative Care
- Patient Blood Management
- Patient Exp. (HCAHPS)
- Peri-Operative Services (MV & LG)
- Pharmacy
- Quality Improvement & Patient Safety (QIPS) Plan
- Rehab Services
- Respiratory Care Services
- Sepsis
- Sleep Center
- Spine Service Line
- Sterile Processing
- Stroke Program
- Urology Service Line
- Utilization Management
- Value Based Purchasing

Standing Items

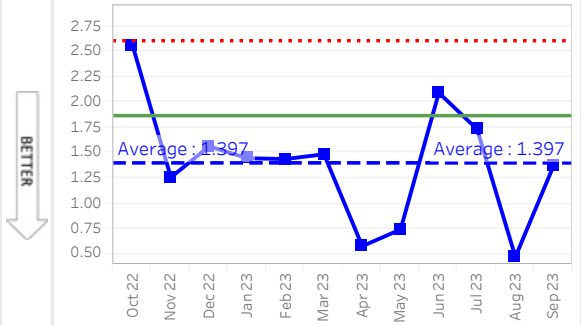
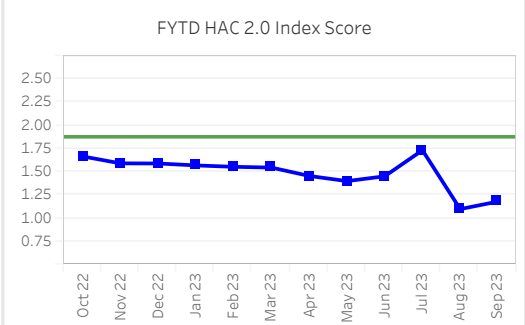
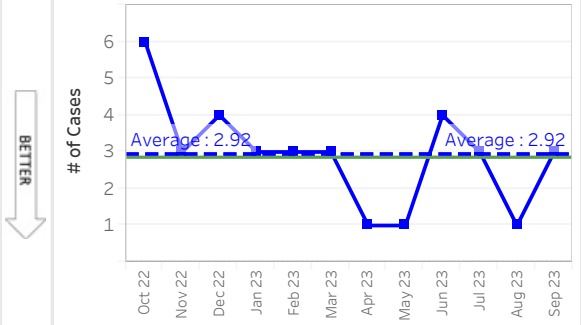
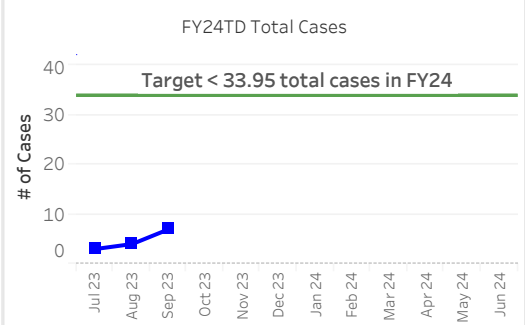
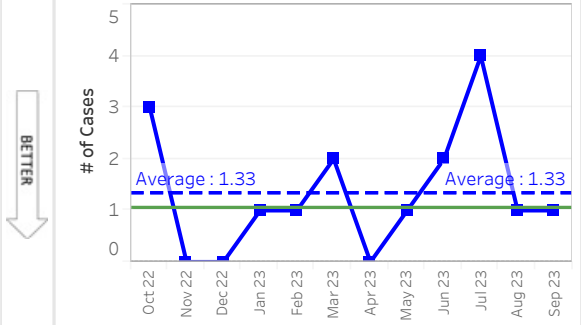
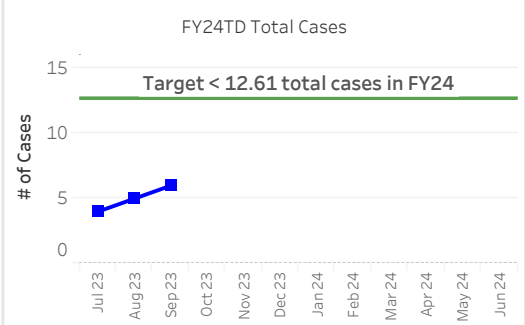
- Regulatory Update

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal HAC Index 2.0 Latest Month : September 2023	1.377	1.180	1.453	1.410 (3.0% ↓)		
HAC Component Clostridium Difficile Infections (C-Diff) Latest Month : September 2023	3 cases	2.33 cases/mo	2.92 cases/mo	2.83 cases/mo		
HAC Component Catheter Associated Urinary Tract Infection (CAUTI) Latest Month : September 2023	1 cases	2.00 cases/mo	1.08 cases/mo	1.05 cases/mo		

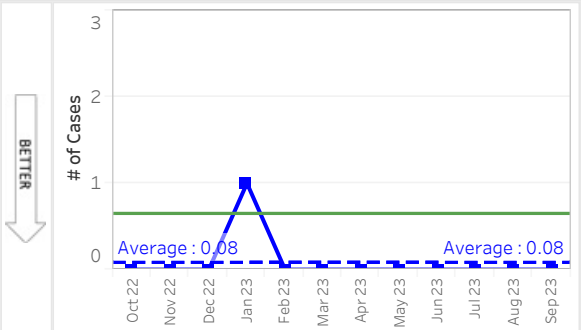
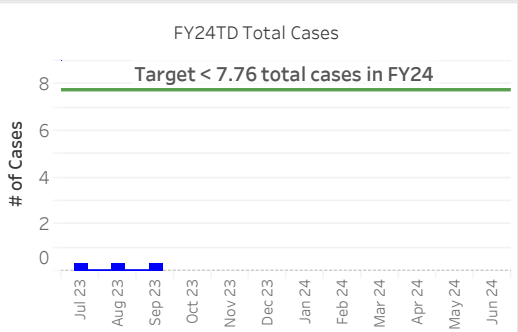
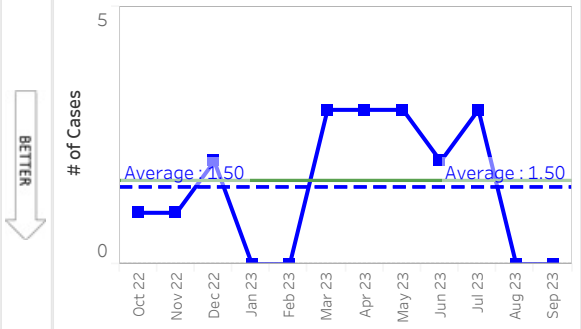
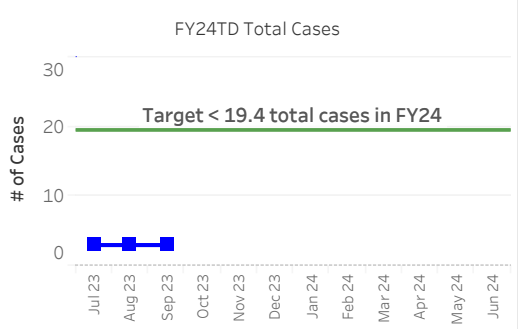
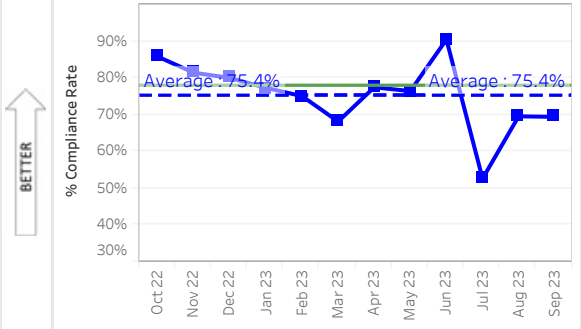
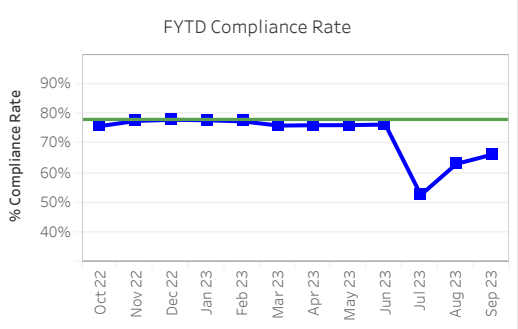
Quality Department | Note : updated as of October 23, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
HAC Component Central Line Associated Blood Stream Infection (CLABSI) Latest Month : September 2023	0 cases	0.00 cases/mo	0.67 cases/mo	0.65 cases/mo		
HAC Component non-ventilator Hospital-Acquired Pneumonia (nvHAP) Latest Month : September 2023	0 cases	1.00 cases/mo	1.67 cases/mo	1.62 cases/mo		
Hand Hygiene (Entry) Compliance % Latest Month : September 2023	69.5%	66.3%	76.5%	78.0%		

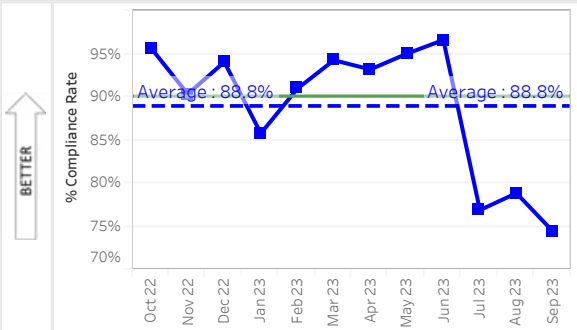
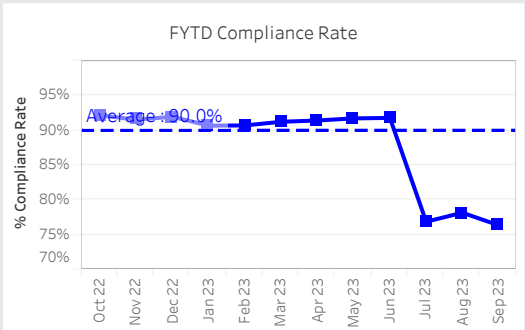
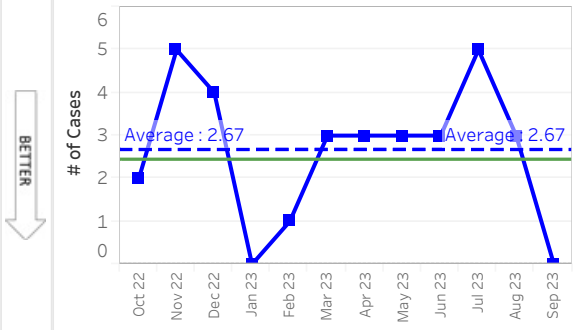
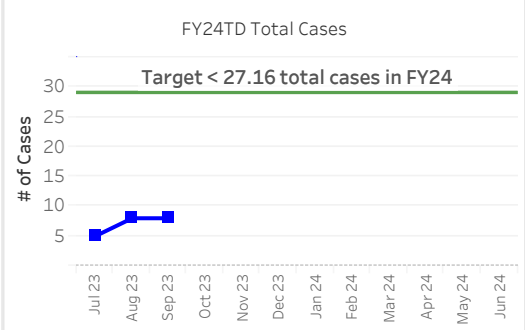
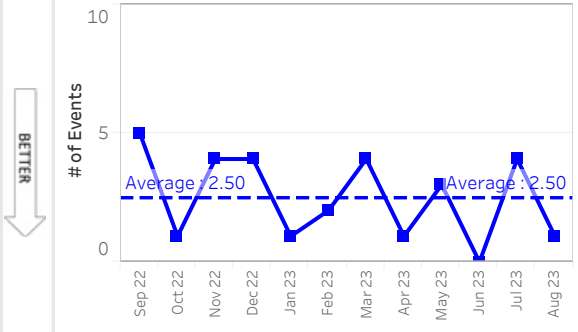
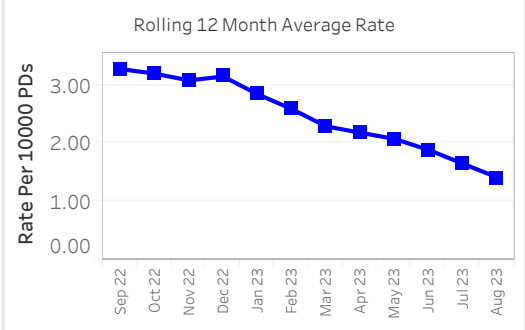
Quality Department | Note : updated as of October 23, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Hand Hygiene (Exit) Compliance % Latest Month : September 2023	74.4%	76.4%	91.8%	90.0%		
Surgical Site Infections (SSI) Latest Month : September 2023	0 cases	2.67 cases/mo	2.50 cases/mo	2.42 cases/mo		
Serious Safety Event Rate (SSER) Latest Month : August 2023	1 events	1.42 (5 / 35222)	1.88 (40 / 212460)	n/a		

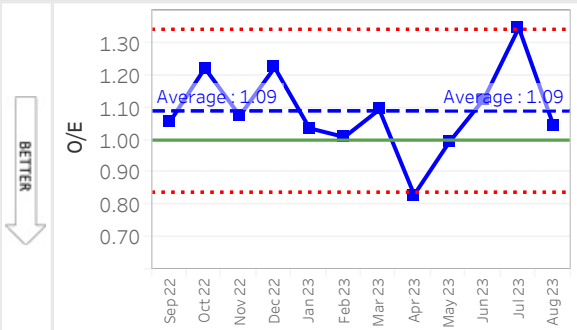
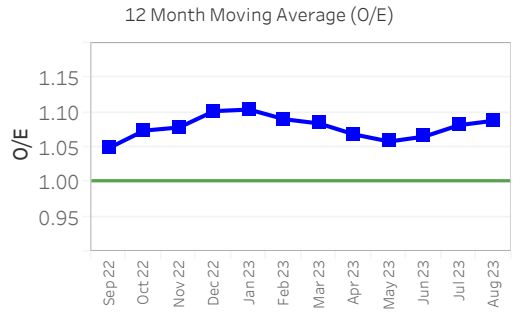
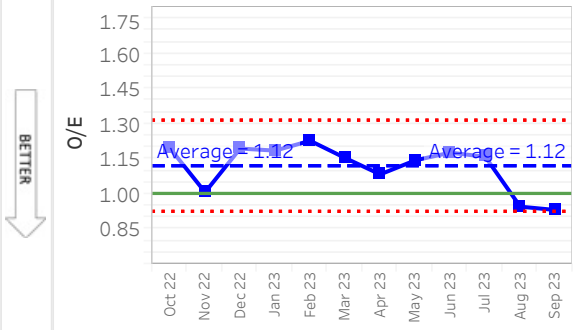
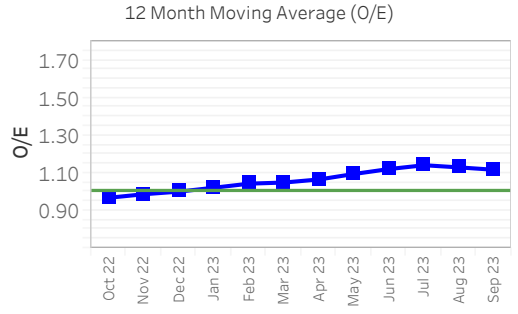
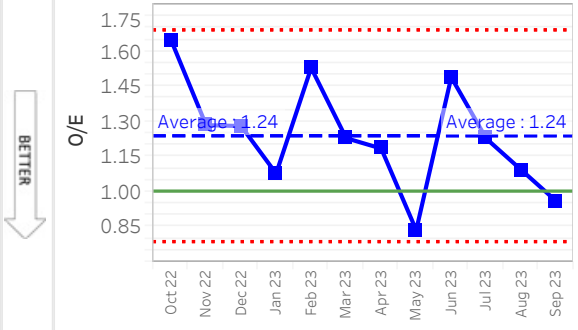
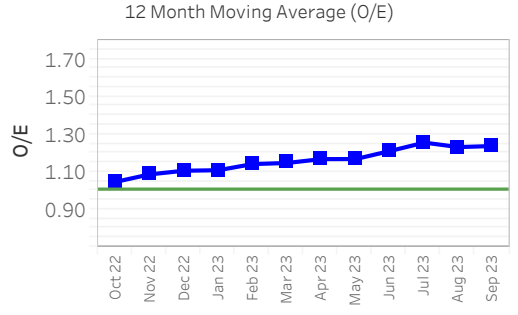
Quality Department | Note : updated as of October 23, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
Readmission Index (All Patient All Cause Readmit) Observed / Expected Premier Care Sciences Standard RA Latest Month : August 2023	1.04 (8.60% / 8.25%)	1.19 (9.84% / 8.27%)	1.07 (8.47% / 7.94%)	1.00		
Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : September 2023	0.93 (1.91% / 2.05%)	1.00 (1.86% / 1.86%)	1.13 (2.21% / 1.96%)	1.00		
Sepsis Mortality Index Observed / Expected Premier Care Sciences Standard RA Latest Month : September 2023	0.96 (10.98% / 11.44%)	1.08 (12.09% / 11.23%)	1.21 (14.07% / 11.59%)	1.00		

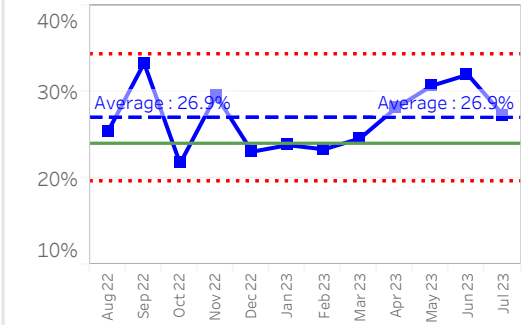
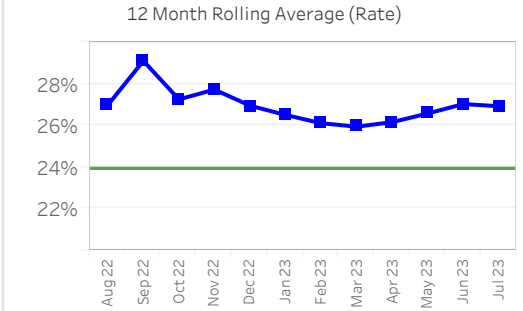
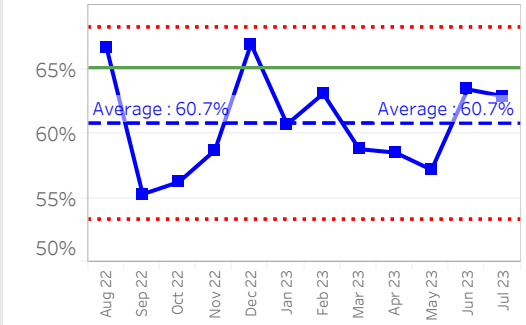
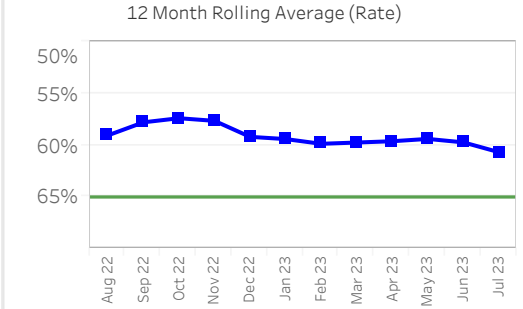
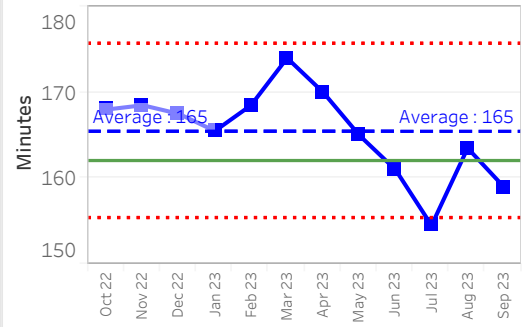
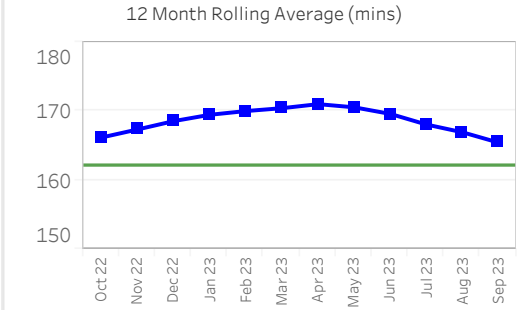
Quality Department | Note : updated as of October 23, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
PC-02 : Cesarean Birth	MV : 29.0% (45 / 155)	MV : 29.0% (45 / 155)	MV : 28.1% (530 / 1883)	23.9% (FY24 ENT Target)		
	LG : 16.0% (4 / 25)	LG : 16.0% (4 / 25)	LG : 20.1% (65 / 323)			
Latest Month : July 2023	ENT : 27.2% (49 / 180)	ENT : 27.2% (49 / 180)	ENT : 27.0% (595 / 2206)			
PC-05 : Exclusive Breast Milk Feeding	MV : 61.3% (179 / 292)	MV : 61.3% (179 / 292)	MV : 58.1% (1966 / 3385)	65.1% (FY24 ENT & MV Target) 70.0% (FY24 LG Target)		
	LG : 71.7% (38 / 53)	LG : 71.7% (38 / 53)	LG : 68.3% (427 / 625)			
Latest Month : July 2023	ENT : 62.9% (217 / 345)	ENT : 62.9% (217 / 345)	ENT : 59.7% (2393 / 4010)			
Median Time from ED Arrival to ED Departure [TAT-D] (Enterprise)	MV : 186 mins	MV : 184 mins	MV : 197 mins	MV : 191 mins		
	LG : 132 mins	LG : 134 mins	LG : 142 mins	LG : 133 mins		
Latest Month : September 2023	ENT : 159 mins	ENT : 159 mins	ENT : 170 mins	ENT : 162 mins		

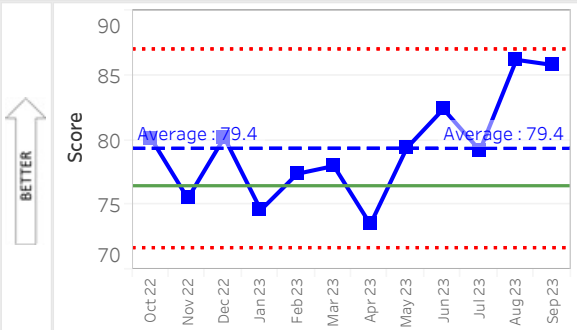
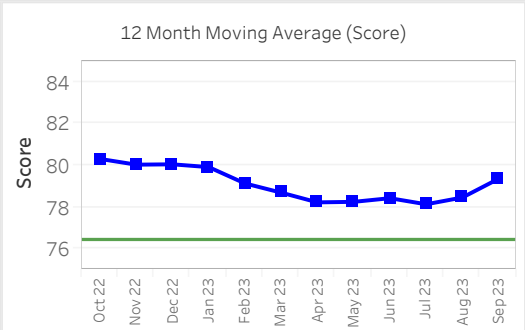
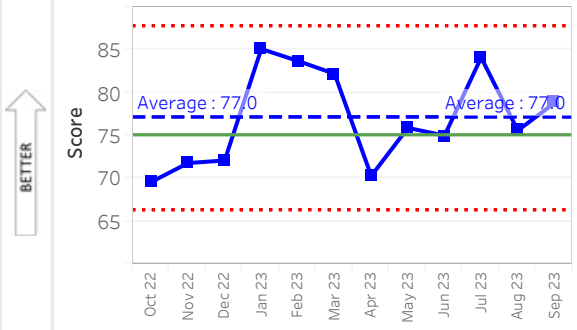
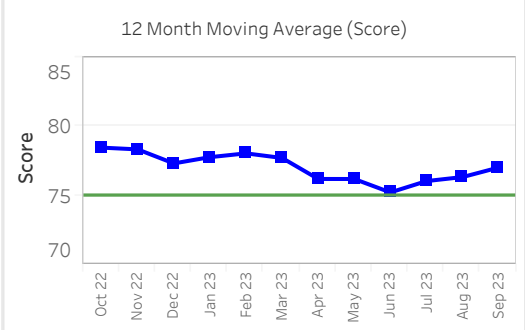
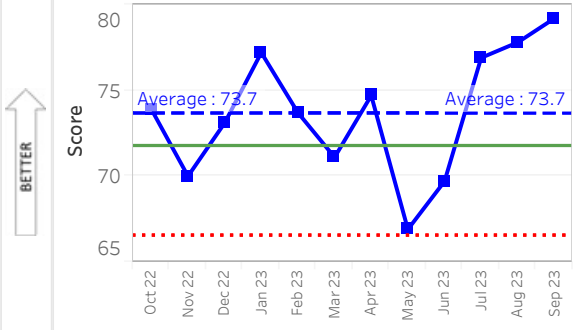
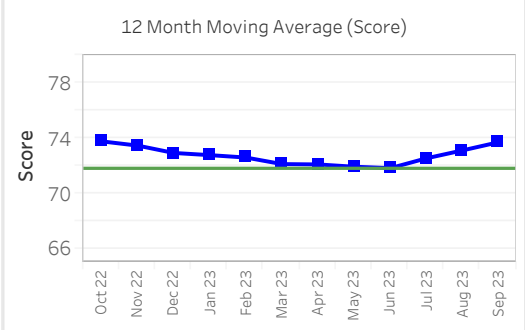
Quality Department | Note : updated as of October 23, 2023

El Camino Health

FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal IP Units - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	85.8	84.0	78.5	76.4		
IP MCH - HCAHPS Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	78.8	79.7	75.0	75.0		
ED Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	79.2	77.9	71.7	71.7		

Quality Department | Note : updated as of October 23, 2023

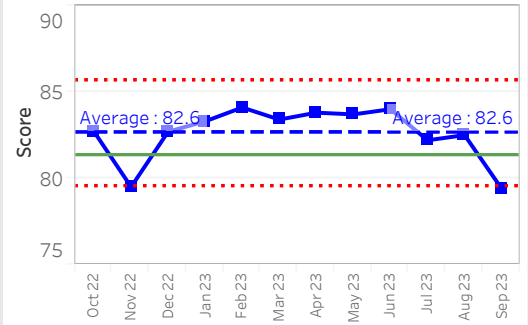
El Camino Health

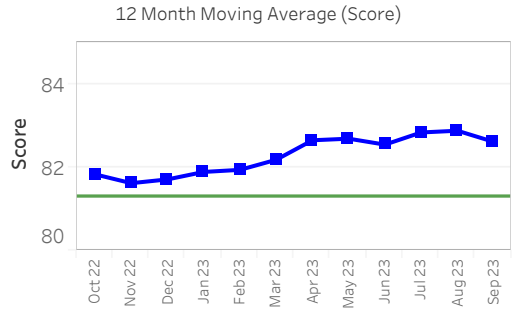
FY24 Enterprise Quality, Safety and Experience Dashboard

September 2023 (unless other specified)

Month to Board Quality Committee : November 2023

Measure	FY24 Performance		Baseline FY23 Actual	FY 24 Target	Trend	FYTD or Rolling 12 Month Average
	Latest Month	FYTD				
*Organizational Goal ECHMN (El Camino Health Medical Network) Likelihood to Recommend Top Box Rating of 'Yes, Definately Likely to Recommend' %, Adjusted Latest Month : September 2023	79.4	81.6	82.7	81.3	BETTER	BETTER





Quality Department | Note : updated as of October 23, 2023

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	FYTD
Safe Care	HAC Index 2.0 Score		1.364	1.805	1.458	1.140	1.453	**1.410**	1.180	**1.180**
	HAC Component: Cdiff Weighted (35%) Rate (per 10,000 Patient Days)		0.878	1.631	1.223	0.881	1.162	**1.128**	0.908	**0.908**
	HAC Component: CAUTI Weighted (*15%*) Rate (per 1,000 Urinary Catheter Days)		0.081	0.097	0.131	0.106	0.103	**0.100**	0.214	**0.214**
	HAC Component: CLABSI Weighted (15%) Rate (per 1,000 Central Line Days)		0.307	0.000	0.048	0.000	0.093	**0.090**	0.000	**0.000**
	HAC Component: nvHAP Weighted (*35%*) Rate (per 1000 Patient Days)		0.098	0.077	0.056	0.153	0.096	**0.093**	0.058	**0.058**
	SSI Rate (per 100 surgical procedures) *(not part of HAC Index)*		0.314	0.552	0.196	0.463	0.380	**0.369**	0.463	**0.463**
Timely	Lab STAT Troponin TAT for ER (received to verification)		93.8%	88.8%	70.9%	78.0%	82.7%	**90.0%**	84.2%	**84.2%**
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)		78.4%	78.3%	78.3%	77.0%	78.0%	**84.0%**	76.3%	**76.3%**
Effective	Risk Adjusted Readmissions Index		1.09	1.05	1.18	1.05	1.07	**1.00**	1.19* (July-Aug)	**1.19* (July-Aug)**
	Risk Adjusted Mortality Index		1.14	1.19	1.14	1.03	1.13	**1.00**	1.00	**1.00**
	Risk Adjusted Sepsis Mortality Index		1.15	1.26	1.37	1.02	1.21	**1.00**	1.08	**1.08**
	PC-02 NTSV C-Section		28.8%	24.7%	24.0%	30.2%	27.0%	**23.9%**	27.2%	**27.2%**
Efficient	Length of Stay O/E		1.19	1.16	1.22	1.19	1.19	**1.15**	1.19	**1.19**
	Median Time from ED Arrival to ED Departure (Enterprise)		176 min	168 min	169 min	165 min	170 min	**162 min**	184 min	**184 min**
Equitable	Homeless Discharge Documentation Compliance		----	'----	----	'----	----	**----**	N/A	**N/A**
	Quality Council Health Equity Item Included in PI efforts (% of depts)		----	----	----	----	----	**----**	0.0% (0/7)	**0.0% (0/7)**
	Sepsis Bundle Compliance by Race	Asian	----	----	----	----	----	**----**	72.7%* (July-Aug)	**72.7%* (July-Aug)**
	Sepsis Bundle Compliance by Race	Hispanic	----	----	----	----	----	**----**	87.5%* (July-Aug)	**87.5%* (July-Aug)**
	Sepsis Bundle Compliance by Race	White	----	----	----	----	----	**----**	90.2%* (July-Aug)	**90.2%* (July-Aug)**
	Sepsis Bundle Compliance by Race	Others	----	----	----	----	----	**----**	50.0%* (July-Aug)	**50.0%* (July-Aug)**
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend		79.9	78.8	76.6	78.4	78.5	**76.4**	84.0	**84.0**
	ED - Likelihood to Recommend (PG)		70.3	72.3	73.8	70.4	71.7	**71.7**	77.9	**77.9**
	MCH - HCAHPS Likelihood to Recommend		72.3	72.1	83.7	74.0	75.0	**75.0**	79.7	**79.7**

Updated: 10/23/23

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 Hospital Data Registries – March 2023 Attachment E

#	Registry	Agency	Content	Focus (Measures)	Subject Matter Expert (SME)	Submission Interval
1	CathPCI Registry®	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the characteristics, treatments and outcomes of cardiac disease patients who receive diagnostic catheterization and/or percutaneous coronary intervention (PCI) procedures	Indication (appropriateness): Patients WITHOUT Acute Coronary Syndrome: Proportion of evaluated PCI procedures that were inappropriate. Process: Proportion of STEMI patients receiving immediate PCI w/in 90' . Outcome: PCI in-hospital risk adjusted mortality (all patients); Composite: Proportion of PCI patients with death, emergency CABG, stroke or repeat target vessel revascularization; PCI in-hospital risk adjusted rate of bleeding events (all	HVI	Quarterly
2	Chest Pain-MI Registry®–(old ACTION)	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Risk-adjusted, outcomes-based quality improvement program that focuses exclusively on high-risk STEMI/NSTEMI patients AMI process and patient care	AMI/ACS process performance: Overall AMI performance composite; STEMI performance composite; NSTEMI performance composite	HVI	Quarterly
3	STS/ACC TVT RegistryTM	STS (Society of Thoracic Surgeons) ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Monitors patient safety and real-world outcomes related to transcatheter valve replacement and repair procedures – emerging treatments for valve disease patients. With 30day and 1 year follow-up	Process: Length of Stay (TAVR & MitraClip)– Median Post Procedure (days) and outcome (TAVR & MitraClip): In Hospital, 30 day observed and 3-year risk adjusted mortality. Risk adjusted Stroke rate	HVI	Quarterly
4	LAAO RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	CMS-mandated Registry. Captures data on left atrial appendage occlusion (LAAO) procedures to assess real-world procedural outcomes, short and long-term safety, comparative effectiveness and cost effectiveness.	Process: Proportion of patients undergoing a LAAO procedure per CMS indications; Proportion of LAAO procedures successful and medication stredegy and outcome: Proportion of patients with a major complication either intra or post procedure and prior to discharge	HVI	Quarterly
5	AFib Ablation RegistryTM	ACC®(American College of Cardiology) NCDR® (National Cardiovascular Data Registries)	Assesses the prevalence, demographics, acute management and outcomes of patients undergoing atrial fibrillation (AFib) catheter ablation procedures.	Process: Proportion of patients undergoing procedure per indications; and outcome: complication rate	HVI	Quarterly
76	STS®- Adult cardiac Surgery	STS (Society of Thoracic Surgeons)	National quality measures and quality improvements with more than 5.8 million records.	Risk adjusted Mortality for isoCABG, isoAVR and MV procedures. Composite quality rating (star rating) for isoCABG, isoAVR and MV procedures	HVI	Quarterly
7	Centers for Medicare & Medicaid Services (CMS) Hospital IQR program	IBM Watson	CMS Required eCQM Core Measures	Quality indicators	Quality	Quarterly
8	National Healthcare Safety Network (NHSN)	CDC, CALNOC, CDPH, Leapfrog	Quality Measures, CDC's data registry for infection data	Quality indicators: Patient Safety Module: SSI Surveillance on 29 ICD10s Facwide/IRF Surveillance: MDRO's: CDIF; MRSA; CRE; VRE Device Associated Surveliace: CLABSI, CAUTI, CLIP Compliance Bundle Healthcare Personnel Safety Module: HCP	Quality; Nursing EW&HS	monthly Yearly
9	Metabolic and Bariatric Surgery Quality Improvement Program (MBSAQIP)	American College of Surgeons	Nationwide accreditation and quality improvement program for metabolic and bariatric surgery. MBSAQIP centers are accredited in accordance with nationally recognized MBS standards.	Risk adjusted, mortality and complication based on 30-day, 6 month, and 1 year follow-up. Follow-up extends through 5 years.	Quality	Rolling continuous data abstraction
10	National Stroke Registry	Get with the Guidelines (GWTG)	Nationally all Primary Stroke Centers report data for comparisons	Quality Indicators	Quality; Neuro	Quarterly
11	EMS Quality Committee	Santa Clara County	Key Stroke data submitted by all county hospitals	Quality indicators	Quality; Neuro	quarterly
12	The Joint Commission Disease Specific Certification Primary Stroke	The Joint Commission	Recertification as a Primary Stroke Center		Quality; Neuro	PRN
13	Association for Behavioral Healthcare	AABH	Outpatient behavioral Health	Patient satisfaction	Behavioral Health	Quarterly
14	BASIS 24 BASC-3	MacLean	Outcomes behavioral Health	Outcomes	Behavioral Health	rolling submission
15	California Maternity Quality Care Collaborative (CMQCC)	Hospital Collaborative	Outcomes Obstetric; California Quality Maternal Child Collaborative (maternal and neonatal data)	Outcomes	Obstetrics	Monthly
16	California Perinatal Quality Care Collaborative (CPQCC)	Hospital Collaborative	Neonatal Outcomes	Outcomes	Neonatal	Monthly

17	California Alliance for Nursing Outcomes	CALNOC	Actionable information and reearch on nursing sensitive quality indicators	Nursing indicators	Nursing	Quarterly
18	National Database of Nursing Quality Indicators	NDNQI	National data base that provides quarterly and annual reporting of structure, process and outcome indicators to evaluate nursing care at the unit leel	Nursing indicators	Nursing	Quarterly
19	American Joint Replacement Registry	American Association of Orthopedic Surgeons	Hip and Knee Replacement Case Profile data, Risk Assessment data, and Outcomes data	Case data including implants, comorbidities, hospital complications. Patient reported outcomes Survey data fro HOOS JR, KOOS JR, and PROMIS-10	Ortho Director	Rolling submission with PRO data drawn quarterly
20	The Joint Commission - Disease-Specific Certification for Total Joints, Hip Fracture, Spinal Fusion	The Joint Commission	Disease-specific (Total Joint, Hip Fracture, Spinal Fusion)		Ortho	Every two years
21	CCORP	CA state OSHA	California state mandated, any adult cardiac surgery related to CABG	Outcome (part of STS) risk adjusted mortality and stroke rate. Comparison with all other CA hospitals	HVI	biannually
22	Santa Clara County-AMI and Cardiac Arrest	Santa Clara County	Santa Clara county mandated. AMI and cardiac arrest patient	EMS process and outcome. Biannually County meeting	HVI	Quarterly
23	National Cancer Data Base/RCRS	American College of Surgeons and the American Cancer Society	Information on patients with malignant neoplastic diseases, their treatments, and outcomes. Data submitted for accreditation application and used for quality benchmarking	Outcomes	Cancer Registry	Monthly and Annually
24	State Registry/SEER	CA Cancer Registry	California state mandated, any reportable cancer cases.	New cancer cases	Cancer Registry	Monthly
25	HCAHPS	Press Ganey	Patient satisfaction survey required by CMS	Patient satisfaction	Patient Experience	2X a week Mon and Thurs
26	Hospital Based Inpatient Psychiatrics Services Core Measures, Hospital IQR program	CMS	HBIPS is just one set of core measures for TJC and CMS	Psychiatric clinical measures	Quality	Quarterly
27	MIRCal for inpatient, emergency room and ambulatory surgery coded data	Office of Statewide Health Planning and Development (OSHPD)	OSHPD state mandated report for IP, ED and AD coded cases on semiannual and quarterly basis.	Data statistics for coded/reported diagnoses, procedures and associated charges.	HIMS Coding	Semiannual for inpatient data and quarterly for ED and ambulatory data
28	Parkinsons Registry	California Department of Public Health	CPDR captures and stores informatin on all Parkinson's disease cases dagnosed or receiving treatment in California. The informaton is used to expand the understanding of Parkinson's disease to ultmately imporove thel lives of those affected.	The prohect is not a study, the enhanced data and informaiton available to better prevent, diagnose and treat Parkinson's disease.	IT Business Applications	Every month
29	Quarterly Tracking of Birth Defects - Neural Tube Defects and Chromosomal Abnormalities	California Department of Public Health Genetic Disease Screening Program	Coded cases for neural tube defects and/or chromosomal abnormalities found in fetus or infants less than one year of age.	Identifying fetus or infants less than one year with neural tube defects for clinical research.	HIMS Coding	Quarterly
30	ICAEl certification	Intersocietal Accreditation Commission	Adult Echocardiography facility standard and guidelines	Ongoing practice requirements: volume, experience, staff educations	HVI?	yearly

31	VQI (Vascular Quality Initiative)	VQI (Vascular Quality Initiative) is a collaboration of the Society of Vascular Surgery	Demographic, clinical, procedural and outcomes data for Carotid Endaarterectomy, Endovascular AAA repair and Peripheral Vascular Intervention procedures	Quality and outcome benchmarks including risk adjusted mortality with follow-up	HVI	Biannually
32	Transcatheter Valve Center Certification	American College of Cardiology	Provides external review that assists hospitals in meeting standards for multidisciplinary teams, formalized training, and shared decision-making with a focus on TVT Registry metrics and outcomes.	Process and Quality: In-Hospital, 30 day, and 1 year mortality and/or readmission, stroke rate, and bi-monthly M&M	HVI	Weekly, Quarterly, and Annual submissions
33	American Heart Association (AHA) Resuscitation Registry	Get with the Guidelines (GWTG)	GWTG-Resuscitation facilitates the efficient capture, analysis and reporting of data that empowers and supports the implementation of current guidelines, creation and dissemination of new knowledge, and development of next generation, evidence-based practice in resuscitation science.	Resuscitation Services Quality Indicators	Quality	Quarterly

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2023 REPORTING PERIOD ATTACHMENT F

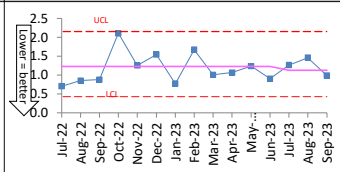
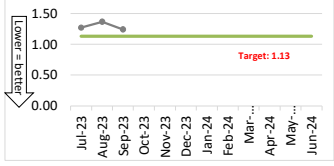
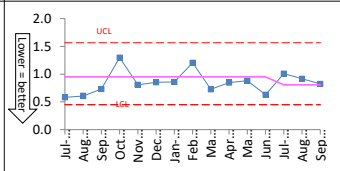
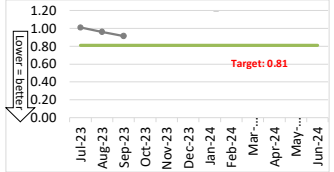
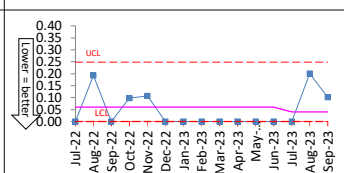
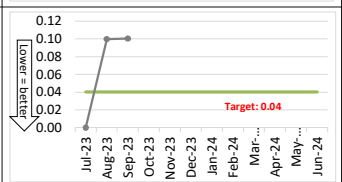
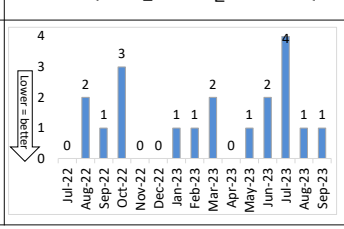
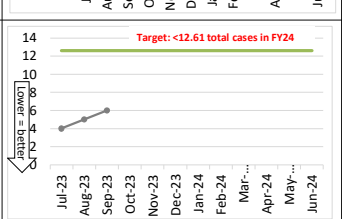
Indicator Name	Indicator Description	Regulatory/Accreditation source
Chart-Abstracted Clinical Core Measures **Hospital Inpatient and Outpatient:** * Measures Required to Meet Hospital IQR Program APU Requirements		
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients	Hospital Outpatient Quality Reporting (OQR) Program
OP-23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke	
PCB-05	Exclusive Breast Milk Feeding	TJC ORYX Performance Measurement Program
PCB-06.0	Unexpected Complications in Term Newborns - Overall Rate	
PCB-06.1	Unexpected Complications in Term Newborns - Severe Rate	
PCB-06.2	Unexpected Complications in Term Newborns - Moderate Rate	
PCM-02a	Cesarean Birth	
PCM-01 *	Elective Delivery	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
SEP-1*	Early Management Bundle	Hospital Inpatient Quality Reporting (IQR) Program
SEP-3T	Sepsis Treatment 3-Hour Window	
SEP-6T	Sepsis Treatment 6-Hour Window	
SHK-3T	Septic Shock Treatment 3-Hour Window	
SHK-6T	Septic Shock Treatment 6-Hour Window	
HBIPS – Hospital-based Inpatient Psychiatric Services		
IMM-2	Influenza Immunization	TJC ORYX Performance Measurement Program
HBIPS-2	Physical Restraint	
HBIPS-3	Seclusion	
HBIPS-5a	Multiple Antipsychotic Medications at Discharge with Appropriate Justification- Overall Rate	
SUB-2	Alcohol Use Brief Intervention Provided or Offered	
SUB-2a	Alcohol Use Brief Intervention	
SUB-3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	
SUB-3a	Alcohol and Other Drug Use Disorder Treatment	
TOB-2	Tobacco Use Treatment Provided or Offered	
TOB-2a	Tobacco Use Treatment	
TOB-3	Tobacco Use Treatment Provided or Offered at Discharge	
TOB-3a	Tobacco Use Treatment at Discharge	

EXTERNAL REGULATORY COMPLIANCE INDICATORS/MEASURES FOR CY 2022 REPORTING PERIOD ATTACHMENT G

2022 Electronic Clinical Quality Measures (eCQM): Requirement includes three self-selected eCQMs and the Safe Use of Opioids measure for three self-selected quarters. Name and description:	**Regulatory/Accreditation source**
eVTE-1 Venous Thromboembolism Prophylaxis	Hospital Inpatient Quality Reporting (IQR) Program and TJC ORYX Performance Measurement Program
eVTE-2 Intensive Care Unit Venous Thromboembolism Prophylaxis	
eSTK-2 Discharged on Antithrombotic Therapy	
eSTK-3 Anticoagulation Therapy	
eSTK-5 Antithrombotic Therapy by the End of Hospital Day Two	
eSTK-6 Discharged on Statin Medication	
ePC-05 Exclusive Breast Milk Feeding	
eED-2 Admit Decision Time to ED Departure-Admit	
eOPI-1 Safe Use of Opioids	

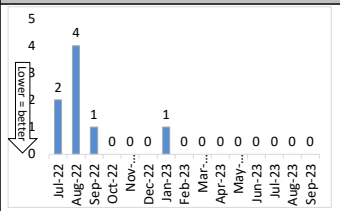
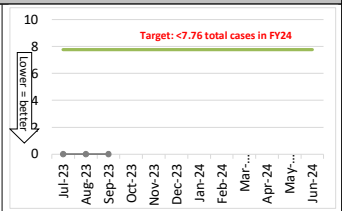
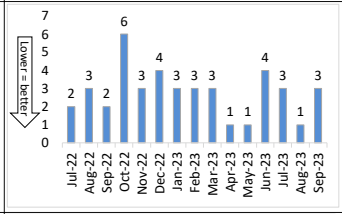
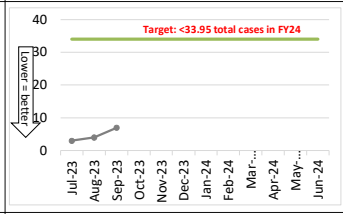
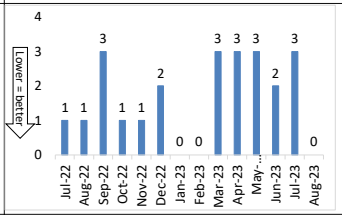
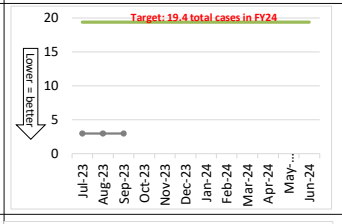
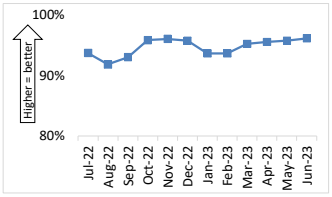
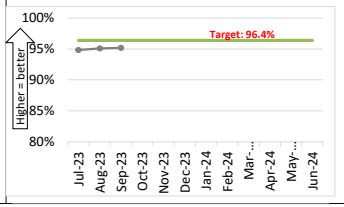
El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
1	**IP Units area Patient Falls Reported to NDNQI** *per 1000 Patient Days (NDNQI reported)* *excludes ED, L&D, and intentional falls (ED rate calculated separately)* **Reporting Period:July - Sept 23**	1.24 (38/30637)	1.24 (38/30637)	1.17 143/122613	1.13 (139 Falls) (3%↓)			FY24 new metrics: 1.13: (139 Falls) 3% reduction.	Andria Mills
2	**All Patient Falls - Internal (ECH licensed facilities)** *All patient falls per 1000 Adjusted Patient Days (EPSI Report)* **Reporting Period:July - Sept 23**	0.92 (53/57855)	0.92 (53/57855)	0.84 194/231502	0.81 (188 Falls) (3%↓)			FY24 new metrics: 0.81: (188 Falls) 3% reduction	Andria Mills
3	**Stage 3, Stage 4 and Unstageable Hospital Acquired Pressure Injury (HAPI) Rate** (excludes skin failure and expired pts) *per 1000 Total Patient days* **Reporting Period:July - Sept 23**	0.10 (3/29895)	0.10 (3/29895)	0.04 4/100605	>= 0.04			FY24 new metrics: >=0.04	Anna Aquino
4	**HAC component** Catheter Associated Urinary Tract Infection **(CAUTI)** **Reporting Period:July - Sept 23**	6	6	13 (1.08/mo.)	12.61 (1.05/mo.) (3%↓)			FY24 new metrics: 12.61 total cases in FY24 (3% reduction of cases)	Catherine Nalesnik

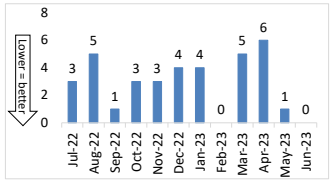
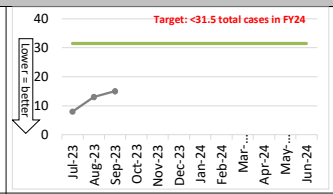
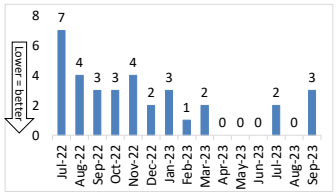
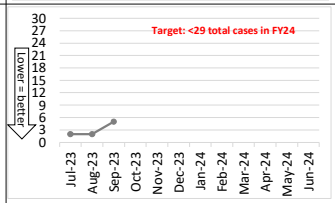
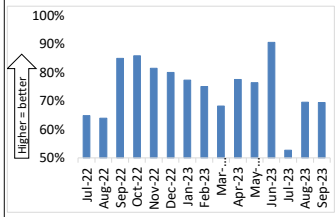
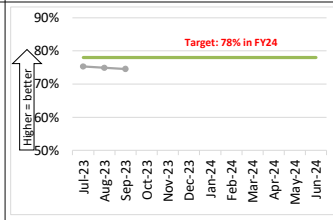
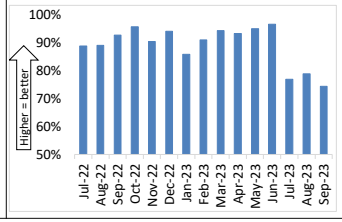
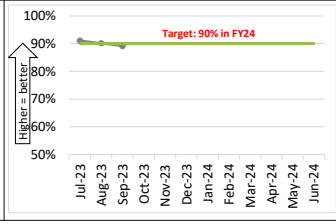
El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
5	**HAC component** Central Line Associated Blood Stream Infection **(CLABSI)** **Reporting Period:July - Sept 23**	0	0	8 (0.67/mo.)	7.76 (0.65/mo.) (3%↓)			FY24 new metrics: 7.76 total cases in FY24 (3% reduction of cases)	Catherine Nalesnik
6	**HAC component** Clostridium Difficile Infections **(C-Diff)** **Reporting Period:July - Sept 23**	7	7	35 (2.92/mo.)	33.95 (2.83/mo.) (3%↓)			FY24 new metrics: 33.95 total cases (3% reduction of cases)	Catherine Nalesnik
7	**HAC component** **Non-ventilator Hospital-Acquired Pneumonia** *(nvHAP)* **Reporting Period: July - Sept 2023**	3	3	20 (1.67/mo.)	19.4 (1.62/mo.) (3%↓)			FY24 new metrics: 19.4 total cases (3% reduction of cases)	
8	**Blood Transfusion Completed** within 4hrs of Issue Time % **Reporting Period:July - Sept 23**	95%	95%	95.8%	↑96.4%			FY24 new metrics: The FY2024 will be over 96.4% (2% improvement from Avg. of FY 2023: 94.6%)	Jeong Chae

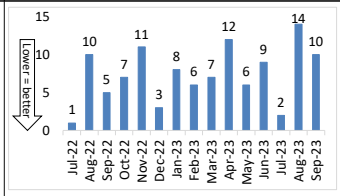
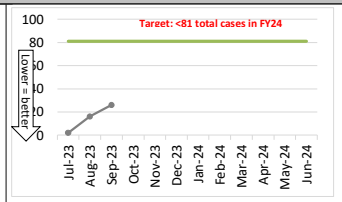
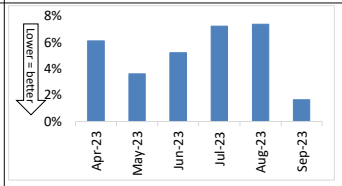
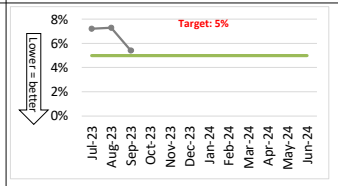
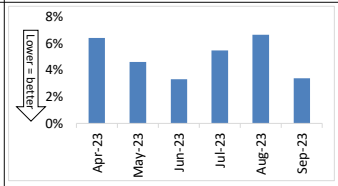
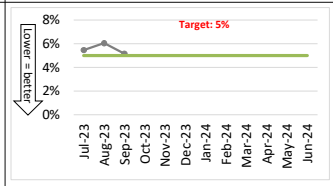
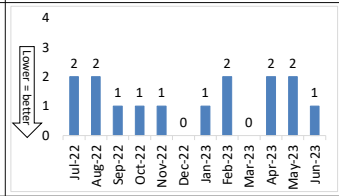
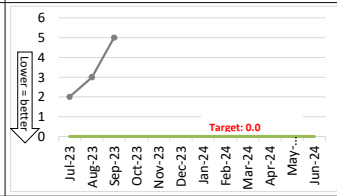
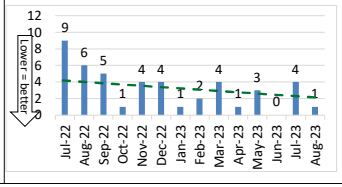
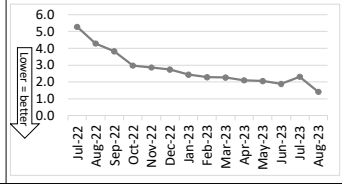
El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
9	**Number of employee Bloodborne Pathogen Exposures (BBPE).** Reporting Period:July - Sept 23	15	15	35 (2.92/mo)	31.5 (2.63/mo.) (10% ↓ from FY23)			FY24 new metrics: The FY2024 will be 31.5 (10% decrease from Avg. of FY 2023: 35)	Michael Rea
10	**Employee Safety: # of Workplace Violence OSHA Reportable Incidents** *# of incidents* Reporting Period:July - Sept 23	5	5	31 (2.58/ mo)	29 (2.42/mo.) (6.4% ↓ from FY23)			FY24 new metrics: new target would be less than 29 or 6.4 %.	Matthew S.
11a	**Hand Hygiene Compliance (Entry) %** Reporting Period:July - Sept 23	66.3% 2649/3996	66.3% 2649/3996	Entry: 76%	Entry: 78%			Hand Hygiene at entry improves FY 23 from 76% to FY 24 to 78%	Lynn Garrett
11b	**Hand Hygiene Compliance (Exit) %** Reporting Period:July - Sept 23	72.5% 3291/4309	72.5% 3291/4309	Exit: 90%	Exit: 90%			Hand Hygiene at exits is consistent at 90% (FY 23 ended at 91%)	Lynn Garrett

El Camino Health

FY24 Q1 Patient and Employee Safety Dashboard

	Safety Metrics	Performance: FY24 Q1	Performance: FY24: FYTD	Baseline: FY23 Actual	Target: FY24 Target/ Goal	Trend	FYTD or 12-month Rolling Average Rate	Comments	Data Owner
						Displaying at least the last 12 months of available data			
12	**Medication Safety:** Medication Errors involving High Risk High Alert Medications **Reporting Period:July - Sept 23**	26	26	85 (7.08/mo)	81 (5%↓ 6.75/mo.)			FY24 new metrics: 5% reduction is 4.	Poopak Barirani
13	**Lab Safety:** Phleb + RN Draws # of Recollected due to Clotted Samples). **Reporting Period:July - Sept 23**	6.04% 33/546	6.04% 33/546	5.5%	<5% of lab draws			FY24 new metrics: <5% of draws in the NICU being recollected due to clotting (Phleb + Lab Combine)	John Mercado
14	**Lab Safety:** Phleb + RN # of Draws in NICU by Lab Staff (MV). **Reporting Period:July - Sept 23**	5.3% 21/397	5.3% 21/397	5.5%	<5% of lab draws			FY24 new metrics: <5% of draws in the NICU being recollected due to clotting (Phleb + Lab Combine)	John Mercado
15	**Never Events Reported to CDPH Rate** (includes expired patients) *per 1000 Adjusted Patient Days* **Reporting period: July - Sept 23**	5	5	15 (1.25/mo.)	0.0				Heidi Yamat
16	**Serious Safety Event Rate (SSER)** # of events/ FYTD = rolling 12 month per 10,000 Acute Adjusted Patient Days *Rate* **Reporting period: July - Sept 23**	5 *as of Aug 23	5 *as of Aug 23	1.21 40/329416					Sheetal Shah

Safety First / Mission Zero:
Our High Reliability Leader Toolkit

At El Camino Health, we are committed to eliminating preventable harm to patients, visitors, employees and medical staff. To achieve our goal of providing consistently safe and error-free care, we will lead the way to extending Safety First/Mission Zero behaviors and tools to every action, both strategic and tactical, from the front line to the executive level.

Leader Skills	Leader Methods
Living the Safety Message	• Start every meeting with a safety message • Put safety first in decision making • Protect those who speak up for safety
Leading Safe and Reliable Operations	• Tiered daily safety huddles • Top 10 safety list • Real-time simulation and testing
Building Engagement and Accountability	• 4 Cs to influence • 5:1 feedback • Fair and just culture
Finding Problems and Fixing Causes Together	• Learning boards • Apparent cause analysis • Sharing lessons learned

Universal Skills Toolkit

I commit to Safety First/Mission Zero behaviors and tools for our patients, families, visitors and colleagues.

S **Speak Up for Safety**	• Share safety concerns with your team. • Immediately notify chain of command about patient and/or workforce harm events. • Speak up using **ARCC:** **A**sk a question. **R**equest an alternative. Voice a **C**oncern: "I have a safety concern." If necessary, escalate through **C**hain of command. • Report safety concerns in appropriate **electronic reporting system**.
A **Accurate Communication**	• Communicate concerns using **SBAR**: **S**ituation – Give a brief statement of the problem. **B**ackground – Share a concise overview of the facts. **A**ssessment – Summarize relevant observations. **R**ecommendation – Provide your suggestion for addressing the situation. • Communicate using **Three-Way Repeat and Read Back**. • Use **letter and number clarification**.
F **Focus on the Task**	• Pay attention to detail, minimize distractions. • Do self checks using **STAR**: **S**top – Pause for a moment to focus your attention on the task at hand. **T**hink – Consider the action you are about to take. **A**ct – Concentrate and carry out the task. **R**eview – Check to make sure that the task was done correctly.
E **Embrace a Questioning Attitude**	• Use **Clarifying Questions** to understand next steps. • Use **QVV** technique when you interpret information. **Q**ualify – Ask yourself if this is a good source of information. **V**alidate – Ask yourself if the information makes sense. **V**erify – If the answers to the above questions are no, check with an expert or known reference before proceeding.
T **Take Thoughtful Action**	• Have procedures in hand for high risk/complex/infrequent tasks so you can easily check what to do and ensure it is done right (**Continuous Use** • Know how to locate your reference materials such as policies, procedures and guidelines, and use when unsure of how to proceed (**Reference Use**). • Use **SORT** technique for problem solving when there is no policy or procedure for guidance. **S**tatement – What is the problem or goal? **O**ptions – What are the possible solutions? Consider consulting with experts or literature. **R**ule Out – Eliminate the improbable or impractical to select the best option. **T**ake Action and Test – Implement the selected option, check if desired result was achieved.
Y **You and Me Together**	• Use **Cross Check** and provide on the spot second opinions. • Use the **Five Tones** in all interactions. Smile and greet others (say hello). Introduce yourself using your preferred name and explain your role. Listen with empathy and an intent to understand. Communicate the positive intent of your actions. Provide opportunities for others to ask questions.

El Camino Health

Safety Event Decision Algorithm

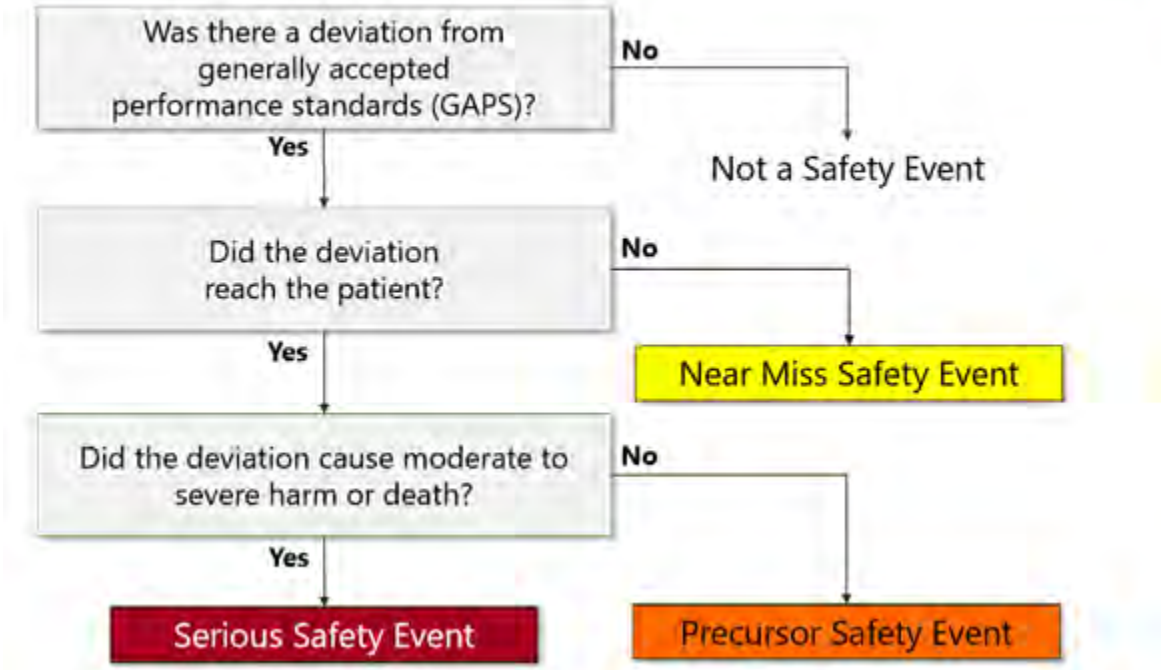


Table 1. HPI SEC Levels of Harm

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch

A14b. Board Officer Elections Procedure (Revised)

El Camino Health

HOSPITAL BOARD OFFICERS
NOMINATION AND SELECTION PROCEDURES
FOR FY24

Approved 05/11/2022

Any current Director of the El Camino Hospital Board is eligible to serve as a Hospital Board Officer. The new Hospital Board Officer terms begin the 1st day of July. El Camino Hospital Board Officer elections shall be held in June annually (if needed). Following the election, it shall be the role of the Board Chair-Elect to work with the Hospital CEO in May and June to develop a slate of Board Advisory Committee Chairs and members for the following fiscal year and to present the slate to the Board for approval in June.

Hospital Board Chair:

1. Interested Directors will declare their interest to the CEO or designee by no later than the 1st day of April. If requested by the CEO, interested Directors will prepare a one-page Position Statement that summarizes the candidate's interest and relevant experience as it relates to the attached Hospital Board Chair competencies, no later than the 15th day of April.

2. Position Statements will be distributed to Board members along with other routine Hospital Board materials one week in advance of the June meeting.

3. Position Statements will be made available to the public and posted on the El Camino Hospital web-site when the Hospital Board materials are issued to the Board.

4. Standard questions for Hospital Board Chair:

    a. What do you see as the ECH strategic priorities over the coming two years?
    b. Name three defining roles of an effective Board Chair.
    c. How would you judge the success of your leadership and the Board at the end of your term?

5. At the June meeting, interested Directors will present the information below, in public session, in the sequence outlined. Approximately 25 minutes will be allocated to each interested Director: five (5) minutes for the Position Statement, ten (10) minutes for responses to standard questions, and (10) ten minutes to respond to general questions from the board and public:

    a. Each interested Director will read his or her Position Statement
    b. Each interested Director will provide responses to the standard questions. (Directors will present one question at a time in random order.)
    c. The Public will be invited to ask interested Directors any questions related to the candidate's interest in the position, and relevant experience as it relates to the Hospital Board Chair competencies
    d. The Board will be invited to ask interested Directors any additional questions related to an interested Director's candidacy.

6. Upon review and discussion of the candidates, the Board will vote in public session. The current Chair will facilitate the discussion and voting process.

7. The Hospital Board Chair will be elected by the Board in accordance with the following procedure at a meeting where a quorum is present.

    a. Preliminary Balloting

        i. Each Board member shall vote for a candidate via electronic submission or paper ballot simultaneously to a neutral party who will announce the vote cast by each Director.
        ii. In the event a majority is not achieved, the vote will be announced for each candidate and the candidate receiving the lowest number of votes will be dropped from the next ballot.
        iii. This procedure will continue until one candidate receives a majority of the votes cast.
        iv. In the event a tie vote occurs (e.g., 3-3 or 4-2-2), interested Directors may be asked additional questions by Hospital Board members and the balloting procedure will continue until a majority is achieved by one candidate.

    b. Selection of a Board Chair

        i. Following the preliminary balloting, the Board shall consider a motion to elect the candidate who has received the majority of the votes in his/her favor.
        ii. If a motion pursuant to Section 7(b)(i) is not adopted by a majority of the Board members present at the meeting when a quorum is present, the Board shall continue to consider motions until a Board Chair is elected.

Hospital Vice-Chair:

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

4. The Vice Chair is the presumptive Chair at the end of the current Chair's term.

Hospital Secretary/Treasurer:

1. At the June Hospital Board meeting, Interested Directors will announce their candidacy and/or nominations taken from the floor following the successful election of the Hospital Board Chair and the Hospital Vice-Chair.

2. Interested Directors will be asked questions, which relate to the candidate's experience, by other Hospital Board members in public session.

3. Voting will follow the same procedure as described in the Hospital Board Chair selection and appointment process above.

A15a. Spotlight Interview Update_ El Camino Health

SPOTLIGHT INTERVIEW

Spotlight Interview Update: El Camino Health

Evy Nitzany, MS, RCES, EP/IR Program Manager, Interventional Services

April 2024

EP LAB DIGEST. 2024;24(4):1,14-17.

When was the electrophysiology (EP) program started, and by whom?

The EP program was started in July 2008 when Bing Liem, MD, joined El Camino Health. With decades of experience as a Stanford EP attending, Dr Liem was instrumental in championing and developing this program throughout its infancy.

What drove the need to implement an EP program?

El Camino Health was assuming leadership in health care in the region, hence the need to provide comprehensive service for the community. Prior to starting this program, patients were transferred to regional academic centers if they required an ablation.

What is the size of your EP facility?

We currently have 2 dedicated EP rooms. One of these rooms has undergone renovation, while the other is in the process. After completion, both rooms will have all EP equipment hardwired on booms. The size of each laboratory is 600 square feet. Our total square footage after renovation will not increase but will be reformatted for optimal space to allow for current and future technologies.

Who manages your EP laboratory, and what is the mix of credentials and experience?

Evy Nitzany has been the EP program manager for the past 8 years. Our EP medical director is Shaun Cho, MD. Our trained staff have a mixture of credentials including registered technologist (RT), cardiac interventional (CI) technologist, vascular interventional (VI) technologist, registered nurse (RN), critical care registered nurse (CCRN), registered cardiovascular invasive specialist (RCIS), registered cardiac electrophysiology specialist (RCES), and certified electrophysiology specialist (CEPS). Experience varies from 0-25 years.

What is the number of staff members?

Our EP laboratory is unique in the sense that we are part of a larger catheterization laboratory that performs diverse procedures across multiple modalities (cardiac catheterization, structural, EP, neuro, interventional radiology [IR], peripheral, etc). We require staff to rotate through all service lines (including EP) and function at a basic level, which entails scrubbing, monitoring, and circulating. The total number of staff who rotate through these rooms is approximately 40. However, staff have the option to train at a higher level in EP, which consists of connecting EP equipment, troubleshooting, and operating the GE recording system and stimulator throughout ablation procedures. This core group of trained individuals currently stands at 10 clinical staff members.

What types of procedures are performed at your facility?

We perform a wide range of EP ablations and cardiac rhythm management procedures. Our 6 operators perform ablations for paroxysmal, persistent, longstanding persistent atrial fibrillation (AF), convergent AF, atrial tachycardia, accessory pathways, atrioventricular nodal reentrant tachycardia, typical/atypical flutter, atrioventricular junction, idiopathic/ischemic ventricular tachycardia (VT), EP studies, and VT induction studies. Our operators also perform implants and generator changes for pacemakers, implantable cardioverter-defibrillators (ICDs), subcutaneous ICDs (S-ICDs), cardiac resynchronization therapy devices, leadless pacemakers, implantable loop recorders, conduction system pacing, and laser and mechanical lead extraction. The only procedure that is not performed at El Camino Health is epicardial VT ablation.

Figure 1. El Camino Health Cath Lab Staff. Top row, from left to right: Yen Lu, RN; Jeanette Johnson, RT; Judy Li, RN; Natali Inboden, RN; Ycienne Jimeno, RN; Holly Butler, RN; SarahMarie Neves, RN; Ian Young, RN; Shawn Arias, RN; Joanne Turner, RN; Marsha Van Loon, RN. Middle row (L to R): Sy Phichith, RN; Arjay Salas, RN; Frank Trinidad, RT; Anthony Nguyen, RN; James Gregg, RT; Angela Hudson, RN; Justin Stanich, RT; Shane Ballance, RN; Matthew Landaiche, RN; Alma Trinh, RT; Jeremy Miller, RT; Wendy N Bertling, RT; Jennifer Massey, RN; Bumshik Eom, RT. Bottom row (L to R): Mark Anthony Pangilinan, RN; Michael San Juan, RN; Martin Luzania, RT; Sian Merriott, RN, EP Program Coordinator, Heart and Vascular Institute; Rita Thomas, RN, Interventional Services Director; Evyatar Nitzany, EP/IR Program Manager; Haiyan Li, RN, Nursing Unit Coor-dinator; Annette West, RN; Trang Nguyen, RN.

Approximately how many catheter ablations, device implants, and lead extractions are performed each week?

On a weekly basis, we average 11.6 ablations, 10.8 device implants, 0.2 lead extractions, and 1.4 Watchman (Boston Scientific) device procedures.

What types of EP equipment are commonly used in the laboratory?

The mapping systems we currently use are the Carto 3 (Biosense Webster, Inc, a Johnson & Johnson company) and EnSite X (Abbott) systems. We use the CardioLab AltiX BT21 recording system (GE) and Micropace stimulator. We also have a CryoConsole Cardiac Cryoablation System (Medtronic) that we use for focal ablation. For radiofrequency (RF) ablation, we use the QDOT Micro (Biosense Webster), ThermoCool SmartTouch SF (Biosense Webster), and TactiFlex Ablation (Abbott) catheters. For diagnostic catheters, we use the Octaray (Biosense Webster), Optrell (Biosense Webster), and Advisor HD Grid mapping catheter, Sensor Enabled (Abbott). We use the Vivid S70 ultrasound machine (GE). The ultrasound catheters used with this system include the NuVision (Biosense Webster), Soundstar (Biosense Webster), and ACUSON AcuNav catheters (Biosense Webster).

What are some of the new technologies and techniques recently introduced in your laboratory? How have these changed the way procedures are performed?

Recently, our operators have switched to using the ensoETM (Attune Medical) esophageal cooling device during AF ablation. With this new device, we are constantly cooling the esophagus at 4º C and can focus on creating an uninterrupted contiguous lesion along the posterior wall in the left atrium (LA) without the worry of creating a thermal burn in the esophagus. This technology has significantly reduced procedural time for our AF ablations as well as reduced the likelihood of esophageal injury.

How is inventory managed in your EP laboratory?

We control our inventory through the WaveMark Solution (Cardinal Health), which is managed by 2 dedicated inventory coordinators. Under this system, which uses radiofrequency identification (RFID), all our supplies are automatically reordered as they are being scanned throughout procedures. The EP program manager and clinical staff work closely with the inventory coordinators to adjust periodic automatic replacement (PAR) levels based off usage to reduce any excess or expiring supplies found in the storage room.

Does your program have a device clinic?

We do not currently have a device clinic at the hospital. Most of our physicians are either independent practitioners or belong to physician groups and follow up with the patients in their respective clinics.

Tell us what a typical day is like in your EP laboratory.

A typical day would consist of both EP rooms running in conjunction with a mixture of ablation and device cases. We usually start the day with our more logistically complex cases that require more resources such as transesophageal echocardiogram (TEE)/anesthesia/operating room (OR) back. An example would be an AF ablation or laser lead extraction. As the day progresses, we move onto our less complex cases, such as atrial flutter ablations. Device cases typically fill the last portion of the day.

Can you describe the extent and use of vascular closure devices in your laboratory? Tell us about your approach for same-day discharge (SDD).

Our current approach for vascular closure is with the use of the Vascade closure device (Haemonetics). This device has provided us with great success in achieving rapid hemostasis with a low complication rate for our EP patients compared with our previous approach of manual compression.

Furthermore, this device has allowed for a shorter bed rest time, which greatly contributes to the comfort of our patients, especially those who have back problems or difficulty urinating while lying flat. Additionally, since patients are ambulating much sooner post procedure, many are able to be discharged the same day. Our SDD cases are elective and currently include some of our ablations, ICD/pacemaker device implants, and Watchman procedures. The physician will determine if the patient is a suitable candidate for SDD and the nursing staff will follow our SDD procedure, which includes nursing assessment requirements in place. Finally, patients who have SDD receive a follow-up phone call the next day.

Has your laboratory recently undergone a national accrediting inspection?

Yes, we have undergone national accreditation for our EP and cardiac catheterization laboratory through the American College of Cardiology. The completion of these 2 accreditations allowed us to achieve HeartCARE Center designation in August 2023. El Camino Health is currently one of only 4 hospitals in California to earn this distinction. As the first heart program in the Bay Area to achieve this recognition, it demonstrates that El Camino Health provides leading-edge cardiovascular care and superior results that are among the best of all area hospitals.
Obtaining this distinction was a year-long journey of learning, collaboration, and process enhancements between hospital departments, physicians, and administration.

How do you ensure timely case starts and patient turnover?

Staff document metrics such as in-room time, stick time, out of room time, and turnover time. Any delays are recorded as well. These metrics are reviewed monthly by management to ensure everything is functioning at an optimal level. If there are any consistent outliers, management performs a process improvement to resolve the issues. Turnover is always a work in progress, but we have reduced this time by having 2 environmental service workers help with turning over our 6 catheterization laboratory rooms. Also, a nurse and tech assist with turnover by pulling supplies or getting the next patient on the table and patched, keeping the daily flow on schedule.

How does your laboratory schedule team members for call?

Call time is based off a 4-week schedule and equally distributed among the clinic staff.

Do you have flexible or multiple shifts? How do you handle slow periods?

The majority of staff have 10-hour shifts from 7:00-5:30. After 5:30, there are 2 call teams for cardiac and IR. Generally, EP cases do not go beyond 5:30, but in the rare cases they do, one of the call teams will be assigned to complete the procedure.
During slow periods, staff is assigned different projects to help the department such as performing outdates on supplies, completing mandatory compliance modules, or education modules, etc.

How are vendor visits managed?

All vendors must be enrolled with Vendormate before they can be allowed into our facility. For vendors that clinically support our EP procedures, we inform them of the schedule the week prior to ensure they arrive for the appropriate cases. For sales reps who do not support procedures and are selling us new product, we have a policy that those supplies must undergo vetting by the value analysis committee prior to being sold in the hospital.

What are the best features of your EP laboratory's layout or design?

Evy Nitzany, MS, RCES, Electrophysiology and Interventional Radiology Program Manager, Interventional Services.

The best feature of our layout is that we have all our mapping system and EP equipment hardwired on booms in our EP laboratories. This convenience reduces the time required for rolling large pieces of equipment in and out of rooms; it also helps minimize any wear and tear on those machines.

What measures has your laboratory implemented to cut or contain costs?

The largest cost saver for our program has been through purchasing most of our disposables reprocessed through third-party companies. This has led to huge cost savings, equating to over a million dollars in annual savings. Furthermore, we are in the process of sterilizing some of our disposable cables in house, which will provide additional cost savings for our program. Another big cost saver for us was through entering service contract agreements with Biosense Webster, Abbott, and GE. Not only did this cover the cost of preventative maintenance and repair/replacement of faulty equipment, it also enabled us to get the latest hardware and software upgrades at no additional cost. This way, we could always stay at the cutting edge of technology while keeping costs low. Finally, we are members of the HealthTrust Performance Group, which has enabled us to contain costs by taking advantage of national contracts that have already been negotiated for all their members.

What quality control measures are practiced in your laboratory?

We have a radiation safety officer who oversees radiation exposure for staff and physicians. Also, we have an infection prevention workgroup that focuses on continuous improvement of the infection prevention processes. The group works closely with departmental management and has implemented several process changes, including correct site prep education, procedure room traffic management, and a surgical site infection prevention checklist that is completed prior to each device procedure requiring an incision. The checklist assists the team in tracking to ensure all the preprocedural prep, antibiotics, and correct prep techniques were used. The checklist also includes intraprocedural infection prevention steps such as irrigation prior to incision closure and if postprocedural aseptic dressing procedures were completed.
We also participate in the National Cardiovascular Data Registry (NCDR) AF Ablation Registry as well as other cardiovascular registries, which help us closely monitor procedural outcomes and benchmark against other facilities providing the same types of procedures.

Finally, another quality control measure we practice is biannual preventative maintenance on all our EP equipment. We work closely with clinical engineering and vendors to complete these tasks.

What works well for your laboratory for onboarding new team members?

Our EP education is divided into basic and advanced levels. We expect all staff members to function on a basic level to circulate or monitor if they are an RN and scrub alongside the physician if they are an RT. We group the trainee with a seasoned clinical staff member who will mentor them through their onboarding process in EP. This period also helps to solidify the workflow among our different operators and mapping systems. This process typically takes a minimum of 4-6 weeks before they can be signed off. For team members who have a strong grasp of the basic level in EP and want to further their skill level, we offer them the advanced level training, which is a structured approach. We start with connectology and basic troubleshooting of equipment while also having them shadow the more experienced core EP staff members who are operating the recording system and stimulator. We later progress to hands-on training of operating the stimulator and recording system for basic EP cases such as AF ablations. Over time, we get them involved in more challenging EP cases such as flutters to EP studies to supraventricular tachycardias to VTs. To further facilitate their foundation, we provide staff with didactic resources such as books, weekend classes hosted by vendors, and online EP courses through Springboard Healthcare.

What continuing education opportunities are provided for staff members?

Continuing education units provided to our core group in EP include online courses through Springboard Healthcare, classes hosted by vendors on weekends, conferences such as the Heart Rhythm Society's annual scientific sessions, and hospital education modules.

Discuss the role of mid-level practitioners in your laboratory.

The nurse practitioners (NPs) in our laboratory provide a huge service to both patients and physicians. Their main responsibilities include providing education to patients prior to admission to discuss the procedure and medications, as well as answering any questions after the case. They also help offset physician workload by entering the H&P, pre- and postoperative orders, and

discharge summaries into Epic. Furthermore, NPs round on the patients pre- and postprocedure as well as see patients in the outpatient clinic. Some of our NPs also perform cardioversions and answer triage/RN concerns from the cardiac unit to help alleviate time for physicians.

Shaun Cho, MD, FHRS, Cardiac Electrophysiology Medical Director, Norma Melchor Heart & Vascular Institute.

Share a memorable case from your EP laboratory and how it was addressed.

As a high-volume AF center, we frequently perform redo AF ablations, including atypical LA flutters. Circuits oftentimes are perimitral, which may pose certain challenges and limitations during endocardial ablation. In one such case, we struggled to achieve flutter termination despite extensive mitral isthmus ablation. The anterior approach (extending from the LA roof to the anterolateral mitral annulus) was unsuccessful, while a prominent distal coronary sinus (CS) limited the success of a traditional posterolateral line. Encouraged by emerging data and our early experience with vein of Marshall (VOM) ethanol ablation, we decided to attempt this technique for this atypical flutter. The CS and VOM were cannulated and the balloon inflated. Upon the first injection of 1 cc of ethanol, we noticed a significant slowing of the tachycardia cycle length by about 30 ms. After the second 1 cc injection, the tachycardia terminated, and the patient was back in sinus. This exemplified a clear epicardial connection for this perimitral flutter and the potential success this technique of ethanol ablation for the VOM may offer. Our physicians are innovative and dynamic in the sense that they are constantly looking to improve patient care by implementing new tools and techniques into their practice.

Tell us more about your use of a third party for reprocessing or catheter recycling. How has it impacted your laboratory?

The 2 companies we currently utilize for third-party reprocessing are Stryker and Sterilmed. Using these companies has positively impacted our laboratory, not only for appropriate disposing of EP cables and catheters that may otherwise end up in a landfill, but also in terms of cost containment. We have helped save the hospital over $1 million. With the platinum tips that these companies collect from our catheters, we earn an additional quarterly rebate.

Does your laboratory perform conduction system pacing?

Over the past year and a half, most of our operators have migrated towards conduction system pacing, specifically left bundle pacing, which seems to be the dominant alternative to right ventricular pacing. Although there is still a lot of data to be collected regarding this new approach, the outcomes seem positive for the patients who are experiencing stable/improved ejection fraction as well as a reduction in cardiomyopathy.

Tell us about your primary approach for left atrial appendage occlusion (LAAO).

Focus on stroke risk mitigation is a priority for our AF patients. Nearly all AF patients with CHA2DS2-VASc scores >2 are considered to be LAAO candidates if there are any safety issues or other compliance barriers to long-term anticoagulation. We have traditionally chosen the Watchman FLX (Boston Scientific) as our default strategy for these patients. Select patients for whom the LAA anatomy is deemed unsuitable are offered the Amulet (Abbott). Intraprocedural imaging has been one of the strengths lending to our success. Our team includes a dedicated cardiologist with expansive experience providing expert TEE imaging throughout the procedure. This has catalyzed our move away from preprocedural imaging, minimizing extra visits and exposure, and improving the patient experience, which has been meaningful in the wake of the COVID-19 pandemic. We have also continued to evolve in this regard by introducing emerging techniques including intracardiac echocardiography (ICE) and 4-dimensional ICE.

Does your program have a dedicated AF clinic and/or a dedicated lead extraction program?

As a community hospital, El Camino Health does not employ their own physicians; instead, doctors are mostly part of larger group practices such as Palo Alto Medical Foundation. There is no need currently to have an AF clinic at our hospital since the patients are seen in the clinics belonging to these larger group practices.

With <10 cases annually, we do not have a dedicated lead extraction program; however, our proximity to the OR and the availability of their staff has made it very suitable to perform complex cases that require OR backup. Our physicians perform both laser lead and mechanical lead extractions.

Discuss your approach to risk factor modification for AF.

Risk factor modification for AF is a very important aspect of our practice. Risk factors such as obesity, sleep apnea, or alcohol use are all contributing lifestyle factors for the eventual development of AF, as well as to potentially improve the success rates of any other therapies. Our physicians have increasingly worked with weight loss clinics and sleep clinics to get patients screened for

potential therapies. Other comorbid conditions such as hypertension or structural disease are addressed rigorously as well. We are fortunate to work in a highly integrated comprehensive clinic; in this setting, our services are aligned, allowing physicians to quickly access them for patients.

Girish A. Narayan, MD, FHRS, Executive Medical Director, Cardiovascular Service Line, Palo Alto Foundation Medical Group.

How does your EP laboratory handle radiation protection for physicians and staff?

All clinical staff and operators wear a dosimeter badge. The clinical staff, vendors, and anesthesiologist in the room all wear lead, while the operator utilizes the Zero-Gravity (Biotronik) suspended radiation protection system. This has significantly benefited some of our doctors who have experienced chronic back pain from heavy lead apron.

What approaches has your laboratory taken to reduce fluoroscopy time? What percentage of cases are done without fluoroscopy? How do you record fluoroscopy times and dosages?

We recently purchased the Azurion image-guided therapy system (Philips), which has provided us with high-quality imaging while emitting a significantly lower x-ray dose. The field of EP in general has seen a rapid advancement in both 3-dimensional (3D) mapping systems and ICE technologies. Our laboratory has certainly experienced this shift in reliance on these tools; as a result, we have seen a significant reduction in the use of x-ray and computed tomography imaging. About 16% of cases are performed completely without fluoroscopy in our laboratory. We record fluoroscopy time using McKesson; however, we are transitioning to Epic Cupid in the coming months.

What are some of the dominant trends you see emerging in the practice of EP?

EP is truly a dynamic field that is constantly innovating and improving through new emerging technologies and techniques. Many of these trends have been implemented in our program. The current buzz in EP is pulsed field ablation. We are looking at purchasing one of these systems but have not yet made a final decision. It will be interesting to see the full impact this technology has in EP.

How do you use digital health and wearable technologies in your treatment strategies? Have you seen an increase in the number of patients using digital health technologies? What challenges or benefits do you associate with that?

Digital health and wearable technologies have an increasing role in the modern EP practice. All our physicians routinely encourage patients to use either an Apple Watch or device such as the KardiaMobile (AliveCor) to document their heart rhythm whenever there is a symptom, and certainly as a way of surveillance for any recurrent AF post ablation. These are very useful techniques to reassure patients about the presence or absence of rhythm abnormalities when they do feel symptoms, though often they do need to be reviewed. The automated detection of AF by the Apple Watch is potentially very useful, though the experience and data are still quite early. Our physicians also have a tremendous number of device patients on remote monitoring, which is clearly an important aspect of digital health that really helps to extend the continuum of chronic care management.

Describe your city or general regional area. How is it unique?

There are a number of well-regarded health care facilities in our area, which makes it very competitive. Being in the heart of Silicon Valley also provides quick access to all the latest and greatest advances such as smartwatches to monitor heart rate or rhythm. Our highly educated patient population is focused on personal health and quick to report any heart rhythm irregularities to their physicians. Although we have a wide mixture of demographics, the general vicinity of our hospital is fairly affluent (being in the heart of Silicon Valley), and we have a fairly large aging population.

Sian Merriot, MSN, RN-BC, CNL, Electrophysiology Program Coordinator RN, Norma Melchor Heart & Vascular Institute.

What specific challenges does your hospital face given its unique geographic service area?

One of the specific challenges our hospital is facing is hardwiring the continuum of care after discharge. The various service providers and entities use different information and data platforms, which can make information sharing, in a protected health information compliant way, a challenge.

Another challenge is the “corporate practice of medicine” in California. We are constantly developing and maintaining positive relationships between administration and physicians, since they are not employed by the hospital, to continue our high quality of care. Communication channels must be open since our hospital works with so many different physician practices.

Our biggest challenge, however, is hiring skilled professionals with EP experience. The Bay Area has a notoriously high cost of living, and all hospitals in this area are encountering this same challenge of hiring or maintaining trained staff who are willing to endure these high costs, even with extremely competitive compensation rates.

Please tell our readers what you consider special about your EP laboratory and staff.

Our program safety is our top priority and we take pride in our low complication rate. Our physicians have decades of experience, and many of them have trained at some of the top institutions in the country. Our EP physicians work well with each other and collaborate with other specialties to allow for the highest level of care for patients. Staff experience varies widely, but we all work well together to onboard new staff and ensure none of the team members ever struggle during procedures. We provide as many resources as possible so that all members on our team feel successful in their understanding of EP and confident in the level of care they provide to the patient. Our team is focused on standardizing and optimizing our workflows while minimizing any unnecessary practices. Our management team also works in unison with the needs of the staff as well as the physicians. Those needs may vary, from acquiring new pieces of EP equipment to implementing new clinical workflows. As a department, we all work together to create a successful program. We work alongside the Heart and Vascular Institute to roll out new initiatives and maintain the NCDR cardiovascular registries, which help closely monitor patient procedural outcomes and benchmark with other facilities providing similar procedures. This outcome data is just one of many tools we use to help continuously improve our high-quality patient care.