

**AGENDA  
REGULAR MEETING OF THE  
EL CAMINO HOSPITAL BOARD OF DIRECTORS**

**Wednesday, May 10, 2023 – 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: 924 6756 7282# 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 as your publicly accountable health partner.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1	<b>CALL TO ORDER/ROLL CALL</b>	Bob Rebitzer, Board Chair	Information	<b>5:30 – 5:31 pm</b>
2	<b>AB 2449 – REMOTE PARTICIPATION</b>	Bob Rebitzer, Board Chair	Information	<b>5:31 – 5:32</b>
3	<b>POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Bob Rebitzer, Board Chair	Information	<b>5:32 – 5:32</b>
4	<b>PUBLIC COMMUNICATION</b> a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.</i> b. Written Correspondence	Bob Rebitzer, Board Chair	Information	<b>5:32 – 5:35</b>
5	<b>MEDICAL STAFF REPORT</b>	Prithvi Legha, MD, MV Chief of Staff Philip Ho, MD, LG Chief of Staff	Information	<b>5:35 – 5:45</b>
6	<b>QUALITY COMMITTEE</b> - <a href="#">Q3 STEEEP UPDATE</a>	Carol Somersille, MD, Chair of Quality Committee; Dr. Holly Beeman, Chief Quality Officer	Information	<b>5:45 – 6:05</b>
7	<b>ADJOURN TO CLOSED SESSION</b>	Bob Rebitzer, Board Chair	Motion Required <i>public comment</i>	<b>6:05 – 6:06</b>
8	<b>POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Bob Rebitzer, Board Chair	Information	<b>6:06 – 6:07</b>
9	<i>Health and Safety Code Section 32106(b)</i> for a report and discussion involving healthcare facility trade secrets: <b>FY23 Q3 STRATEGIC METRICS STATUS and FY24 STRATEGIC METRICS PLAN</b>	Dan Woods, Chief Executive Officer	Discussion	<b>6:07 – 6:37</b>
10	<i>Health and Safety Code Section 32106(b)</i> for a report and discussion involving healthcare facility trade secrets: <b>FY23 Q3 FINANCIALS and STRATEGIC UPDATE</b>	Carlos Bohorquez, Chief Financial Officer	Discussion	<b>6:37 – 6:47</b>
11	Report involving <i>Gov't Code Section 54957(b)</i> for discussion and report on personnel performance matters – Senior Management: <b>EXECUTIVE SESSION</b>	Bob Rebitzer, Board Chair	Discussion	<b>6:47 – 6:57</b>

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
12	<b>CONSENT CALENDAR</b> <i>Any Board Member may remove an item for discussion before a motion is made.</i>	Bob Rebitzer, Board Chair	Motion Required	<b>6:57 – 7:13</b>
	<b>Approval</b> Gov't Code Section 54957.2: a. Minutes of the Closed Session of the Hospital Board (04/17/2023) <b>Reviewed and Recommended for Approval by the Quality, Patient Care, and Patient Experience Committee</b> Health & Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: b. Credentialing and Privileges Report <b>Information</b> <b>Reviewed and Approved by the Finance Committee</b> Health & Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets: c. Physician Financial Arrangement Expenses			
13	<b>ADJOURN TO OPEN SESSION</b>	Bob Rebitzer, Board Chair	Motion Required	<b>7:13 – 7:14</b>
14	<b>RECONVENE OPEN SESSION/ REPORT OUT</b>	Bob Rebitzer, Board Chair	Information	<b>7:13 – 7:14</b>
	To report any required disclosures regarding permissible actions taken during Closed Session.			
15	<b>CONSENT CALENDAR ITEMS:</b> <i>Any Board Member or member of the public may remove an item for discussion before a motion is made.</i>	Bob Rebitzer, Board Chair	Motion Required  <i>public comment</i>	<b>7:14 – 7:17</b>
	<b>Approval</b> a. <a href="#">Hospital Board Minutes (04/17/23) Open Session Minutes</a> b. <a href="#">Policies, Plans and Scopes of Services</a>			
16	<b>CEO REPORT</b> a. <a href="#">Update</a> b. <a href="#">Pacing Plan</a>	Dan Woods, Chief Executive Officer	Information	<b>7:17 – 7:22</b>
17	<b>BOARD COMMENTS</b>	Bob Rebitzer, Board Chair	Information	<b>7:22 – 7:29</b>
18	<b>ADJOURNMENT</b>	Bob Rebitzer, Board Chair	Motion Required  <i>public comment</i>	<b>7:29 – 7:30</b>

**Upcoming Regular Meeting:** June 14, 2023

**El Camino Hospital Board of Directors Memo**

**To:** El Camino Hospital Board of Directors  
**From:** Carol Somersille, MD, Chair Quality, Patient Care and Patient Experience Committee and Holly Beeman, MD, MBA, Chief Quality Officer  
**Date:** May 10, 2023  
**Subject:** FY23 Third Quarter Board Quality Dashboard (STEEEP)

**Purpose:**

To update the Board of Directors on FY23 Second Quarter Board Quality Dashboard (STEEEP) through end of FYQ3 unless otherwise noted.

**Summary:**

The El Camino Health Board Quality Dashboard (STEEEP) is based on the Quality Framework first shared in Crossing the Quality Chasm (Institute of Medicine, 2001). By striving to deliver care, which is Safe, Timely, Effective, Efficient, Equitable and Patient Centered, El Camino Health is focused on optimizing and improving our performance and processes in these six quality domains.

The third quarter results are shown in green/yellow/red performance scheme. Measures shaded in **GREEN** are at or exceeding target. Those in **YELLOW** are within 5% of the target. Measures in **RED** are off target by greater than 5%.

1. **Safe Care: Hospital Acquired Condition Index** (lower is better). This metric is a composite of the weighted rates of 5 component measures:

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

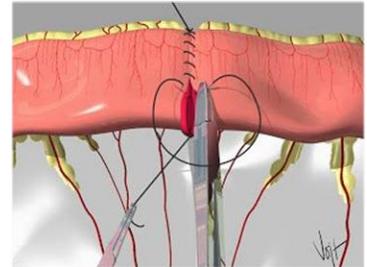
During March, the index was 0.90 which is **favorable** to target of 0.986. Year to date the HAC Index is 0.961, **favorable** to the FY23 target of 0.986.

- A. **C. Difficile Infection:** There have been three C. Diff infections per month in the third quarter. This is **unfavorable** to our target of having < 2.85 infections on average per month. In-process measures to reduce C. Diff infection are accurate timing of testing and hand hygiene. Both are improving favorably.
  - i. Compliance with following our testing and screening policy. Since October/November when we had several events which were classified as hospital acquired because of gaps in our testing and screening processes. This has been resolved with updating the standard procedure, and, more impactful, the robust education of our staff by our education team. We have

not had a single occurrence of delayed or missed testing resulting in a 'false' hospital acquired infection.

Our hand-hygiene campaign has been effective. 'Secret shoppers measure hand-hygiene compliance. The # of observations has increased by 127% (from 1,113 to 2,537 per month). Compliance with hand washing with soap and water prior to exiting a C. Diff isolation room has increased to 91% from 40%. We still have work to do. We are encouraged by the progress our teams have made.

- B. Surgical Site Infection:** There has been one surgical site infection in the third quarter of FY23 (to date). This was a colon surgery post-operative infection on our Mountain View Campus. There have been a total of four colon surgery infections and one rectal surgery infection in FY23. All but one of these surgeries were performed laparoscopically. The bacteria cultured from the wounds of these cases grew out intestinal bacteria suggestive of anastomotic leaks. During resection of colon cancer, the cancerous colon segment is resected and the healthy colon segments on either side of the excised cancerous area are attached to one another (anastomosis) to recreate a continuous output track. This is a common source of 'leak' and infection, which is why of all surgeries performed; colon resection surgery has one of the highest rates of surgical site infection. This area of surgical practice has our full attention.



The specific type of bacteria were different in each case as were the operating rooms where the surgery was performed, and, the surgical teams were different in each case. Since implementing utilization of a "clean closure tray" the peri-op teams have been tracking compliance with this practice. Both colon case SSI's since go-live of the clean closure tray did use a clean closure tray during surgery. The patients in each of these events had significant co-morbidities including invasive colon cancer, which increases their risk of an infection as the integrity of the colon tissue is compromised even before the surgery begins. For perspective, 195-colon surgeries have been performed in FY2023 without infection.

- C. Non-ventilator Hospital Acquired Pneumonia (nvHAP)**—Year to date we are **favorable** to FY23 target and **improved** from prior year performance. Quality Manager, Theresa Legion RN, has identified NEW evidence-based data and best practice information that has published within the past 12 months to guide our approach to prevention of nvHAP. Our teams are focused on increasing oral care (brushing, rinse, etc.) to reduce risk of pneumonia. We have an opportunity to increase oral care compliance through clinical protocol redesign and staff and physician education.

- D. Patient falls on inpatient units**—March performance is **favorable** to target. Year to date, we are **unfavorable** to target. We project being at or below goal (favorable) at year-end. The results of the pilot exploring the impact of using EPIC cognitive computing a predictive analytics (Artificial Intelligence) to reduce falls demonstrated a statistically significant decrease in falls, and, a statistically significant improvement in nurse’s perception of AI.

**Falls** Predictive Analytics Tool (Ann Aquino)

	Pre-Implementation	Control Group 4A	AI Test Group 4B
May – Aug 2022	Fall	2	3
	No fall	1270	1055
	Fall rate	0.16%	0.29%
<b>Post-Implementation</b>			
Sept – Dec 2022	Fall	9	1
	No fall	1259	1015
	Fall rate	0.71%	0.10%

**2. Timely:**

- A. ED Imaging Turnaround Time.** The FY23 enterprise target for imaging turnaround time in the ED is to have 84% of studies completed and read within 45 minutes. Current performance is **unfavorable** to target (78.2%) through March 2023. Of the 20% of studies not read within 45 minutes, several have delays > 180 minutes. Physician staffing and recruiting of radiologists presents a significant challenge to providing timely care and imaging services for ECH patients in the ED. ECH management is working with Imaging Physician Leadership to address the delays.

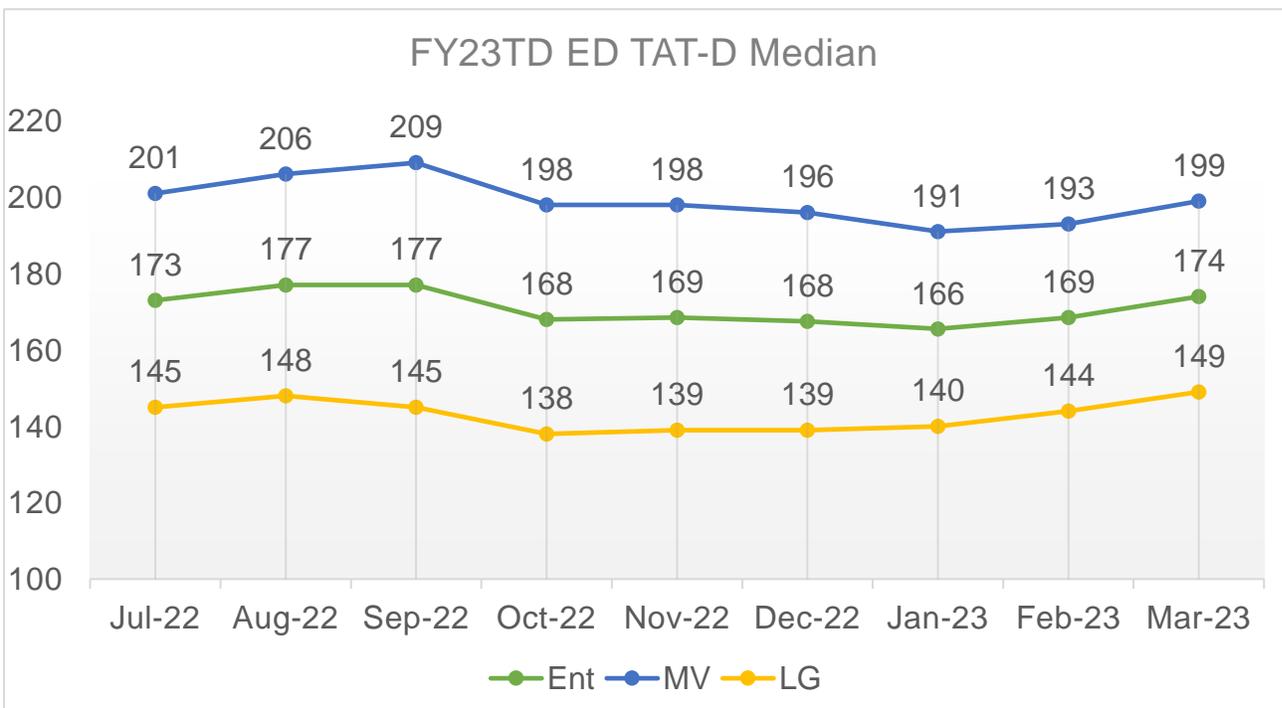
**3. Effective:**

- A. Risk Adjusted Readmission Index.** Lower is better. Readmission Index for the third quarter of FY23 is 0.98, **favorable** to our target of 1.00. YTD our index through March 2023 is 1.04, **unfavorable** to target. The dashboards our Director of Clinical Quality Analytics has created have animated our ability to identify and focus on the key drivers of readmissions, and, track improvement as interventions are deployed. As an example, we now have the ability to track the readmission rate by SNF on a daily basis. This directs our multidisciplinary teams to focus on providing support, education and partnership to those SNFs who accept our sickest patients, and, have a greater readmission rate than other agencies.
- B. Mortality Index.** Lower is better. Mortality Index for third quarter (1.10) and year to date (1.08) are **unfavorable** to target of 0.85. The driver of this increase is the increase in Sepsis Mortality. Deaths from sepsis represent 38% of expirations in January 2023, 52% in February 2023 and 47% in March 2023.
- C. Sepsis Mortality Index:** Sepsis mortality for March and year to date is **unfavorable** to target. Sepsis mortality is affecting overall mortality **unfavorably**. Compliance with the sepsis bundle of treatment is low (42%). The in process measure of giving a fluid

bolus within 3 hours of time of presentation is our greatest opportunity for improvement. Through the course of FY23 the “fluid bolus” intervention has decreased from 80% to 44%. We are currently collaborating with Information Technology to consider and vet implementation of an artificial intelligence tool; Sepsis DART™. Our current information technology capability does not allow for real-time feedback on patient condition and timely completion of bundle elements at the point of care. The Sepsis DART™ tool monitors and communicates regarding all aspects of sepsis treatment bundles to the right clinicians at the right time. It also maintains information on septic patients between care locations and shifting staff. If we do move forward with this AI solution, go live would not be for several months. In the interim, we look forward to collaborating closely with the newly hired Medical Director of the Emergency Department to identify how we can re-animate the engagement of staff/physicians for early detection and timely treatment of patients with sepsis. Dr. Madvani’s first day in the role is April 28, 2023.

**D. PC-O2: Cesarean Birth (NTSV--nulliparous, term, singleton, vertex):** Core measure data for PCO-02 through December shows an improvement/reduction in cesarean section rates compared to the first quarter. Going forward in FY24, we will share more contemporaneous data on NTSV on our monthly enterprise dashboard. There are three categories of indications for a NTSV cesarean delivery; elective maternal choice/request, fetal indications, labor arrest/disorder. Our primary elective cesarean section rate is 3%, which is low compared to California benchmarks. The process improvement focus of the maternal child health team is on reducing the cesarean section rate for ‘labor disorders’.

**E. Emergency Department Turnaround Time for Pts Discharged from ED: ED TAT-D (unfavorable):** Emergency department turnaround time for discharged patient (ED TAT-D) is currently at a median of 171 minutes enterprise wide, with our goal being 164 minutes.



The Emergency Department in Mountain View has 32 beds, with 12 beds in Los Gatos. Annualized 2023 census in Mountain View projects to 57,395 (FY22 51,969) and in Los Gatos projects to 20,677 (FY22 17,088). This significant increase along with an increase in inpatient census has presented operational challenges. There are multiple factors that affect ED TAT-D, including inpatient bed capacity, mental health patient volume and holds, workflows and ancillary support (laboratory & radiology). Inpatient bed capacity is a significant driver of functional Emergency Department bed capacity as patients are frequently held in the Emergency Department waiting for an inpatient bed. Mental health patients often have prolonged stay awaiting assessment and disposition/transfer. Efforts to alleviate the overcrowding in Mountain View this FY have included operationalizing 5 additional observation beds (in endoscopy) and 4 additional treatment spaces for low acuity patients. We assembled a Process Improvement team in January to focus on reducing our ED TAT-D. The team has identified each of the components of the total ED TAT-D and assessed potential opportunities. We have identified and are focused on opportunities around:

- radiology turnaround times
- laboratory turnaround times
- disposition decision to discharge

#### 4. Patient Experience Measures

- Inpatient Likelihood to Recommend:** Inpatient units overall did not meet goal for March but did see an improvement from February due to increased attention and focus on nurse leader rounding, communication and bedside shift report. Many units increased their scores including a record-breaking 2C (increased their power of 3 from 71% to 78% and their nurse leader rounding improved from 80% to 94%). Los Gatos exceeded their target and Med Surg in Los Gatos continues to do well with their increased focus. We continue to emphasize being proactive and ensuring that the bedside shift report is happening. Coaching and supporting our leaders and new staff is also helping.
- Maternal Child Health Likelihood to Recommend:** Mountain View MCH exceeded target again as did overall MCH. Improvements were seen in environmental categories such as noise, visitor and family accommodations. In addition, staff worked together, a key driver, also increased. The team continues to focus on proactive rounding and service recovery due to construction noise.
- ED Likelihood to Recommend:** The ED dipped in March largely due to increased length of stay and holding patients in the ED waiting for an inpatient bed. A lot of work is being done to improve the efficiency of the lower acuity patients to ensure we decrease their wait times. Staff worked together, a key driver, increased also as we are working on our staffing models. We are definitely seeing an impact of having an ED Navigator on board to help with communication about wait times, service delivery and service recovery.
- ECHMN Likelihood to Recommend Care Provider:** Will be reported on in the ECHMN quarterly report at this meeting.

FY23 Quarterly Board Quality Dashboard (STEEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance				
		FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY 22	FY 23	FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FYTD
Safe Care	HAC Index	1.05	1.3	1.6	0.86	1.066	0.986	0.80	1.28	0.60		0.96
	HAC Component: Clostridium Difficile Infection (C.diff)	8	8	7	14	9.25	8.56	7	13	9		9.7
	HAC Component: Surgical Site Infections (SSI)	5	4	7	2	4.5	4.16	6	10	1		5.7
	HAC Component: nvHAP	36	29	26	24	28.75	26.59	26	31	20		25.7
	HAC Component: IP Units area Patient Falls Reported to NDNQI	26	48	47	32	38.25	35.38	25	50	35		36.7
	HAC Component: HAPI Stage 3, Stage 4 and Unstageable	0	3	3	2	2.00	1.85	2	2	0		1.3
Timely	Stroke: TTITT (time to intravenous thrombolytic therapy) <= 30 min	25% (1/4)	10% (1/10)	75.0% (6/8)	0% (0/6)	28.6% (8/28)	50%	50% (4/8)	71.4% (5/7)	75.0% (3/4)		63.2% (12/19)
	Stroke: Door-to-Groin <= 90 minutes	50% (1/2)	28.6% (2/7)	50% (1/2)	25% (1/4)	33.3% (5/15)	50%	100% (2/2)	75.0% (3/4)	50.0% (3/6)		66.7% (8/12)
	Imaging TAT: ED including Xray (target = % completed <= 45 min)	80.35%	79.68%	82.26%	74.14%	79.01%	84%	78.43%	78.34%	78.28%		78.35%
Effective	Risk Adjusted Readmissions Index	1.05	0.96	1.12	1.06	1.05	1.00	1.02	1.10	0.98		1.04
	Risk Adjusted Mortality Index	0.99	0.92	0.99	0.85	0.94	0.85	1.03	1.08	1.10		1.08
	Risk Adjusted Sepsis Mortality Index	1.07	1.01	1.10	0.91	1.02	0.98	1.02	1.27	1.17		1.15
	PC-02 NTSV C-Section	25.8%	25.0%	24.1%	28.3%	25.80%	23.5%	28.8%	24.7%	n/a		26.8%
Efficient	OP18b: Median Time from ED Arrival to ED Departure (Enterprise)	160 min	156 min	162 min	169 min	162 min	162 min	176 min	168 min	169 min		171 min
Equitable	% Patients - Ethnicity documented	98.1%	97.9%	97.8%	97.8%	97.9%	----	97.6%	97.0%	96.6%		97.1%
	% Patients - Race documented	98.6%	98.5%	98.0%	98.1%	98.3%	----	97.8%	97.3%	97.3%		97.5%
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	82.0	80.2	81.5	79.4	80.8	81	79.9	78.8	76.6		78.5
	ED - Likelihood to Recommend (PG)	73.1	75.8	77.4	71.5	74.5	75	70.3	72.3	73.8		72.1
	MCH - HCAHPS Likelihood to Recommend	79.4	81.0	82.1	82.8	81.3	81.5	72.3	71.1	83.7		75.3
	ECHMN (El Camino Health Medical Network)	---	---	83.6	82.8	83.2	83.4	81.1	81.6	83.6		82.2

Updated: 4/19/23

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

Legend:

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



**Minutes of the Open Session of the  
El Camino Hospital Board of Directors  
Monday April 17, 2023**

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

**Board Members Present**

**Bob Rebitzer**, Chair  
**Lanhee Chen, JD, PhD\*\***  
*(joined at 6:40pm)*  
**Peter Fung, MD**  
**Julie Kliger, MPA, BS**  
**Julia E. Miller**,  
 Secretary/Treasurer  
**Jack Po, MD, Ph.D.**, Vice-Chair  
**Carol A. Somersille, MD**  
**George O. Ting, MD**  
**Don Watters**  
**John Zoglin**

**Others Present**

**Dan Woods**, CEO  
**Carlos Bohorquez**, CFO  
**Meenesh Bhimani, MD**, COO  
**Cheryl Reinking**, CNO  
**Deanna Dudley**, CHRO  
**Holly Beeman, MD**, CQO  
**Mark Adams, MD**, CMO  
**Jon Cowan**, Sr. Director  
 Government Relations &  
 Community Partnerships

*\*\*via teleconference*

**Others Present (cont.)**

**Omar Chughtai**, CGO\*\*  
**Deb Muro**, CIO\*\*  
**Shahab Dadjou**, President, El  
 Camino Health Medical Network\*\*  
**Vineeta Hiranandani**, VP of  
 Marketing and Communications\*\*  
**Priya Shah**, Assistant General  
 Counsel  
**Stephanie Iljin**, Manager,  
 Administration  
**Brian Richards**, Information  
 Technology

Agenda Item	Comments/Discussion	Approvals/ Action
1. <b>CALL TO ORDER/ ROLL CALL</b>	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:32 p.m. by Chair Bob Rebitzer. Director Chen was absent at time of roll call. Chair Rebitzer reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-29-20 dated March 18, 2020.	<b>The meeting was called to order at 5:32 p.m.</b>
2. <b>CONSIDER APPROVAL FOR AB2449 REQUESTS</b>	Chair Rebitzer asked the Board for declarations of AB2449 request for approval. None were noted.	
3. <b>POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Chair Rebitzer asked the Board for declarations of conflict of interest with any items on the agenda. None were reported.	
4. <b>PUBLIC COMMUNICATION</b>	Chair Rebitzer invited the members of the public to address the Board, and no comments were made.	
5. <b>QUALITY COMMITTEE REPORT</b>	Chair Rebitzer briefly mentioned that at the next meeting, the quality report will be a focused review. Dan Woods noted that due to a clerical error, the report was not included in advance of the meeting, and Dr. Holly Beeman would provide a verbal report.	Action: Next month's focused review more in-depth information on health equity – a national patient safety goal
6. <b>ADJOURN TO CLOSED SESSION</b>	Motion to adjourn to closed session at 5:42 p.m. pursuant to <i>Gov't Code Section 54957.2</i> for approval of the minutes of the Closed Session of the Hospital Board (3/08/2023); Renewal of MV & LG Urology Panel Agreements; Medical Staff Bylaw Revisions; pursuant to <i>Health and Safety Code Section 32155</i> for a report of the Medical Staff; and deliberations concerning reports on Medical Staff quality	<b>Adjourned to closed session at 5:42 p.m.</b>

	<p>assurance matters: (Medical Staff Credentialing &amp; Privileges Report).</p> <p><b>Motion:</b> to adjourn to closed session at <b>5:42 p.m.</b></p> <p><b>Movant:</b> Watters  <b>Second:</b> Rebitzer  <b>Ayes:</b> Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen  <b>Recused:</b> None</p>	
<p><b>7. AGENDA ITEM 12: RECONVENE OPEN SESSION/ REPORT OUT</b></p>	<p>The open session was reconvened at <b>7:19 p.m.</b> by Chair Rebitzer. Agenda Items 9-12 were addressed in closed session.</p> <p>During the closed session, the El Camino Hospital Board of Directors approved the minutes of the Closed Session of the Hospital Board (3/08/2023), Renewal of MV &amp; LG Urology Panel Agreements; The Medical Staff Bylaws Revisions, and the Credentials and Privileges Report, as reviewed and recommended for approval by the Quality, Patient Care and Experience Committee by a unanimous vote of all Directors present (Directors Chen, Fung, Kliger, Miller, Rebitzer, Somersille, Ting, Watters, and Zoglin).</p>	
<p><b>8. AGENDA ITEM 13: CONSENT CALENDAR</b></p>	<p>Chair Rebitzer asked if any member of the Board or the public wished to remove an item from the consent calendar for discussion. Director Miller requested that the minutes from 02/15/2023 be amended to read: "Director Miller shared information about two significant donations to the El Camino Health Foundation."</p> <p><b>Motion:</b> to approve the consent calendar to include:</p> <ol style="list-style-type: none"> <li>a. Minutes of the Open Session of the Hospital Board (2/15/2023)</li> <li>b. Investment Committee Member Appointments</li> </ol> <p><b>Movant:</b> Watters  <b>Second:</b> Po  <b>Ayes:</b> Chen, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Chen  <b>Recused:</b> None</p>	<p><b><i>The consent calendar was approved</i></b></p>
<p><b>9. AGENDA ITEM 14: FY24 BOARD UPDATES</b></p>	<p>Chair Rebitzer asked Ms. Priya Shah, Assistant General Counsel, to review the proposed Hospital Bylaw Suspension implications with the Board of Directors. Ms. Shah explained that the approval of resolution 2023-01 would extend the Vice Chair and Secretary/Treasurer officer's current term one year, thereby re-aligning the officer elections with the current Chair's term.</p> <p><b>Motion:</b> To approve Resolution 2023-01</p>	<p><b><i>Resolution 2023-01 was approved</i></b></p> <p>Action:          FY24 Board meeting cadence to remain as is.</p>

	<p><b>Movant:</b> Miller  <b>Second:</b> Somersille  <b>Ayes:</b> Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> None  <b>Recused:</b> None</p> <p>Chair Rebitzer facilitated a discussion regarding the results of the FY23 Board survey. Feedback included:</p> <ul style="list-style-type: none"> <li>• Keep the number of meetings as is</li> <li>• Pace more time to talk on the agendas</li> <li>• More strategy oversight, the board needs exposure to operational details, access to information from various committees</li> <li>• Move the Board Retreat to an earlier date</li> <li>• Report of all Committees</li> <li>• Limit the number of slides, read in advance, and have more discussion in the room</li> </ul>	<p>Move Board Retreat to earlier.</p>
<p><b>10. AGENDA ITEM 15:                  CEO REPORT</b></p>	<p>Mr. Woods provided a brief CEO report including the following highlights:</p> <ul style="list-style-type: none"> <li>• The Medical Staff Physicians have now completed 99% of HRO training.</li> <li>• Implemented FloPatch as an innovative new technology and is the world's first wireless, wearable Doppler ultrasound system</li> <li>• Signed contract to begin working with The Equity Project (TEP) as our external diversity consulting partner.</li> <li>• Auxiliary donated 3,049 volunteer hours for the month of February</li> </ul>	
<p><b>11. AGENDA ITEM 16:                  BOARD COMMENTS</b></p>	<p>Chair Rebitzer asked if there were any comments from the board members. None were noted.</p>	
<p><b>12. AGENDA ITEM 17:                  ADJOURNMENT</b></p>	<p><b>Motion:</b> To adjourn at 7:21 p.m.  <b>Movant:</b> Fung  <b>Second:</b> Po  <b>Ayes:</b> Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> None  <b>Recused:</b> None</p>	<p><b><i>The meeting adjourned at 7:21 p.m.</i></b></p>

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

\_\_\_\_\_  
 Stephanie Ijlin, Manager of Administration

Prepared by: Stephanie Ijlin, Manager of Administration  
 Reviewed by: Tracy Fowler, Director of Governance Services

Department	Policy Name	Revised	Doc Type	Notes	Committee Approvals
<b>New Business</b>					
Emergency Mgmt	1. Emergency Management – Pandemic Plan	<b>None</b>	Plan	<ul style="list-style-type: none"> <li><b>None</b></li> </ul>	<ul style="list-style-type: none"> <li>Emergency Mgmt</li> <li>Infection Prevention</li> <li>ePolicy</li> <li>MEC</li> </ul>
Pharmacy	2. MERP – Medication Error Reduction Plan	Revised	Plan	<ul style="list-style-type: none"> <li>Updated Reference section</li> </ul>	<ul style="list-style-type: none"> <li>Medication Safety</li> <li>P&amp;T</li> <li>ePolicy</li> <li>MEC</li> </ul>
Health Library	3. Scope of Service – Health Library & Resource Center	Revised	Scope of Svc	<ul style="list-style-type: none"> <li>Updated Sections: Staffing, Level of Service Provided</li> </ul>	<ul style="list-style-type: none"> <li>ePolicy</li> <li>MEC</li> </ul>
Spiritual Care	4. Scope of Service Spiritual Care	Revised	Scope of Svc	<ul style="list-style-type: none"> <li>Updated Level of Service Provided section</li> </ul>	<ul style="list-style-type: none"> <li>ePolicy</li> <li>MEC</li> </ul>



Origination 09/2020  
Last Approved N/A  
Effective Upon Approval  
Last Revised 09/2021  
Next Review 1 year after approval

Owner **Matthew Scannell: Director Safety & Security Services**  
Area **Emergency Management**  
Document Types **Plan**

## Emergency Management - Pandemic Plan

### COVERAGE:

All El Camino Health staff, medical staff, and volunteers.

### PURPOSE:

This procedure is intended to protect employees, physicians, volunteers, patients, contractors, and visitors minimizing exposure to a pandemic event.

1. The ability of El Camino Health (ECH) to develop a coordinated health care strategy to effectively prepare and provide for pandemic patients is a critical capacity. Because of the nature of viruses and their natural ability to mutate and become more or less of a threat to humans, there remains uncertainty as to when and how a pandemic will evolve, and its effect on local conditions that will influence decision-making within the health care system. ECH must be prepared for the rapid pace and dynamic characteristics of a pandemic virus.
  - El Camino Health should be equipped to care for:
    - A limited number of patients infected with the virus as part of normal operations
    - An overwhelming increase in the number of patients in the event of escalating transmission of pandemic virus.
  - The hospital is committed to:
    - Identifying and isolating all potential patients with the pandemic virus
    - Implementing infection control practices to prevent transmission
    - Providing medical treatment to patients

- Ensuring rapid and frequent communication within the hospital, with other health care facilities, and with the Santa Clara County Public Health Department (SCCPHD).

## 2. Planning Assumptions

1. The number of ill people requiring outpatient medical care and hospitalization will overwhelm the local health care system.
2. El Camino Health will maximize the medical surge capacity and capability. However, when hospital capacity is exceeded, Care Centers will be needed for patients who can safely be managed outside of the acute care setting; hospitals will be reserved for patients needing the most sophisticated care.
3. The increased health care demands associated with a pandemic virus cannot be managed by health care facilities alone. An effective pandemic response must include cooperative strategies that use a variety of health care entities including hospitals, clinics, long-term care facilities, private practice physicians, and home health care providers.
4. Hospitals and other health care entities will likely experience staffing shortages throughout the pandemic period and into the subsequent recovery period. Under specific emergency conditions, volunteers, retired health care professionals, and trained unlicensed personnel may be used to provide patient care in a variety of health care settings.
5. Current resources for mass fatality care at all levels, including health care facilities, the county morgue and mortuaries, may be inadequate to meet the challenges posed by a pandemic virus.
6. To maximize health care resources and achieve the optimal benefit for the most people, traditional standards of care may need to be altered. "Sufficiency of care," medical care that may not be of the same quality as that delivered under non-emergency conditions but that is sufficient for need, may be the standard of care during a pandemic.

## DEFINITIONS:

- A. **Alert Period** – El Camino Health defines the Alert Period as the first confirmed human-to-human transmission of the virus in the United States
- B. **Pandemic Period** – El Camino Health defines the Pandemic Period as the first confirmed human-to-human transmission of the virus in the Bay Area.
- C. **Pandemic Action Table** – provides a summary of actions and responsibilities during a pandemic event. See: *Pandemic Plan Action Table*.
- D. **Pandemic virus**: global outbreak of a new virus. Pandemics happen when new (novel) viruses emerge which are able to infect people easily and spread from person to person in an efficient and sustained way. The virus can spread quickly because most people will not be immune and a vaccine might not be widely available to offer immediate protection.

## REFERENCES:

- Centers for Disease Control (CDC) - CDC's Emergency Communication System – [www.cdc.gov](http://www.cdc.gov)
- Santa Clara County Public Health Department (SCCPHD) - <http://sccphd.org>
- Infection Control – Seasonal Influenza Procedure
- [Emergency Management - COVID-19 Control Plan](#)

## PROCEDURE:

### Decision Making

#### A. Alert Period

1. Unless directed otherwise by the Santa Clara County Public Health Department (SCCPHD), El Camino Health shall enter the Alert Period as outlined in the subsequent sections of this plan upon notification by the SCCPHD of the first confirmed case of the pandemic in the United States.
2. Upon entering the Alert Period, the hospital shall convene an emergency pandemic task force to review/revise this plan that includes:
  - a. Use of the Hospital Incident Command System (HICS) at both hospital campuses for a sustained continuity of hospital operations and patient care services:
    - i. Specific pandemic planning strategies that incorporate current local, state and federal guidance
    - ii. Triggers for activating the hospital's internal pandemic emergency plan
    - iii. Assignment of authority and responsibility for aspects of the pandemic plan and response within the facility
    - iv. Patient triage systems
3. **Pandemic Period**
  - a. El Camino Health shall implement the Pandemic Period plans outlined in the subsequent sections when the first confirmed case of the pandemic virus upon either the notification of SCCPHD, or the awareness of a sudden surge of patients during the initial phases of the pandemic within the Bay Area.

### Hospital Surveillance

- The goal of disease surveillance is to serve as an early warning system to detect an increase in illness in the hospital & community.

#### A. Methods

Monitor illness symptoms in Santa Clara County. The SCCPHD will define the symptoms for

the current virus.

1. ECH ED participates in syndromal surveillance. A tally sheet of major symptoms of ED patients is filled out each day and faxed every 8 hours to SCCPHD.
2. ESSENCE is a computer syndromal surveillance system which is available to hospitals for automatic reporting. ECH is not participating in ESSENCE at this time.

## B. Alert Period

1. SCCPHD may require:
  - a. Laboratory confirmed - associated hospitalizations to be placed on the reportable disease list.
  - b. Specimens from patients meeting the case definition for suspect infection are sent to the Santa Clara County Public Health Lab (SCCPHL).
2. ECH lab has a procedure in place for safe transport of specimens to SCCPHL.
3. The following procedure for monitoring employee absenteeism will be implemented.
  - a. **All** employees calling in sick with symptoms will be required to leave a voice mail message on a designated **FLU LINE**, that will be published by Employee Wellness and Health in addition to following their normal department sick call procedures.
    - i. The employee will be asked to provide the following information:
      - a. Name
      - b. Department where they work
      - c. Contact telephone number
      - d. Symptoms they are exhibiting
      - e. Duration of symptoms.
    - b. The **FLU LINE** will be monitored by the Employee Wellness and Health Services Department on a daily basis Monday through Friday.
    - c. A tally sheet of the number of sick calls with the specified symptoms will be filled out daily and faxed to the Infection Prevention Department for review and correlation with the Emergency Department data.

## C. Pandemic Period

1. ECH will provide status reports through the EMResource messaging. Early in this period, case level reporting will be done. As the pandemic spreads, batch reporting will be done. SCCPHD reporting forms are provided in the county plan.

# Infection Control

- The goals of infection control are:
  - To limit transmission of the pandemic virus from infected patients to non-infected patients and staff
  - To provide infection control guidance to the hospital on managing pandemic

patients.

- Since a vaccine for the pandemic virus may not be available immediately, and antiviral drugs may be in limited supply, the ability to limit transmission will depend upon the use of appropriate infection control measures

#### **A. Alert Period**

1. ECH has a respiratory protection program in place for designated clinical staff. Powered Air-Purifying Respirators (PAPRs) are worn by staff when providing care for a patient with a suspect or known airborne transmitted disease.
  - a. In the event that the number of PAPRs is insufficient to protect staff, N-95 masks may be used. However, just-in-time fit testing will need to be completed for all staff prior to using the N-95 mask.
2. Central Stores will order additional supplies of PPE to maintain an adequate supply for the average daily census. The estimated minimum quantities are five sets of PPE used per day for each infected patient. See Section 9 for additional information on surge capacity. A procedure for acquiring additional supplies in an emergency will be developed.
3. All staff is educated on the importance of containing respiratory secretions to prevent the transmission of disease during employee orientation. Emphasis is also placed on staff being prepared at home with emergency supplies which include gloves and masks.
4. Respiratory hygiene etiquette signs and masks are available at the main entrances to the hospital

#### **B. Pandemic Period**

1. Detection of persons entering the hospital with suspect or known pandemic virus.
2. Instruct persons with signs of respiratory illness to use respiratory hygiene etiquette. This includes:
  - a. Respiratory hygiene stations with supplies of masks, tissues and gel and posted signs in appropriate languages with instructions to immediately report symptoms of respiratory infections as directed.
  - b. Instructions on the proper use and disposal of masks and tissues, and the use of antimicrobial gels after contact with respiratory secretions. Emphasis on covering the nose/mouth with tissues or with an arm when coughing and sneezing.
  - c. Spatial separation of persons with respiratory infections in common areas if possible.
3. Entrances to the hospital may be restricted for patients and visitors and a separate, designated entrance for employees.
4. A designated area will be used for daily screening employees for virus symptoms. This will include monitoring temperature and signs & symptoms of the virus.
  - a. A designated colored dot will be placed on staff badges once the virus is

ruled out. The color of the dots will change every day.

5. Security or other staff will be available to assist with screening at the entrances
6. Visitors will be screened for signs and symptoms of the virus before entry into the hospital. Anyone suspicious for the virus will not be permitted inside the facility.
7. Family members who accompany patients with the pandemic virus are assumed to be exposed and should wear masks.
8. Only visitors who are necessary for the patient's well-being and care shall be allowed in the hospital.
9. Non infected visitors will be instructed on proper use of PPE and hand hygiene before entering and leaving a patient's room.

### C. Management of Infectious Patients

#### 1. Patient Placement

- a. Limit admission to pandemic virus patients with severe complications who cannot be cared for outside the hospital.
- b. These patients should be placed on airborne precautions for a minimum of 5 days to 14 days from onset of symptoms or as directed by the SCCPHD.
  - i. Immuno-compromised patients may be placed on isolation for the duration of their illness.
- c. A pandemic unit shall be established within the hospital. Assess available spaces for patient care and isolation capabilities. This should be done early in the course of a local outbreak.
- d. Personnel assigned to cohorted patient care units should not float to other units. The number of personnel entering this unit should be limited to those necessary for patient care and support.
- e. Health care workers should be vigilant to avoid:
  - i. Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved):
  - ii. Adjusting PPE after contact with infected patient.
  - iii. Improper removal of PPE.
  - iv. Contaminating environmental surfaces that are not directly related to the patient (door knobs, light switches, etc.)
- f. Health care workers should practice careful hand hygiene.

#### 2. Personal Protective Equipment (PPE)

- a. Respiratory Protection
  - i. **Powered Air-Purifying Respirators (PAPR):** Staff taking care of infected patients will wear a PAPR when in close contact with an infected patient whenever possible.

- ii. **N-95 Masks:** Should the need for PAPRs exceed the available quantity, N-95 masks may be used. However, just-in-time fit testing of the N-95 masks must be completed by each employee prior to use.
  - a. Ideally the mask should be worn once and discarded. If in short supply, this may be changed. If patients are in a common area, one mask may be worn for multiple patients over a short period of time.
  - b. Change masks when they become soiled or contaminated.
  - c. Do not leave a mask dangling around the neck.
  - d. After touching or when discarding the mask, perform hand hygiene.

b. Gloves

- i. Gloves should be worn for contact with all body fluids including respiratory secretions.
- ii. Remove and discard gloves after contact with a patient. Perform hand hygiene.
- iii. If gloves are in short supply, priorities for glove use may need to be established.

c. Gowns

- i. Wear an isolation gown if soiling of clothes is anticipated. Most patient contact does not require the use of a gown. Procedures that involve close contact with the patient or the generation of aerosols require the use of a gown.
- ii. Gowns should be used only once and then properly disposed of and hand hygiene performed. If gowns are in short supply, priorities for their use may need to be established.

d. Goggles or face shields

- i. If sprays or splatters of infectious material are likely, goggles or a face shield should be worn.
- ii. Eye protection should be properly disposed of and hand hygiene performed.

3. Patient transport

- a. Limit patient movement and transport outside the isolation area. Consider having a portable X-ray machine for use with the area.
- b. If transport is essential, patient must wear a regular mask and perform hand hygiene before leaving the area.

4. Standard precautions are used for:

- a. Disposal of wastes
  - b. Handling contaminated linen (*linen cart kept in room*)
  - c. Handling dishes and eating utensils
  - d. Handling and reprocessing used patient care equipment
  - e. Environmental cleaning and disinfection
5. Cleaning and disinfection of an occupied room or area
- a. Wear gloves according to facility policy and wearing respiratory protection as defined above. Gowns are not necessary for routine cleaning.
  - b. Keep areas around patient free of unnecessary supplies and equipment
  - c. Use only approved disinfectants.
  - d. Pay special attention to frequently touched surfaces.
6. Cleaning and disinfection after discharge or transfer
- a. Follow standard precautions
  - b. Postmortem care-follow standard precautions
7. Employee Health Issues
- a. Implement a system to educate personnel about employee health issues related to the pandemic.
  - b. Screen all personnel for virus symptoms before they come on duty.
  - c. Personnel who are at high risk for complications of the virus (pregnant women, immuno-compromised persons) should be informed about their medical risk and offered a job away from infectious patients
8. Control of hospital-acquired transmission
- a. If limited hospital-acquired transmission is detected, appropriate controls should be implemented. These may include:
    - i. Co-horting of patients and staff on affected units.
    - ii. Restriction of new admissions to the affected areas.
    - iii. Restriction of visitors to affected areas.
  - b. If wide spread hospital-acquired transmission occurs, these controls:
    - i. Restrict all nonessential persons.
    - ii. Stop admissions not related to pandemic and stop elective surgeries.

## Hospital Risk Communications

### A. Information Sources

1. Information regarding a pandemic and the planning for it is available from a variety of sources, including, but not limited to:

- a. Centers for Disease Control (CDC) - CDC's Emergency Communication System – <http://www.pandemicflu.gov>
  - b. California Department of Health Services - California Health Alert Network (CAHAN)
  - c. Santa Clara County Public Health Department (SCCPHD) - <http://www.sccgov.org/portal/site/phd/>
2. To reduce the likelihood of conflicting or confusing messages during Alert and Pandemic periods across the health care system, El Camino Health 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 health care facilities. The hospital Public Information Officer (PIO) shall maintain a close working relationship with the SCCPHD PIO.

## B. Alert Period

Upon activation of the Hospital Command Center (HCC) and implementation of Hospital Incident Command System (HICS), the following procedures will be put into place:

1. External Communication to Health Networks
  - a. The hospital Public Information Officer (PIO) shall be the single-source contact with the SCCPHD PIO. The hospital PIO shall be assigned by the Incident Commander under the hospital's HICS plan.
  - b. The hospital Infection Prevention staff will assist with the tracking of local transmissible respiratory diseases, case definitions, and new epidemiological findings.
2. External Communication to Public
  - a. The PIO shall work with the SCCPHD, HCC and Community Relations to create appropriate messages for staff, patients, and the general public.
  - b. Possible resources for distributing information could be:
    - i. Social Media (Facebook, Twitter, etc.)
    - ii. Mass notification system (e.g. Everbridge)
    - iii. Recorded Messages on special hot line
    - iv. Hospital Website
    - v. Printed bulletins
    - vi. Radio – KCBS (740 AM)
3. Internal Communication to Staff
  - a. Education and training shall be provided to all staff and volunteers. See Section 5 – Education and Training of this plan.
  - b. Information and messages for staff and volunteers including updated

information on the hospital status, staffing needs, and other pandemic information provided by the SCCPHD shall be distributed using appropriate channels.

- c. The content of the communications shall be determined by:
  - i. PIO
  - ii. Liaison Officer
  - iii. Infection Prevention
  - iv. Human Resources
- d. Possible resources for distributing information can include
  - Recorded Messages on special hot line
  - Hospital Website
  - Mass Notification System (e.g. Everbridge)
  - "All ECH" email
  - Vocera broadcasts
  - Printed bulletins
  - FAQ

**C. Pandemic Period**

During the pandemic period, the hospital PIO will:

1. Maintain a single source of contact with SCCPHD PIO, ensuring information is updated, as needed.
2. Maintain internal and external communications as outlined during the Alert Period.

## Education And Training

**A. Information Sources**

1. Offering information and education prior to an event can be addressed by designating a local educational leader who will plan, conduct and execute training and educational opportunities on topics such as:

Topic	Responsible Party	Status/Action
Awareness of global or local transmissible respiratory infectious diseases	<ul style="list-style-type: none"> <li>• Nursing Education Manager</li> <li>• Safety Officer</li> </ul>	<ul style="list-style-type: none"> <li>• See Information from SCCPHD</li> <li>• Documentation from CDC</li> <li>• See Infection Control Exposure Control Plan</li> </ul>

Topic	Responsible Party	Status/Action
Identification of infection control practices, isolation, quarantine, and home care as appropriate or needed to respond to a possible pandemic	<ul style="list-style-type: none"> <li>• Infection Prevention</li> </ul>	<ul style="list-style-type: none"> <li>• See Information from SCCPHD</li> <li>• See Infection Control Exposure Control Plan</li> </ul>
Awareness of comprehensive standard precautions policies incorporating hand and respiratory hygiene protocols to be practiced at all times as a means of general infection control and prevention	<ul style="list-style-type: none"> <li>• Infection Prevention</li> </ul>	<ul style="list-style-type: none"> <li>• See Infection Control Exposure Control Plan</li> <li>• Ongoing revisions and updates as necessary</li> </ul>
Use of PPE to decrease disease spread and how to assist patients and visitors on PPE use	<ul style="list-style-type: none"> <li>• Infection Prevention</li> <li>• Nursing Education</li> <li>• Employee Wellness and Health Services</li> </ul>	<ul style="list-style-type: none"> <li>• HealthStream Training</li> <li>• Ongoing</li> </ul>
Cross-training of Clinical and Non-clinical staff who are not currently direct caregivers to provide care as needed	<ul style="list-style-type: none"> <li>• Nursing Education</li> <li>• Safety Officer</li> </ul>	<p>Upon notification of <i>Alert Status</i> by SCCPHD</p> <ul style="list-style-type: none"> <li>• Town Hall Meetings</li> <li>• Additional Training</li> </ul>
Education of patients, family members and visitors	<ul style="list-style-type: none"> <li>• Nursing Education</li> <li>• Infection Prevention</li> <li>• Education Director</li> <li>• Community</li> </ul>	<ul style="list-style-type: none"> <li>• See information from SCCPHD</li> <li>• Develop an El Camino Health-specific Pandemic memo.</li> </ul>

COPY

Topic	Responsible Party	Status/Action
	Relations	

B. Additional Resources from Pandemic Plan (Attachments)

1. Home Isolation Checklists: *SCC Home Isolation Checklist*
2. Website Reference Tool: *Pandemic Reference Tools*
3. Home Preparedness Checklist: *Home Preparedness Information*

## Patient Triage

A. Pandemic Triage Supply List

Item Description	Quantities*	
	Mountain View <sup>[1]</sup>	Los Gatos <sup>[2]</sup>
Monitors	2	1
PAPR	45	10
N95 Masks	2000	1000
Surgical Masks	2000	1000
Oxygen tanks	4	2
Oxygen Masks	4	2
Antimicrobial Hand Gel	24 bottles	12 bottles
Antimicrobial Wipes	10 containers	5 containers
Medium Gloves	720 boxes	360 boxes
Isolation gowns	450	225
Tympanic Thermometer	2	2
Thermometer covers	1000	500
Emesis Basins	250	125
Signs to explain how to fill out self-history	2 - 4	2 - 4
Tents	2	2
Chairs	4	4
Heaters	4	4
Garbage Cans	2	2
Wheelchairs	2	2
Copies Home Isolation Checklist	100, Copy as needed	100, Copy as needed

<sup>[1]</sup> The numbers represent estimated supplies for 150 people for 3 days.

<sup>[2]</sup> The numbers represent estimated supplies for 75 people for 3 days.

# Clinical Guidelines

- El Camino Health is utilizing the clinical guidelines as outlined by the SCCPHD Department in the Pandemic Preparedness and Response Plan.
  - Note: Refer to SCCPHD website for current revision

## A. Overview

Refer to Module V - Clinical Guidelines and Disease Management for a complete description of guidelines for health care providers.

The CDPH “Pandemic Influenza Preparedness and Response Plan” acknowledges, “The management of a pandemic is based primarily on sound clinical assessment and management of individual patients as well as an assessment of locally available resources such as rapid diagnostics, antiviral drugs and vaccines, and hospital beds.”

Health care providers play an essential role in detecting an initial case of novel or pandemic virus in a community. Early detection through heightened clinical awareness of disease and swift action for isolation and initiation of treatment can benefit the individual patient and may slow the spread of the virus within the community. Rapid diagnosis and intervention with clinical care can potentially avert severe complications.” (from the California Department of Health Services Pandemic Influenza Preparedness and Response Plan, Draft. Appendix 5, January, 2006.)

## B. Alert Period

1. Hospital Pandemic Plans should include a defined process for ensuring that clinical guidance received from SCCPHD and California Department of Public Health (CDPH) is shared with clinical staff.
2. SCCPHD has developed “Clinical Algorithm for Case Management- Alert period” (Tool M5-4) (See attachment - SCC Clinical Algorithm (Alert Period)), that should be used by all SCC clinicians in evaluating and diagnosing a novel virus. This includes both clinical criteria and epidemiological criteria.

## C. Pandemic Period

SCC Hospitals should implement plans to assure that clinical guidance received from SCCPHD and CDPH are shared with all clinicians (See attachment - SCC Clinical Algorithm (Pandemic Period)).

# Vaccines And Antiviral Drugs

- El Camino Health is utilizing the Vaccines and Antiviral Drugs section as outlined by the Santa Clara County Public Health Department in the Pandemic Influenza Preparedness and Response Plan.
  - Note: Refer to SCCPHD website for current revision: <http://www.sccgov.org/portal/site/phd/>.

## A. Overview

Refer to Module V - Clinical Guidelines and Disease Management for a complete description of

the use and administration of vaccines and antiviral drugs during a pandemic.

Once the characteristics of a new pandemic virus are identified, the development of a pandemic vaccine will begin. Recognizing that there may be benefits to immunization with a vaccine prepared before the pandemic against a virus of the same subtype, efforts are underway by the federal government to stockpile vaccines for subtypes with pandemic potential. As supplies of these vaccines become available, it is possible that the federal government will recommend that some health care personnel and others critical to a pandemic response will be vaccinated to provide partial protection or immunological priming for a pandemic strain. HHS has not finalized policies for the use of pre-pandemic vaccine. During a pandemic, these recommendations will be updated, taking into account populations that are most at risk.

Antiviral drugs effective against the circulating pandemic strain can be used for treatment and possibly prophylaxis during a pandemic. Decisions regarding whether to prioritize use of antivirals for treatment over prophylaxis, or for prophylaxis over treatment, will be determined, to the extent possible, on the basis of demonstrated efficacy of the antiviral agents against novel and pandemic virus strains.

**B. Alert Period**

SCC hospitals will:

1. Monitor updated HHS information and recommendations on the development, distribution, and use of a vaccine.
2. Work with SCCPHD on plans for distributing vaccine.
3. Provide estimates of the quantities of vaccine needed for hospital staff and patients using SCCPHD criteria.
4. Develop a hospital pandemic vaccination plan.

**C. Pandemic Period**

SCC hospitals will:

1. Follow SCCPHD guidelines for use and administration of antiviral drugs for prophylaxis measures and treatment, if available.
2. Implement the hospital pandemic vaccination plan, as directed by SCCPHD.

## Surge Capacity

- Refer to Emergency Management Plan – Hospital Surge Capacity Plan

## Mortuary Issues

- Refer to Emergency Management Plan – Mass Fatality Plan

## Security – Facility Access

**A. Alert Period**

Upon notification that the hospital has entered an Alert Period, as defined by the Santa Clara

County Public Health Department, the following may be enforced:

1. The Hospital Command Center (HCC) shall be activated.
  - a. The HCC shall direct all actions of the hospital, including:
  - b. Decisions regarding the temporary closure of the hospital to new admissions and transfers.
  - c. Restricting hospital access to employees, patients, and essential visitors only.
    - Essential visitors include family members, care-givers of patients, vendors delivering essential supplies, and those approved by the HCC.
  - d. Non-essential visitors will not be allowed access.

2. Security

Upon notification that the hospital has restricted access Security shall:

- a. Lock all exterior hospital doors. Access will be by card key only.
- b. Contract additional security staff to assist with and enforce lock down of the facility.
- c. Follow directions from the HCC. (See *Emergency Management Security Plan* for more information.)

3. Facilities

Upon notification that the hospital has restricted access Facilities shall:

- a. Coordinate with the HCC to define and set up a screening area for all patients and visitors to the hospital. Specifics will be determined by the HCC.
- b. This space may be external to the main hospital buildings, such as
  - Large tent – secure an extended rental of a large event-type tent
  - Parking garage
  - Other space deemed appropriate.
- c. This space will require lighting, electrical power, chairs, cots, tables, gurneys, and other equipment requested by the clinical staff.
- d. EVS and general stores will assist with providing and setting up of equipment.
- e. Facilities will arrange for the leasing of equipment, as needed.

**B. Pandemic Period**

Upon notification by the HCC that the hospital has entered a pandemic period the following additional measures will be taken.

1. HCC
  - a. Code Triage will be called.

## 2. Security

- a. Follow the Emergency Security Plan under the direction of the HCC. (Emergency Management - Security Plan)
- b. Card key access to external doors may be disabled.
- c. All hospital entrances shall be secured.
- d. Officers or other staff shall be posted at all entrances.
- e. Security may request additional assistance from the Labor Pool.
- f. Only staff that have been screened by Employee Wellness and Health Services will be allowed entry.

## 3. Facilities

- a. Facilities will assist in setting up a screening area for all employees.
- b. This entrance will be separate from the patient/visitor screening area.
- c. Any employee must be approved for entry by Employee Wellness and Health Services.

# Occupational Health

- Novel viruses can often have an explosive impact in the health care setting and preventing transmission is an important concern for the protection of staff and patients and to ensure that El Camino Health can maintain its core functions.

## A. Alert Period

Upon notification that the hospital has entered an Alert Period, as defined by the Santa Clara County Public Health Department, the following will occur:

1. All staff and extended staff involved in the care of patients should be vaccinated with the most recent seasonal human influenza vaccine.
2. All staff and extended staff who have traveled within the past 10 days (or as specified by SCCPHD) by airplane or from an area considered high-risk by Infection Prevention shall be screened by Employee Wellness and Health Services before reporting to work.
3. All staff and extended staff will need to be vigilant for symptoms of the virus for up to one week, or as specified by the SCCPHD, after their last exposure to an infected patient.
4. All staff and extended staff who become ill should do the following:
  - a. Seek medical care but prior to arrival notify their health care provider they may have been exposed to the suspect virus.
  - b. Notify Employee Wellness and Health Services
  - c. Stay home until 24 hours (or as defined by SCCPHD) after resolution of fever and symptoms unless one of the following applies:
    - i. An alternative diagnosis is established that explains the health care worker's illness

- ii. Diagnostic tests are negative for the virus
- d. While at home, ill persons should practice good respiratory and hand hygiene to lower the risk of transmitting the virus to others.

## B. Pandemic Period

1. All staff and extended staff will be screened for symptoms before they are allowed to enter any ECH facility.
  - a. Main Hospital at both Mountain View and Los Gatos: a single entrance will be made available for all Health care workers of main hospital facility to be screened for clearance to work. This includes staff working in the Women's Hospital, Willow, Oak, Cedar, Sobrato, Taube, Melchor and Park Pavilion, Los Gatos Rehab and PPI.
2. Screening criteria will include:
  - a. Temperature
  - b. Employee Wellness and Health Services symptom review questionnaire (see *EHS Symptom Review Questionnaire*).
3. Each "cleared" staff will be provided with a colored indicator to be worn for the entire shift to signify that they have been met the criteria for being able to report for duty that day.
  - a. Health care workers will not be allowed to enter any ECH facility without the appropriate colored wrist band.
  - b. The colored indicator (e.g., wrist bands or dots) will be changed daily.
4. Any health care worker who becomes symptomatic while on duty will be required to don a surgical mask and report to EWHS for a medical evaluation.
5. Concern EAP will be available for counseling for any employee of El Camino Health.
6. Rest and meal breaks will be provided through the Labor Pool. This will be coordinated through the HICS Logistics Branch (Employee Health and Well-Being Unit Leader).

*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.*

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## Attachments

[Pandemic Plan - Action Table.docx](#)

[Pandemic Plan - Home Preparedness Information.docx](#)

[Pandemic Plan - Pandemic Reference Tools.docx](#)

[Pandemic Plan - SCC Clinical Algorithm \(Alert Period\).docx](#)

[Pandemic Plan - SCC Clinical Algorithm \(Pandemic Period\).docx](#)

[Pandemic Plan - SCC Home Isolation Checklist.docx](#)

## Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	04/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	03/2023
Infection Prevention Committee	Delfina Payer: Quality Data Analyst	02/2023
Emergency Management Committee	Daniel Peck: Mgr Environmental Hlth&Safety	01/2023
	Daniel Peck: Mgr Environmental Hlth&Safety	11/2022

## History

**Sent for re-approval by Peck, Daniel: Mgr Environmental Hlth&Safety** on 11/15/2022, 12:19PM EST

No changes

**Last Approved by Peck, Daniel: Mgr Environmental Hlth&Safety** on 11/15/2022, 12:19PM EST

**Last Approved by Peck, Daniel: Mgr Environmental Hlth&Safety** on 1/25/2023, 2:30PM EST

Approved by EM Committee 1-24-2023

**Last Approved by Payer, Delfina: Quality Data Analyst** on 2/16/2023, 6:08PM EST

Approved by ICC 2/16/23

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 3/13/2023, 10:39AM EDT

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ePolicy 3/10/23

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/13/2023, 3:38PM EDT

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

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 4/3/2023, 3:31PM EDT

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 4/3/2023, 5:01PM EDT

MEC 3/23/23

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

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

COPY

Status **Pending** PolicyStat ID **12809854**



Origination 11/2020  
Last Approved N/A  
Effective Upon Approval  
Last Revised 04/2023  
Next Review 1 year after approval

Owner Poopak Barirani:  
Asst Director  
Pharmacy  
Area Pharmacy  
Document Plan  
Types

## MERP - Medication Error Reduction Plan

**Coverage**

**COVERAGE:**

El Camino Hospital Mountain View & Los Gatos

## MERP (Medication Error Reduction Plan)

**OVERVIEW:**

In 2001 the California legislature passed legislation resulting in HSC 1339.63 which required every general acute care hospital to adopt a formal plan to eliminate or substantially reduce medication-related errors. Ensuring that our patient population receives quality health care is and always has been of utmost importance to El Camino Hospitals.

Medication error reduction is one of our key areas of focus. This plan is an opportunity to evaluate our strategies for safe medical practices related to professional practice, or health care product, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

This plan outlines multiple methods for reducing medication errors and will address each of the following strategies:

1. Evaluate, assess, and include a method to address the 11 elements: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding,

dispensing, distribution, administration, education, monitoring, and use to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.

2. Annual review of the plan to assess the effectiveness of the implementation of procedures and systems related to the 11 elements.
3. Modify the plan as warranted when vulnerabilities or deficiencies are noted to achieve the reduction of medication errors.
4. Evaluate and assess ability and progress in implementing information technology requirements and how technology implementation is expected to reduce medication-related errors.
5. Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.
6. Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical, information technology and administration to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.
7. Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate e.g., ISMP and medication safety publications.

## **References:**

1. [SB1875 & HSC 1339.63\(g\)](#)

## **Objectives:**

### **REFERENCE:**

- : [SB1875 & HSC 1339.63\(g\)](#)

### **OBJECTIVES:**

1. Create a common understanding of the current state of medication errors in the healthcare industry and to create a non-punitive system of reporting errors.
2. Define medication processes that support medication safety throughout the 11 elements.
3. Improve the clinical decision making process related to medication use.
4. Improve communication among the health professionals and patients.
5. Monitor Medication error events.
6. Enterprise Medication Safety Committee, RN-RX Council MV and RN-RX Council LG and Pharmacy & Therapeutics Committee (P&T) review and evaluate various components of medication management: practices, processes, and usage, compliance and safety concerns.

## Structure:

### STRUCTURE:

- A. A collaborative multidisciplinary approach has been organized to ensure adequate participation of hospital personnel. Each of the following participate in the medication safety improvement process:
1. care staff. Pharmacy and Nursing Leadership coordinate the meetings. The councils make recommendations, advise, and provide guidance and recommendations related to nursing practice and operationalizing initiatives. RN-RX reviews ISMP newsletters as part of the agenda. RN-RX is also the approving body for Automated Dispensing Machines (ADM) override requests.
  2. Medication Safety Committee: The members of the committee include representatives of medical staff, pharmacy, nursing, and quality/patient safety and adhoc members. The committee is responsible for the evaluation and implementation of the MERP and reports directly to P&T. The Medication Safety Committee analyzes medication error reports, medication usage, medication shortages and participates in MERP. This is a committee that proposes action plans for process improvement and makes recommendations to P&T.
  3. MERP subcommittee: The members include: Pharmacy, Nursing and other ad hoc members. MERP subcommittee will be directly working on the Medication Error Reduction Plan and will report to Medication Safety. Responsible for monitoring compliance and developing action plans related to 11 MERP elements.
  4. Pharmacy and Therapeutics (P&T) Committee: Medical Staff Committee consisting of Physicians, Chief Nursing Officer (CNO), Senior Director of Quality , pharmacists, dietician, pharmacy informatics staff, nursing leadership and ad hoc members. P&T reviews a summary of medication error/event reports and adverse drug reactions, approves/monitors formulary deletions and additions, reviews recalls/medications in short supply, MERP plan, and approves policies and procedures.
  5. Hospital Quality Committee & Patient/Employee Safety Committee: Medication Safety and Pharmacy Department reports medication safety activities to these committees.
  6. Medical Executive Committee: Reviews P&T reports, reviews and approves policies and procedures.
  7. Pharmacy Department: Review of medication use related to procedures and systems: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use; medication errors.
- B. Medication Error Reporting process:
1. Errors, near misses, safety and system issues are reported by hospital staff using the electronic system for reporting of unusual occurrence and patient safety issues.
  2. The reports are reviewed by risk management and clinical leadership. Trends for medication errors will be identified and analyzed by Med Safety and MERP

committee on a regular basis and takes actions as appropriate.

3. Medication error trends and MERP plans are reported to P&T for review and approval.
4. P&T refers physician specific issues to appropriate Medical Staff committees and process issues to Hospital Quality Committee as needed.

C. Communication of Medication Safety Information:

1. Staff and Department Meetings
2. Departmental or organizational newsletters such as Pharmacy Newsletter, and InTouch (nursing newsletter), Pharmacy-Nursing Connection Newsletter
3. Resources provided include computer based drug information programs (e.g., UpToDate, Micromedex/Lexicomp , as well as other available references in the intranet "Tool Box")
4. Policies and Procedures: Policies and procedures are available online on the hospital's intranet.
5. Director of Pharmacy sends monthly Nursing ISMP and biweekly overall Institute of Safe Medication Practices Acute Care Edition to all pharmacy and nursing staff.
6. External sources of information will be reviewed and shared with staff as appropriate. Examples of sources include but are not limited to the following: FDA Medwatch list serve, California State Board of Pharmacy list serve, The Joint Commission Sentinel Event Alert list serve, the ASHP Patient Safety News list serve, the Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI).

## ~~Medication Error Reporting and Monitoring:~~

## MEDICATION ERROR REPORTING AND MONITORING:

- A. Definition: A "medication-related error" means any preventable medication-related event that adversely affects a patient and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:
  1. Prescribing
  2. Prescription order communications
  3. Product labeling
  4. Packaging and nomenclature
  5. Compounding
  6. Dispensing
  7. Distribution
  8. Administration

9. Education
10. Monitoring
11. Use

B. Proactive identification of actual and potential medication related errors:

1. Medication Safety Committee: Continuous performance improvement review mechanism for medication errors both potential and actual. Reviews medication errors, performs regular assessments, and conducts ongoing evaluation of the medication systems and procedures.
2. Identification of the potential medication-related errors are done by reviewing a variety of patient safety related publications such as ISMP Medication Safety Newsletter, FDA MedWatch, The Joint Commission Sentinel Event Alerts, ASHP Patient Safety List-Serve and California Board of Pharmacy e-mail alerts, identifying any issues that are pertinent at the facility and then implementing suggested changes.

C. Voluntary Non-Punitive Reporting System:

1. Potential or actual medication-related errors are primarily identified via non-punitive unusual occurrence reporting system by hospital staff, which can be submitted anonymously.
2. Actual or potential (near miss) medication-related errors are identified by all staff and physicians.
3. Adverse Drug Reaction (ADR) reports may be done via unusual occurrence system, telephone hot-line or by pharmacy generating reports on reversal agents.

## Process:

## PROCESS:

A. Plan Development Process:

1. Multidisciplinary MERP subcommittee members evaluate the current plan and facilitate the assessment of MERP. Potential or actual medication errors and adverse medication events are discussed at Medication Safety Committee and then reported to Pharmacy & Therapeutics.
2. Analysis of Medication Errors: MERP sub-committee reviews medication errors to identify trends, categorize, and identified the opportunities for reductions of errors.
3. MERP Subcommittee is responsible for identifying annual goals for MERP.

B. Assessment:

1. Baseline assessment of medication related problems and annual review of the effectiveness of the plan are performed using an objective based critical review. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions to achieve goals.

C. Requirements for Assessing the Effectiveness of MERP:

1. Evaluate, assess, and include a method to address each of the procedures and systems listed under 1339, H&S, subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medications.
2. Categorize and focus on evaluating 11 elements of the MERP implementation for ongoing improvement.

## Refer to ECH detailed Fiscal Year MERP Crosswalk (Medication Safety Committee)

*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.*

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### Attachments

[Final-FY2022-Medication Safety and MERP annual report.pdf](#)

[MERP FY2021 Annual and FY22 Plan.pdf](#)

[MERP Trends and Accomplishments FY2020.pdf](#)

### Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	04/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2023
P & T Committee	Mojgan Nodoushani: Manager Clinical Pharmacy	01/2023
Medication Safety Committee	Poopak Barirani: Asst Director Pharmacy	12/2022
	Poopak Barirani: Asst Director Pharmacy	12/2022

## History

**Draft saved by Santos, Patrick: Policy and Procedure Coordinator** on 12/9/2022, 1:01PM EST

**Edited by Santos, Patrick: Policy and Procedure Coordinator** on 12/9/2022, 1:02PM EST

Starting approval process

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 12/20/2022, 1:21PM EST

Uploaded FY22 Annual Report Attachment, per email from Deep M.

**Comment by Barirani, Poopak: Asst Director Pharmacy** on 12/20/2022, 2:10PM EST

policy has remained the same, we just updated with FY22 summary and plan for FY23

**Last Approved by Barirani, Poopak: Asst Director Pharmacy** on 12/20/2022, 2:11PM EST

policy is the same, we just update annually with the accomplishments of pervious year (in this case FY22) and plan for the next year (in this case FY23)

**Last Approved by Barirani, Poopak: Asst Director Pharmacy** on 12/20/2022, 2:12PM EST

**Last Approved by Nodoushani, Mojgan: Senior Manager-Clinical Pharmacy** on 1/27/2023, 2:46PM EST

Approved at P&T on 1/26/2023

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 2/22/2023, 1:02PM EST

Removed FY23 in title, per ePolicy; formatting correction.

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 2/22/2023, 1:02PM EST

ePolicy 2/17/23

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/13/2023, 3:55PM EDT

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/30/2023, 4:24PM EDT

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

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3:39PM EDT

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 4/3/2023, 4:34PM EDT

MEC 3/23/23

COPY



Origination	11/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2023
Next Review	3 years after approval

Owner	Joy Tobin: Health Library Res Ctr Coord
Area	Scopes of Service
Document Types	Scope of Service/ADT

## Scope of Service - Health Library & Resource Center

### Types and Ages of Clients Served

The Health Library & Resource Center provides health related resources for adults, older adults and their caregivers, physicians and employees of El Camino Health. Affiliation with El Camino Health is not required to use the services of the Health Library & Resource Center.

### Scope and Complexity of Services Offered

The El Camino Health Library & Resource Center offers a comprehensive range of health information in its combined consumer and medical library. The Center, which is free and open to the public, is dedicated to helping patients, families, physicians, employees and the community find the resources and information they need to make informed decisions about their health. The following is a list of the services available in the Center.

- A Health Library
- Family caregiver assistance (eldercare consulting)
- A Health Library & Resource Center free membership program that includes: Free check-out privileges for health library materials and home access to medical and consumer health journals on line
- Medicare health insurance counseling (HICAP)
- Advance Health Care Directive assistance (AHCD)
- Support Groups
- Wellness programs:

~~Blood pressure screenings~~

- Consult the Dietitian
- Consult the Pharmacist
- Special community service projects such as Health Fairs, screenings, etc.

## Staffing

The staff providing services includes ~~two~~one medical ~~librarians~~librarian and one part time resource center coordinator. Operational oversight is provided by the Sr. Director of Government Relations and Community Benefit Partnerships.

## Level of Service Provided

The Health Library & Resource Center provides outpatient information and ~~referral~~referrals to patients and their families, community members, physicians and employees using center policy and procedure guidelines. The Center in Mountain View is open to the public Monday ~~through, Wednesday and~~ Friday 8:30 a.m. to 5:00 p.m. and Tuesday and Thursday 8:30 a.m. to 1:00 p.m. ~~The Center at El Camino Health Los Gatos is open to the public Tuesday and Thursday from 8:30 a.m. to 5:00 a.m. to 5:00 p.m.~~ The Center at El Camino Health Los Gatos ~~Currently due to COVID-19 the HLRC is not open to the public Monday through Thursday from 9:00 am~~ community in person only by telephone and email assistance. to 3:00 p.m.

## Standard of Practice

The Health Library & Resource Center is governed by Joint Commission on Accreditation of Health care Organizations standards.

*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	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	04/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2023

Department Medical Director  
or Director for non-clinical  
Departments

Joy Tobin: Health Library Res  
Ctr Coord

01/2023

Joy Tobin: Health Library Res  
Ctr Coord

01/2023

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## History

**Sent for re-approval by Tobin, Joy: Health Library Res Ctr Coord** on 1/10/2023, 3:31PM EST

**Draft saved by Tobin, Joy: Health Library Res Ctr Coord** on 1/17/2023, 1:07PM EST

**Last Approved by Tobin, Joy: Health Library Res Ctr Coord** on 1/17/2023, 1:16PM EST

**Draft saved by Tobin, Joy: Health Library Res Ctr Coord** on 1/24/2023, 11:56AM EST

**Edited by Santos, Patrick: Policy and Procedure Coordinator** on 1/24/2023, 12:05PM EST

Updated by owner; restarting approval process.

**Last Approved by Tobin, Joy: Health Library Res Ctr Coord** on 1/24/2023, 12:20PM EST

**Last Approved by Tobin, Joy: Health Library Res Ctr Coord** on 1/24/2023, 1:08PM EST

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 2/1/2023, 2:24PM EST

Updated doc type

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 2/22/2023, 12:53PM EST

ePolicy 2/17/23

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/13/2023, 3:36PM EDT

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/30/2023, 4:26PM EDT

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 4/3/2023, 3:42PM EDT

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 4/3/2023, 4:49PM EDT

MEC 3/23/23



Origination	09/2015
Last Approved	N/A
Effective	Upon Approval
Last Revised	04/2023
Next Review	3 years after approval

Owner	John Harrison: Chaplain
Area	Scopes of Service
Document Types	Scope of Service/ADT

## Scope of Service Spiritual Care

### Types and Ages of Patient Serviced

Spiritual Care is provided of all age groups: To in-patients, their families, hospital and Medical Staff; Auxiliary as requested.

### Assessment Methods

The members of the Spiritual Care Service seek to assist patients, families and staff to:

1. Identify spiritual needs.
2. Identify and utilize their religious resources (beliefs, rituals, sacraments).
3. Identify needs for spiritual/religious contacts within their faith community.

### Scope and Complexity of Services Offered

The mission of the El Camino Hospital Spiritual Care Service is to provide spiritual and emotional support to patients and their families, hospital staff, physicians and auxiliary; to provide a healing environment within the hospital, recognizing and working to strengthen our ties within local religious communities.

Services include:

- Administration of Sacraments.
- Provision of active listening, referrals, presence, emotional and spiritual support, prayer, crisis intervention, grief work for individuals and small groups.
- The provision of devotional materials upon request.

- The maintenance of a spiritual care resource library for staff and physical use upon request.
- The knowledge of policies relating to ethical issues regarding effective treatment and/or termination of treatment.
- Serve as an advocate for patients/families in collaborative decision making/participating in care conferences as appropriate.

## Appropriateness, Necessity and Timeliness of Services

Patients will receive an initial visit from the Chaplain/Spiritual Care volunteer. Those patients who have indicated Do Not Visit (DNV) upon Admission will not be visited.

## Staffing

The Hospital Chaplain is available Monday through Friday.

Staff consists of Chaplains and Spiritual Care volunteers.

The chaplain's office hours are 9AM-5PM Monday through Friday. Occasional variations from this will be recorded on the chaplain's voice mail.

Between the hours of 5PM and 9AM or when chaplain unavailable, contact the Shift Supervisor for spiritual and religious concerns. The shift supervisor will determine if the chaplain needs to be contacted.

In preparation for contacting the shift supervisor, clergy, or chaplain, please address the following questions:

- Does the patient or family belong to a particular faith community?
- What is their religious background?
- Do they have a pastor, priest or rabbi who can be contacted?
- What is the nature of the patient or family's request?
- Is the support requested religious or spiritual?
- Can the nursing or support staff respond to the expressed need?
- Is the concern urgent?
- Could the concern be addressed by a phone call to the patient or family?

## Religious Concerns

Rites and Rituals - Prayer, sacraments (anointing, sacrament of the sick, baptism, confession) may be arranged. See The Toolbox for information on various religious personnel available.

Additional resources are located in the Tool Box

# Spiritual Concerns

*Meaning of illness, death, loneliness or fear*

Patients with these concerns can be supported by the materials included in the Spiritual Care Resource Binders, located on each nursing unit. Included in the binders are prayers for specific situations, which can be used by nursing staff and/or copied and given to patients and families. The binders also include information about interacting with patients and families from cultures other than our own.

Requests can be made in the chaplain's office or patient experience for hospital musicians.

# Ethical Concerns

*Questions regarding treatment options, end of life issues, withdrawal of treatment*

When appropriate, patients and families can be given a handout entitled "Making a Loving End of Life Decision". Referrals can be made to the Ethics Hotline x8228

# Level of Service Provided

~~The level of services provided is dependent on identified patient and staff needs.~~

The level of services provided is dependent on identified patient and staff needs. There are restrictions upon the Chaplain/spiritual care staff (i.e., Covid 19 patients, Carbapenem Resistant Enterovacteriaceae (CRE) patients). These isolated patients will receive spiritual care by telephone or video calls.

# Standard of Practice

Additional practices are described in department Policies and Procedures. State regulations in Title 22 are followed.

*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	Stephanie Iljin: Manager Administration	Pending
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	04/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2023

Department Medical Director  
or Director for non-clinical  
Departments

John Harrison: Chaplain

12/2022

John Harrison: Chaplain

12/2022

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## History

**Sent for re-approval by Harrison, John: Chaplain** on 12/6/2022, 12:02PM EST

**Last Approved by Harrison, John: Chaplain** on 12/13/2022, 11:32AM EST

**Last Approved by Harrison, John: Chaplain** on 12/13/2022, 11:36AM EST

**Draft saved by Harrison, John: Chaplain** on 1/17/2023, 12:11PM EST

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 1/17/2023, 12:43PM EST

Moved draft edits into pending version.

**Draft saved by Santos, Patrick: Policy and Procedure Coordinator** on 1/17/2023, 12:43PM EST

**Draft discarded by Santos, Patrick: Policy and Procedure Coordinator** on 1/17/2023, 12:43PM EST

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 1/17/2023, 12:44PM EST

ePolicy 1/13/23

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 1/31/2023, 3:12PM EST

MEC 1/26/23

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/13/2023, 3:36PM EDT

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 3/30/2023, 4:26PM EDT

**Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator** on 4/3/2023, 3:42PM EDT

**Last Approved by Encisa, Franz: Director Quality and Public Reporting** on 4/3/2023, 5:01PM EDT

MEC 3/23/23

**CEO Report  
May 10, 2023  
Dan Woods, Chief Executive Officer**

## **Operations**

**Neurosciences:** For the 14th straight year, the ECH Peter. C. Fung, MD Stroke Center received the American Heart/Stroke Association's Gold Plus award for evidence-based stroke care for 2022. This award is based on a national data registry, and reflects ECH's timely and accurate care of all stroke patients despite the pandemic. The Peter C. Fung Stroke Center and the emergency department set a new ECH record for fastest administration of anti-thrombolytic drug therapy for an acute stroke patient. The therapy was delivered just 12 minutes after patient arrival, following a CT scan of the head. Timely stroke care is critical as the brain loses millions of cells for each minute that blood flow has stopped.

A new electrophysiology cardiac treatment is being performed at El Camino Health. The treatment consists of the traditional transcatheter endo ablation on the inside of the heart followed by a cardiothoracic surgery epicardial ablation on the outside of the heart to treat longstanding persistent atrial fibrillation.

## **Medical Staff**

Thanks to a Foundation grant, we have initiated an enterprise wide patient mobility initiative based on a highly successful program developed by Johns Hopkins University. This is an evidence based approach which has been shown to positively impact length of stay, falls, readmissions, pressure injuries, hospital acquired infections, thromboembolic events, and post-acute care needs.

## **Human Resources**

### **HR Operations**

PRN Contract Negotiations started on April 5<sup>th</sup> and we have reached 10 tentative agreements on non-economic issues

### **Total Rewards**

El Camino Hospital received \$4.3 million in funding from the California Department of Healthcare Services to be awarded to eligible employees under the "Worker Retention Payment" program in response to the COVID-19 pandemic. Total Rewards is working with Finance/Payroll to distribute these payment to eligible employees within the next few weeks.

## **Nursing**

The El Camino Health Nursing Division has been participating in an International Nursing Research Study since 2020 titled "**Magnet4Europe**". The study takes place in six European countries and at 68 hospitals across the US. The aim of this multi-year, multi-site study is to measure the well-being of clinicians before, during and after an intervention. The designed interventional is to provide US guidance to hospitals in Europe on achieving the evidenced-based Magnet standards and principles known to improve the practice environment in hospitals. Last year, several nurse leaders had the opportunity to present in Mechelen, Belgium with the promise that the Belgium nurses would visit the

US the following year which is now scheduled for June. They will spend time touring and visiting with our nurses learning about shared decision making and other Magnet principles.

### **Information Services**

MyChart activation continues to increase in which ECHMN patients having an active MyChart account has reached 71%, placing ECH clinics in the top 10% percentile of all Epic customers.

The ability to transmit H&P notes from an external Epic organization (ex: PAMF) to ECH was implemented with this month's Epic Upgrade. This capability will improve the efficiency and satisfaction for surgeons and the OR.

### **EI Camino Health Foundation**

In period 9, EI Camino Health Foundation received \$304,619 in donations. This brings total funds raised by March 31, 2023 to \$9,455,547, which is 98 percent of goal for fiscal year 2023.

In April, EI Camino Health Foundation received a \$100,000 gift from a new donor to name the 5-bed pod in the neonatal intensive care unit of the renovated Orchard Pavilion. The couple made the gift in gratitude for the care their family received from the NICU nurses, doctors, and staff, who they now consider lifelong friends.

The first phase of the ASPIRE Parent Education Program gift from the Thomas and Donna Whitney Education Foundation will come to fruition on May 9, when the ASPIRE Symposium, The Parenting Curve Collaborative, launches. The free virtual event, which was planned by ASPIRE Consortium Coordinator Nahal Zakerani, PhD, will feature presentations on mental health topics related to parenting youth and young adults, and a live panel conversation facilitated by Dr. Jennifer Zumarraga.

Planning has commenced for Norma's Literary Luncheon, which will be held on Tuesday, June 13 in the garden of the historic Marini House in Los Altos. Pulitzer Prizing winning novelist Jennifer Egan will be the featured speaker.

### **Corporate Health Services**

Concern is working with multi-specialty medical groups to support their physician well-being programs.

We are in discussion with a number of large school districts that are interested in a higher level of mental health support for their teachers. School personnel are dealing with increased levels of conflict between students, teachers and the community. They would like creative solutions to assist their employees.

Chinese Health Initiative hosted an Ask-a-Doc webinar on Cardiac Testing and partnered with Milpitas Library to distribute the bilingual Health Resource Guide for Chinese Seniors. CHI received a resolution by EI Camino Healthcare District to recognize CHI's contribution in providing culturally and linguistically competent education and services.

The South Asian Heart Center engaged 402 new and prior participants in screening, education, and coaching programs to prevent heart disease and diabetes and completed 833 consultations and coaching sessions. We hosted 9 lifestyle workshops and health information events attended by 312 participants and community members.

## **Marketing and Communications**

On the media front, El Camino Health received coverage in a national CNN Story on Colorectal Cancer including Dr. Shane Dormady. In addition, Ashish Mathur was featured in the Brown Women Health Podcast How to Have Better Heart Health: Insights from the South Asian Heart Center.

For social media, over the past 30 days, our total impressions are up 149% across all platforms our post link clicks are up more than 65%, and our post engagements are up more than 52%. The Doctor's Day post was our top-performing post for April.

3/28/2023

El Camino Hospital Board												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/17	9/14	10/12	11/9	12/7	JAN	2/15	3/15	4/5	5/10	6/14
<b>STANDARD</b>												
Public Communication		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports (Informational and Consent item, unless requested)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Consent Approvals (recommended by Committees) <sup>1</sup>		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Session		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
CEO Report <sup>2</sup>		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
<b>STRATEGY</b>												
Strategic Planning <sup>3</sup>		✓			✓	✓		✓			✓	
Board Retreat												
<b>QUALITY<sup>4</sup></b>												
Quality Committee Report			✓		✓			✓			✓	
Medical Staff Report			✓		✓			✓				✓
<b>FINANCE<sup>4</sup></b>												
Financials <sup>5</sup>		✓			✓			✓			✓	
Budget Review & Approval												✓
<b>COMPLIANCE</b>												
Annual Corporate Compliance Summary						✓						
<b>GOVERNANCE</b>												
Board Self-Assessment & Action Plan			✓									
Board Officer Election Process Review									✓			
Board Officer Elections										✓		
Director, Committee Member, and/or Chair Appointments												✓
Committee Charter Review												✓
<b>EXECUTIVE PERFORMANCE</b>												
CEO Performance Evaluation & Compensation				✓								

1: Includes credentialing and privileging report, polices, physician agreements, etc.

2: Includes organizational reports on Foundation, CONCERN, Pathways, etc.

3: Includes strategy implementation (as needed), and reports on Performance & Strategic Goals, El Camino Health Medical Network, Enterprise Risk Management, etc.

4: On off months, materials are provided in the Board meeting packet, but will not be reviewed as part of the agenda.

5: Includes capital expenditures, investment committee update, and audited financials in October