

**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 <i>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.</i> b. Written Public Comments <i>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.</i>	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	<i>Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs:</i> QUARTERLY FINANCE AND STRATEGIC MARKET SHARE UPDATE	Carlos Bohorquez, Chief Financial Officer	Discussion	6:12 – 6:42
9	<i>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:</i> APPROVE CREDENTIALING AND PRIVILEGING REPORT	Mark Adams, MD, CMO	Motion Required	6:42 – 6:45
10	<i>Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:</i> 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: <i>Items removed from the Consent Calendar will be considered at the end of the regular agenda.</i> 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	Bob Rebitzer, Board Chair	Motion Required	6:52 – 6:55
14	<u>BOARD OFFICER ELECTIONS</u> 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
15	<u>CEO REPORT</u>	Dan Woods, Chief Executive Officer	Discussion	7:20 – 7:25

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
16	BOARD ANNOUNCEMENTS	Bob Rebitzer, Board Chair	Information	7:25 – 7:29
17	ADJOURNMENT <u>APPENDIX</u>	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 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 to 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 hemodialysis catheters. In FY23 the majority of CLABSIs were related to hemodialysis 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.

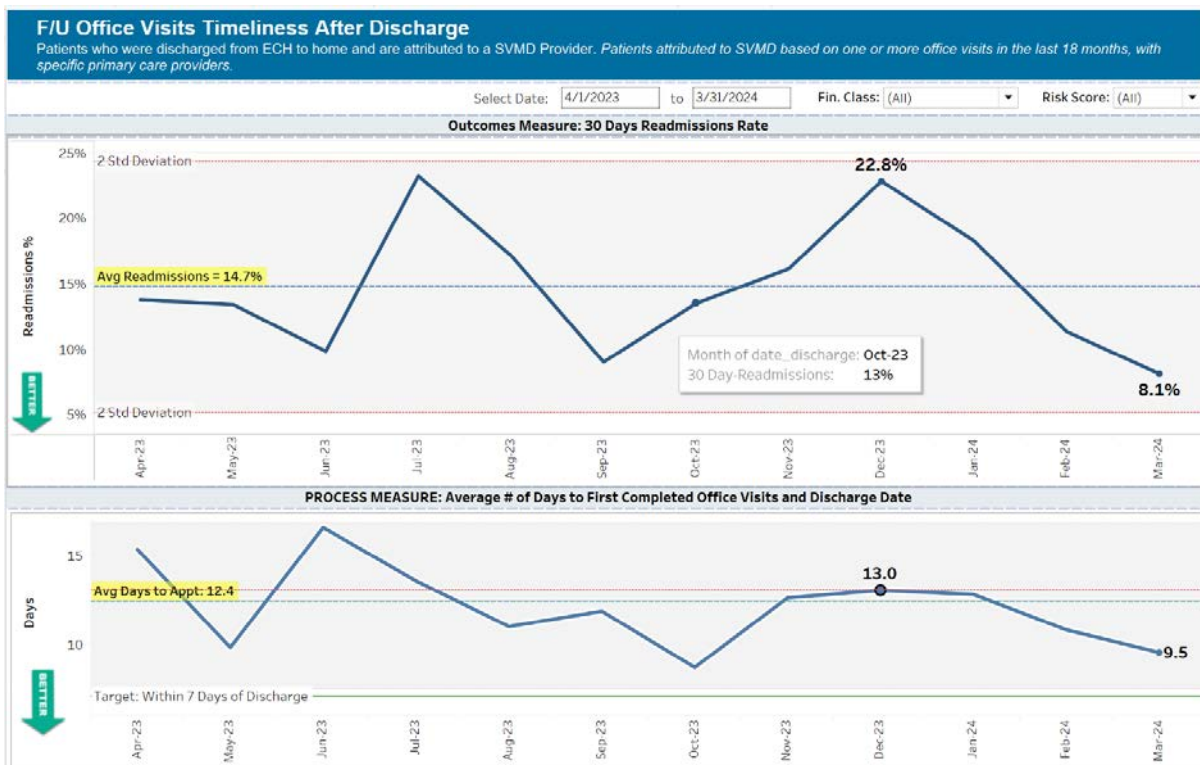
B. Timely

1. **Lab STAT Troponin Turnaround Time for Emergency Department (received to verification).** ¹The 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 Joint Commission and CMS requirements to engage leadership and clinical management staff in health equity initiatives.
- 3. Sepsis Bundle Compliance by Race.** We continue to track and learn from the practice of segregating some of our quality measures by race, while simultaneously enhancing the accuracy of the race data we collect from our patients at registration. The reliability of the 'race' data provided by our patients needs to be improved before we can extract meaningful insights about sepsis bundle compliance across different racial groups. In collaboration, the Health Equity Department and the Quality Data Management Department have developed a race and ethnicity algorithm that enables accurate and consistent segregation of clinical outcomes based on these critical demographic data. Furthermore, in partnership with the Sepsis Quality Team, we have established the first-of-its-kind Health Equity Sepsis Bundle Compliance Dashboard. This tool allows us to accurately identify gaps and plan for initiating process improvement project in specific groups.

F. Patient Centered

1. **Inpatient HCAHPS Likelihood to Recommend.** For the month of 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. **EI 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

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	<ul style="list-style-type: none"> • President of Foundation • ePolicy • MEC
Human Resource	2. HR – Aerosol Transmissible Disease (ATD) Exposure Control Plan	Revised	Plan	2. Updated Sections: References, Procedure	<ul style="list-style-type: none"> • 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 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.

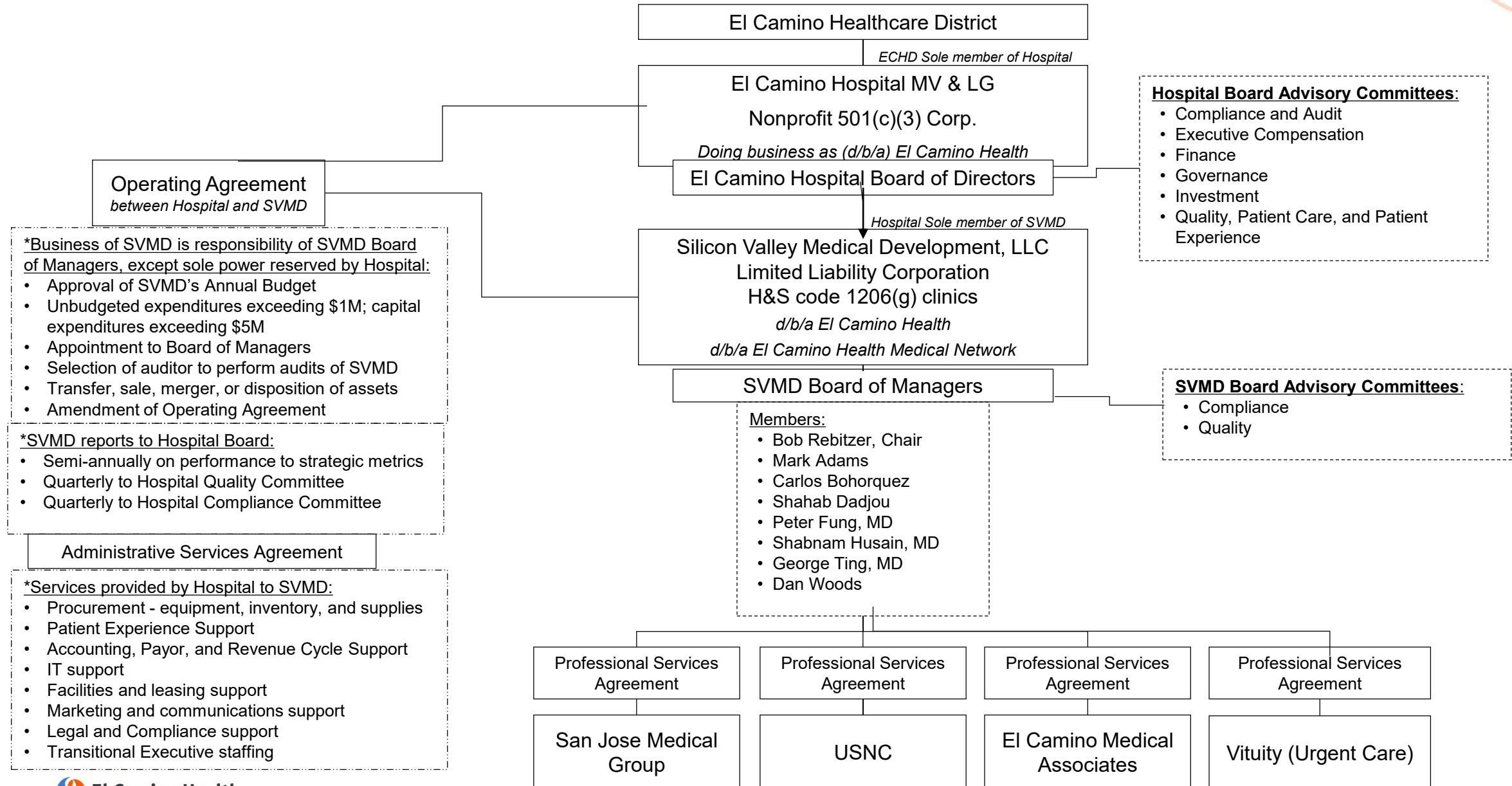
Report:

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 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 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

FY24 Quarterly Board Quality Dashboard (STEEP)

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

STEEP: 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

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
	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)

**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, ACOG
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.	

<p>5. CONSENT CALENDAR</p>	<p>The consent calendar was presented to the Board for approval and a request was made by Director Zoglin to remove item (d) for discussion.</p> <p>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”</p> <p>Movant: Miller Second: Watters Ayes: Doiguchi, Miller, Po, Somersille, Ting, Watters, Zoglin Noes: None Abstentions: None Absent: Chen, Fung, Rebitzer Recused: None</p> <p>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.</p>	<p>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.</p> <p>ECHB Committee Governance Policy to come back to the next meeting.</p>
<p>6. BOARD OFFICER ELECTIONS PROCEDURE</p>	<p>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.</p>	<p>Staff to send an email to the Board letting them know who has expressed interest in serving as an officer.</p>
<p>7. CEO REPORT</p>	<p>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.</p>	
<p>8. RECESS TO CLOSED SESSION</p>	<p>Motion: To recess to closed session at 4:47 pm.</p> <p>Movant: Ting Second: Doiguchi</p>	<p>Recessed to closed session at 4:47 p.m.</p>

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

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)

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**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, ACOMO
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	<p>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.</p> <p>Motion: To approve the Credentialing and Privileging report</p> <p>Movant: Ting Second: Watters Ayes: Doiguchi, Miller, Po, Somersille, Ting, Watters, Zoglin Noes: None Abstentions: None Absent: Chen, Fung, Rebitzer Recused: None</p>	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.	

	<p>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.</p>	
<p>4. AGENDA ITEM 10A: FINE TUNING OUR STRATEGY</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p><i>Staff to pace the ECHMN value report with a similar methodology each year</i></p>
<p>5. AGENDA ITEM 10B: 2027 PERFORMANCE MILESTONES</p>	<p>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.</p>	<p><i>Staff to review and revise the strategic plan for FY 25 goals based on market dynamics and external factors discussed in the meeting</i></p>
<p>6. AGENDA ITEM 10C: BEST PRACTICES FOR SETTING AND EVALUATING ENTERPRISE GOALS</p>	<p>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</p>	

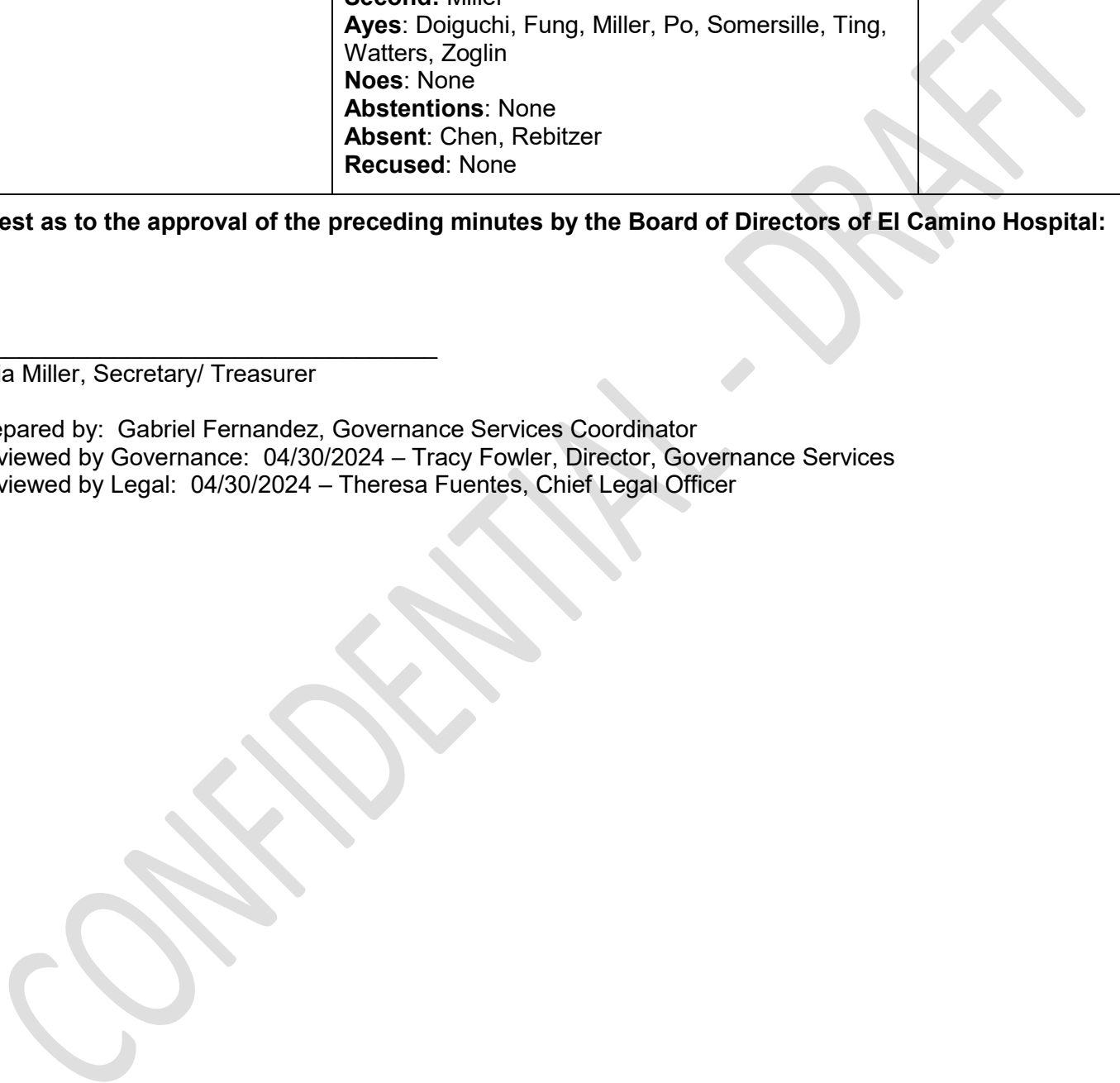
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	<p>that management should be able to set goals that maintain current high performance, not set aspirational goals, and be held accountable for these high-performance deriving goals for FY25 and beyond.</p>	
<p>7. AGENDA ITEM 11: RECONVENE TO OPEN SESSION</p>	<p>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</p>	<p><i>Reconvened to Open Session at 8:03 pm</i></p>

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



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, ~~23108 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



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 Type 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/oshfiles/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.](http://www.dir.ca.gov/Title8/5199.html)
- [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.](https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html)
- [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.](https://www.cdc.gov/niosh/topics/respirators/)
- [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.](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134)

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

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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).

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

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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..

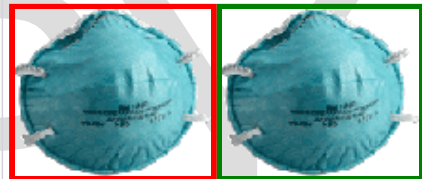
PAPR (Powered Air Purifying Respirator):

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.	
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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, EWS 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.

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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 RPP 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](#)

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[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

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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

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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

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A14b. Board Officer Elections Procedure (Revised)

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

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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 Coordinator; 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 4° 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?

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.



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

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.

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.



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

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 leading 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, FHRSC, 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.

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.



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

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.

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