

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

**Wednesday, February 7, 2024 – 5:30 pm**

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

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 917 3695 6200# No participant code. Just press #.**

To watch the meeting, please visit: [ECH Board Meeting Link](#)

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

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

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

	<b>AGENDA ITEM</b>	<b>PRESENTED BY</b>	<b>ACTION</b>	<b>ESTIMATED TIMES</b>
1	<b>CALL TO ORDER AND ROLL CALL</b>	Bob Rebitzer, Board Chair	Information	<b>5:30 – 5:31 pm</b>
2	<b>CONSIDER APPROVAL FOR AB 2449 REQUESTS</b>	Bob Rebitzer, Board Chair	Possible Motion	<b>5:31 – 5:32</b>
2	<b>POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Bob Rebitzer, Board Chair	Information	<b>5:32 – 5:33</b>
3	<b>PUBLIC COMMUNICATION</b> a. Oral Comments <i>This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.</i> b. Written Public Comments <i>Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.</i>	Bob Rebitzer, Board Chair	Information	<b>5:33 – 5:35</b>
4	<b>QUALITY FOCUSED REVIEW</b> - <a href="#">Receive STEEEP Dashboard Update</a> - <a href="#">Approve HAC 2.0 Weighting as Reviewed and Recommended for Approval by the Quality Committee</a>	Carol Somersille, MD Quality Committee Chair; Holly Beeman, MD Chief Quality Officer	Motion Required	<b>5:35 – 6:00</b>
5	<b>RECESS TO CLOSED SESSION</b>	Bob Rebitzer, Board Chair	Motion Required	<b>6:00 – 6:01</b>

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
6	<i>Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs:</i> <b>QUARTERLY FINANCE AND STRATEGIC MARKET SHARE UPDATE</b>	Carlos Bohorquez, Chief Financial Officer	Discussion	6:01 – 6:26
7	<i>Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs:</i> <b>STRATEGIC PLAN</b> - Strategic Plan Implementation – Q2 FY24 Metrics	Dan Woods, Chief Executive Officer	Discussion	6:26 – 6:46
8	<i>Health &amp; Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:</i> <b>APPROVE CREDENTIALING AND PRIVILEGING REPORT</b>	Mark Adams, MD, Chief Medical Officer	Motion Required	6:46 – 6:50
9	Report involving Gov't Code Section 54956.9(d)(2) conference with legal counsel – pending or threatened litigation: <i>Knowles v. El Camino Hospital</i> <i>Spalinger v. El Camino Hospital</i> <b>LEGAL UPDATE</b>	Dan Woods, Chief Executive Officer Theresa Fuentes, Chief Legal Officer	Discussion	6:50 – 6:55
10	<i>Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:</i> <b>EXECUTIVE SESSION</b>	Bob Rebitzer, Board Chair	Discussion	6:55 – 7:00
11	<b>RECONVENE TO OPEN SESSION</b>	Bob Rebitzer, Board Chair	Motion Required	7:00 – 7:01
12	<b>CLOSED SESSION REPORT OUT</b> To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	7:01 – 7:02
13	<b>CONSENT CALENDAR ITEMS:</b> <i>Items removed from the Consent Calendar will be considered at the end of the regular agenda.</i>  a. <a href="#">Approve Hospital Board Open Session Minutes (12/06/23)</a> b. Approve Minutes of the Closed Session of the Hospital Board (12/06/2023) c. <a href="#">Approve Compliance and Audit Committee Member Appointment as Reviewed and Recommended for Approval by the Compliance and Audit Committee</a> d. <a href="#">Approve ECH Severance Benefits Period as Reviewed and Recommended for Approval by the Executive Compensation Committee</a> e. <a href="#">Approve ECHB Guidelines for Communication with the CEO and Other El Camino Hospital as Reviewed and Recommended for Approval by the Governance Committee</a>	Bob Rebitzer, Board Chair	Motion Required	7:02 – 7:10

	<b>AGENDA ITEM</b>	<b>PRESENTED BY</b>	<b>ACTION</b>	<b>ESTIMATED TIMES</b>
	f. <a href="#">Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee</a> g. <a href="#">Receive Report on Educational Activity – Director Miller</a> h. <a href="#">Receive Report on Educational Activity – Director Somersille</a> i. <a href="#">Receive FY24 ECHB Pacing Plan</a> j. <a href="#">Receive FY24 ECHB Follow Up Items</a>			
<b>14</b>	<b><a href="#">CEO REPORT</a></b>	Dan Woods, Chief Executive Officer	Discussion	<b>7:10 – 7:15</b>
<b>15</b>	<b>BOARD ANNOUNCEMENTS</b>	Bob Rebitzer, Board Chair	Information	<b>7:15 – 7:20</b>
<b>16</b>	<b>ADJOURNMENT</b>  <b><a href="#">APPENDIX</a></b>	Bob Rebitzer, Board Chair	Motion Required	<b>7:20</b>

**Next ECHB Regular Meetings:** March 13, 2024; April 17, 2024; May 8, 2024; June 12, 2024

**El Camino Health Board of Directors  
Board Meeting Memo**

**To:** El Camino Hospital Board of Directors  
**From:** Holly Beeman, MD, MBA, and Chief Quality Officer  
**Date:** February 7, 2024  
**Subject:** STEEEP Dashboard through December 2023

**Purpose:**

To update the El Camino Hospital Board of Directors on quality, safety, and experience measure performance through December 2023 (unless otherwise noted). This memo will describe performance from the STEEEP Dashboard.

**Situation:**

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

**A. Safe Care**

**Hospital Acquired Condition Index 2.0**

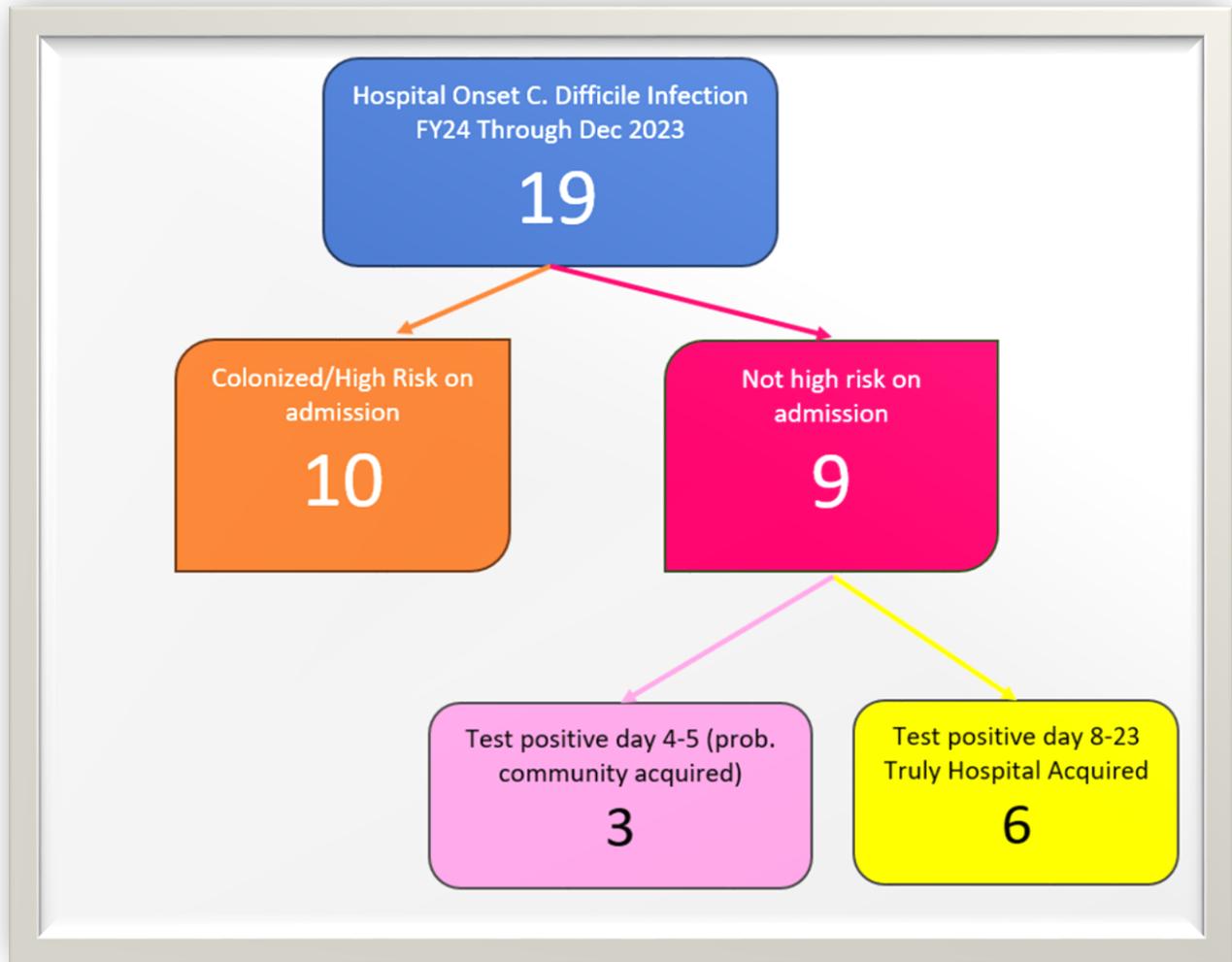
This measure is a composite of four measures as illustrated below.

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

1. HAC Index 2.0 is the strategic quality and safety goal for FY24. For the month of December (1.284) and Fiscal Year-To-Date (1.300) we are **unfavorable** to target of (1.201)

1.1. **C. Difficile Infection:** The C. Diff rate per patient days x 10,000 (1.112) for the second quarter and year to date (0.880) are **unfavorable** to target (0.805). There have been 19 hospital acquired infections in FY24. Of these 19 C. Difficile infections, six were likely

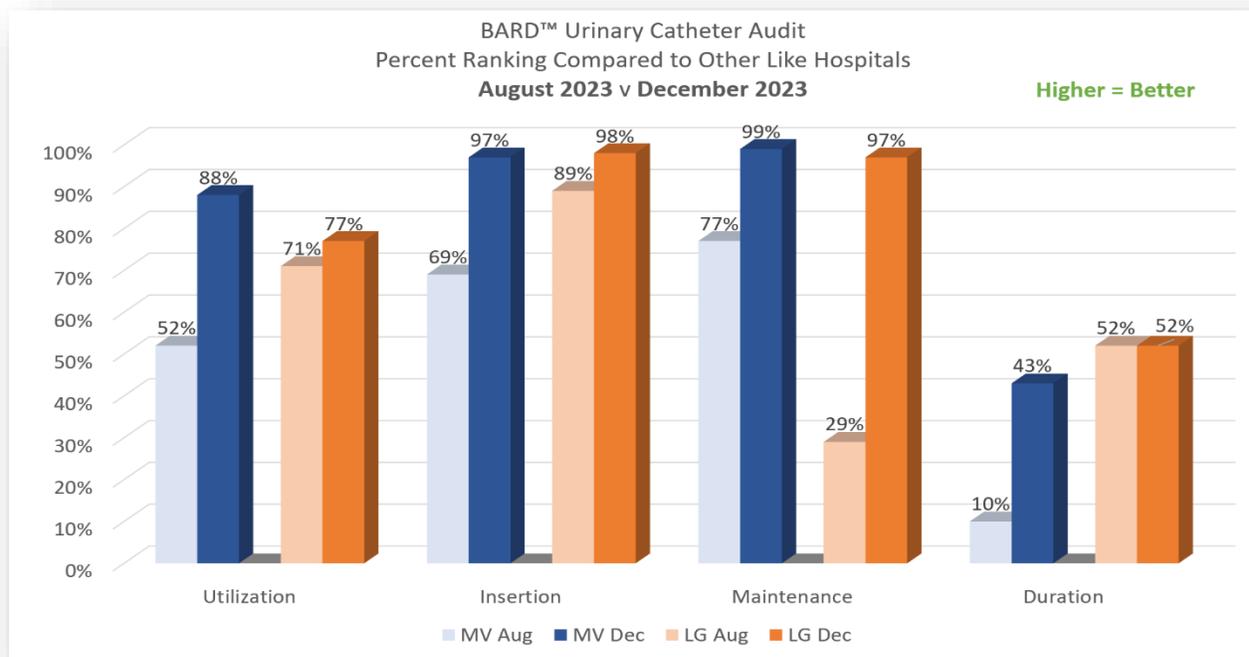
preventable. Areas of focus to decrease C. Diff are twofold. First, hospital wide



education on C. Diff screening, testing and prevention. Second, deployment of enterprise-wide hand hygiene program

- 1.2. Catheter Associated Urinary Tract Infection (CAUTI):** The rate of catheter associated urinary tract infection per catheter days for Q2 (0.192) is significantly improved from Q1 (0.356) and is approaching target (0.166). As of January 29, 2024, it has been 56 days since the last CAUTI in Mountain View and 176 days since the last CAUTI in Los Gatos. There have been nine CAUTI year to date with a goal to have less than twelve for the fiscal year. There were four infections in July, and one per month in August through December 2023. Eight of the nine patients with CAUTI were profoundly ill and unstable resulting in an ICU stay and close fluid management via prolonged utilization of a urinary catheter (> 3 days). Having too much or too little intravascular fluid can result in catastrophic damage to the lungs, kidneys, and heart. Close fluid management involves meticulous measurement of fluids going in and fluid going out (urine). The most accurate way to monitor urine output to be accurate to the milliliter is via an indwelling urinary catheter.

Process improvement foci to reduce CAUTI are 1. Remove catheters as soon as possible when clinically appropriate, and 2. Ensure insertion and maintenance best practices are followed. To achieve shorter catheter duration, our infection prevention team rounds on every single patient with a catheter in for greater than three days and collaborates with the nurse and physician to review indications for the catheter and direct attention to the importance of removing the catheter as soon as clinically appropriate. This intervention is likely contributing the improved performance in the second quarter of FY24. Optimizing catheter insertion and maintenance performance has been achieved through partnership amongst our Infection Prevention team, unit champions and BARD™, the vendor who provides our catheters. We requested an independent audit from BARD™ of our catheter practices in August 2023 with a re-visit and audit in December 2023. There has been significant improvement in the 4-month interval between audits. The results are depicted in the bar graph below which illustrates our percentile ranking compared to other like hospitals in catheter best practices. You will appreciate that the domain of catheter duration is where we continue to have the greatest opportunity. This informs our focus on removing catheters timely when clinically appropriate. “When in doubt, take it out!”



1.3. **Central Line Associated Blood Stream Infection (CLABSI).** The rate of CLABSI for second quarter (0.075) and year to date (0.039) are favorable to target (0.150). There has been one CLABSI year to date. This time in FY23 there were seven CLABSIs. The isolated CLABSI was in a NICU patient whose mother was colonized during pregnancy with the same organism which grew in the central line. This suggest the neonate was colonized at birth and this was likely not a hospital acquired infection. Per CDC guidelines, however, we count it this as a CLABSI. Our focus, to sustain our favorable CLABSI performance, is on optimizing care and management hemodialysis catheters. In FY23 the majority of CLABSIs were related to hemodialysis catheters.

- 1.4. **Non-ventilator Hospital-Acquired Pneumonia (nvHAP).** The FY24 Q2 nvHAP rate (**0.081**) improved from Q1 (**0.125**) and is approaching target (0.080). Two interventions, mobilizing our patients out of bed, and having regular oral care are in place. Both practices are contributing to the successful decrease in nvHAP infections affecting our patients.
2. **Surgical Site Infection.** The rate of surgical site infections for FY23 Q2 (**0.31**) is **favorable** to target (0.369). There have been no total knee replacement (TKR) infections in FY24. As of January 29, 2024, it has been 294 days since the last TKR infection in Los Gatos and 271 days in Mountain View. Process improvement has included staff education on hand hygiene, surgical attire, and sterile equipment processing. These initiatives have decreased surgical site infections for TKR surgeries. The OR departments are continuing their work on vendor behavior and reducing traffic and door opening during orthopedic joint replacement surgical procedures.

**B. Timely**

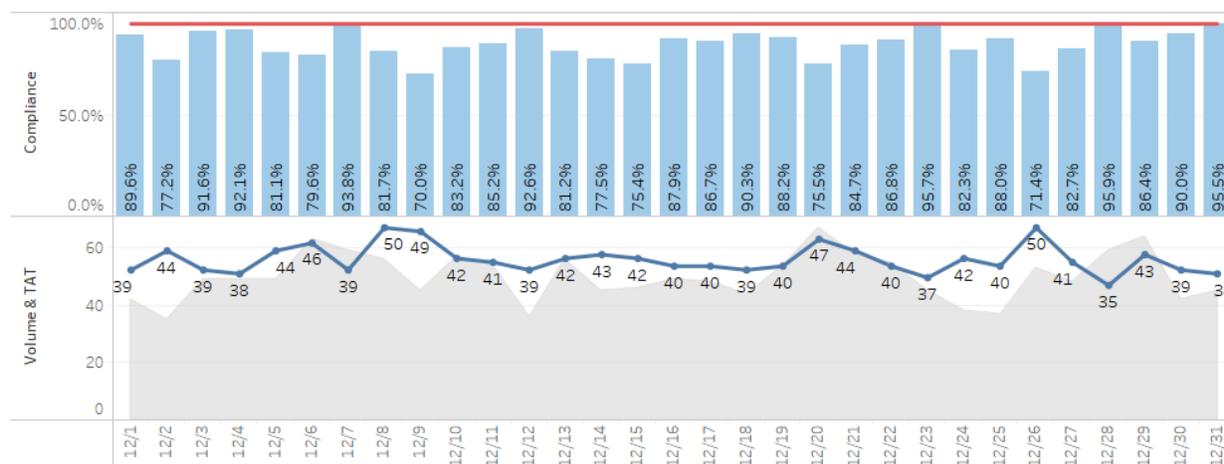
1. **Lab STAT Troponin Turnaround Time for Emergency Department (received to verification).** <sup>1</sup>The goal is to have 90% of results back within (40 minutes). Performance in Q2 FY24 (**81.3%**) is unfavorable to target. Below is a detailed analysis of gaps and corrective actions to improve our performance.

What is affecting our TAT?		
Item	Description	Corrective Action
<b>Dxl Downtime (Analytical Instrument Running Troponin Test x2)</b>  <b>OR</b>  <b>DxA Downtime (Chemistry line processing the specimens for testing on the Dxl)</b>	We continue to experience downtimes for our Dxl & DxA instrumentation.  Increase in TAT may be seen when at least 1 instrument is down or if the line is down/partial down. Details of errors can be sent on request.	Continue to monitor downtimes and escalate to vendor ones that we frequently see.
<b>High Troponin Values</b>	Troponin values above a certain threshold is at risk for cross-contamination between subsequent specimens tested.  When identifying a high troponin value, we are required to remove	The manufacturer is aware of this limitation, and we have escalated for a resolution multiple time.  Currently no update on their end for a resolution.

<sup>1</sup> A troponin test measures the levels of troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage there is to the heart, the greater the amount of troponin there will be in the blood. Outcomes of patients experiencing a heart attack (myocardial infarction) in the ED improve when interventions occur timely. Having the results of troponin blood test within 40 minutes to inform care team of the patient’s cardiac status enables timely intervention.

	the reagent from the instrument and perform maintenance to eliminate cross-contamination risks. This takes time to perform.	
<b>Maintenance</b>	<p>Maintenance of the Dxl or DxA will require periodic downtimes.</p> <p>The time for maintenance may be increased due workload as the staff have to juggle both maintenance and releasing of patient results. Delays can be exacerbated with staffing shortages.</p>	Beckman Coulter to help identify process improvement opportunities in the next month.
<b>Critical Calls</b>	<p>Critical calls affect our TAT as we release the result to the patient only after we make the phone call to the care team.</p> <p>Depending on the capacity for the unit to quickly answer the call, this will delay our release times (affecting this metric).</p>	<p>Now, we are calling a large number of troponin results.</p> <p>We are working with the cardiovascular service line to adjust the critical call threshold.</p>

Daily metric for Troponin TAT for December 2023



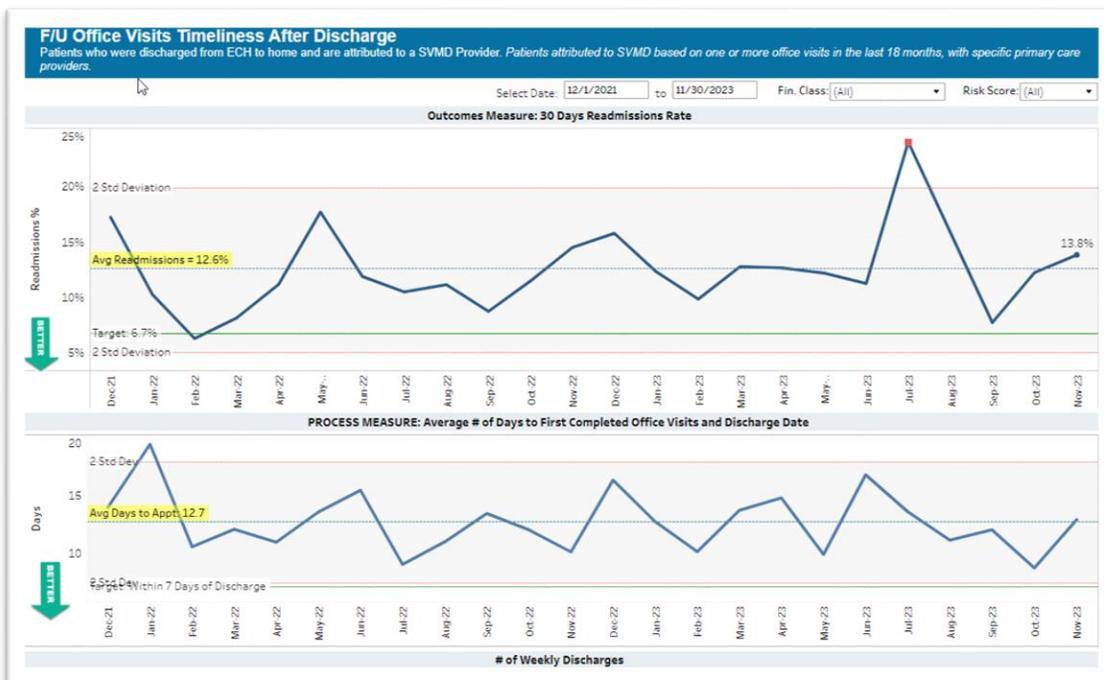
**2. Imaging Turnaround Time: ED including X Ray (target + % completed <= 45 minutes).** Performance for Q2 (76.5%) and YTD (76.4%) are unfavorable to target (84%). Root cause of the delays relates to the suboptimal performance of the 'night hawk' radiology vendor who performs readings for the hospitals after hours. A transition to the new nighttime partner will take effect February 13, 2024. Within 3-months of this transition, we anticipate a significant improvement (decrease) in reading times.

**C. Effective**

**1. Risk Adjusted Readmission Index.** Performance through November YTD (**1.13**) is **unfavorable** to target (1.0). Having timely follow-up with a clinician within 14 days of discharge decreases readmissions. A recent publication demonstrated a 42% decreased risk of being readmitted within 30 days of discharge for those patients seen in a post discharge clinic within 14 days of discharge. (Michael Baldino D.O., April 2021)

*Avoidable 30-day readmissions cost the Center for Medicare and Medicaid Services (CMS) \$17 billion per year.<sup>1</sup> As a result, the Hospital Readmission Reduction Program (HRRP) was enacted in 2012 as a part of the Patient Protection Affordable Care Act.<sup>2</sup> This directive set penalties for hospitals with excess readmissions for diagnoses commonly associated with adverse events. (Michael Baldino D.O., April 2021)*

El Camino Health teams are focused on ensuring patients who have an SVM D primary care provider have timely follow up post discharge. The readmission rates for these patients tracks closely with their ability to be seen timely after discharge. See screenshot below “F/U Office Visits Timeliness After Discharge” from the tableau dashboard created by Steven Sun (Director Clinical Data Analytics) and his team. The top chart shows readmission rates for SVM D patients following hospitalization at ECH. The bottom chart shows the average number of days between discharge and follow up appointment with SVM D primary care physician. Animating the benefits for our patients of being an enterprise, the ECH ambulatory and inpatient teams are collaborating to optimize navigation and integration of care between the hospital and clinic setting.



**2. Risk Adjusted Mortality Index.** Performance for FY24Q2 (1.13) and YTD (1.07) are **unfavorable** to target (1.00). Mortality index tracks, and for this time frame, is driven by the sepsis mortality.

**3. Sepsis Mortality Index.** Performance for FY24Q2 (1.32) and YTD (1.20) is **unfavorable** to target (1.0). You may recall from the focused review on sepsis shared with you in November 2023, that compliance with the 7 elements of the sepsis bundle correlates strongly with patient outcomes. Bundle compliance for both campuses remains excellent through FY23Q2. Every single sepsis mortality is reviewed. Reviews from the past quarter highlight that patients are being transferred from SNFs to ECH to die with end stage complications of disease and sepsis. There is no change in care or attention to bundle compliance which would have prevented these end-of-life patients from expiring. To provide better care to end-of-life patients and their families we are looking forward to the re-establishment of a comprehensive inpatient hospice program (GIP—General Inpatient Care) now that our new Medical Director of Palliative care joined the organization in November 2023. If a terminal patient presents at the end of life, and we have the capability of caring for the patient and their family in an inpatient hospice setting, the support for the patient, and the impact on our mortality measurement is favorable. Patients admitted to GIP are no longer counted in the mortality tracking. We are doing an excellent job of caring for patients with sepsis. We have an opportunity to improve the support we provide to patients and their families at the end of life through a robust GIP program.

**4. PC-02 Nulliparous Term Singleton Vertex C-Section (NTSV).** Since assuming the inaugural role of Chief Quality Officer for ECH in November 2021, this is the first time I have born witness to a cesarean section rate of 23.2% for nulliparous women having a singleton vertex pregnancy! The FY24Q2 performance (23.2%) is **favorable** to target of 23.9%. The maternal child health service line is a leader in recognizing and addressing the cultural norms and expectations of our patients in how they view, engage with and approach health care. Greater than 63% of patients who deliver at ECH are Asian. In our experience, South Asian patients have a low tolerance for the uncertainties, risks, and pain involved with a vaginal delivery and low threshold for requesting a cesarean section. The MCH team, in recognition of the preferences and perspectives of our South Asian maternity patients, has created a culturally sensitive and clinically appropriate pre-natal childbirth education program for S. Asian expectant families.

#### **D. Efficient**

1. **Length of Stay O/E (LOS O/E).** Length of stay is a measure of operational efficiency. The quality of care a patient receives is reliant on the navigation, coloration and efficiency achieved through operational excellence. Having timely, coordinated, and appropriate care has a profound impact on the overall quality of care our patients receive. Performance YTD (1.20) is **unfavorable** to target (1.15). A formidable challenge to decreasing length of stay for patients whose discharge disposition is a skilled nursing facility (SNF) are the barriers payors have in place to authorize timely discharge to a SNF. Our teams our optimizing care coordination within our system to decrease length of stay. Here are specific interventions in place:

- We have created a centralized care plan in Epic that pulls together important information about the patients care plan. Information includes the medical care plan for the day, rehab recommendations, discharge destination, social drivers of health, and estimated date of discharge. This tool allows the care team to obtain pertinent information in a timely way without having to dig through the chart. Additionally, we

are tracking delays to obtain more insight into the primary reasons for delays in patient throughput.

- Multidisciplinary rounds (MDR) have been activated on 2C, and they continue in Los Gatos. Both teams have incorporated use of the centralized care plan in MDR. At the 30-day check-in we have seen a significant LOS decrease of **-0.5 days** on 2C for the pilot population.
- We now have 3 skilled nursing facility transfer agreements in place (Cedar Crest, Grant Cuesta and Mountain View Health Care). These agreements help us expedite discharge to SNF for the self-pay and MediCal patients. We transfer about 3-4 patients per month utilizing the transfer agreements and are working to increase utilization of the transfer agreements.
- The discharge lounge continues to be open Monday-Friday and nursing and case management work together to identify appropriate patients who can discharge to the lounge to help expedite discharges and increase bed capacity.

**2. Median Time from ED Arrival to ED Departure (Enterprise).** The current FY24Q2 performance (**154 minutes**) and YTD (**156 minutes**) is **favorable** to the target of 165 minutes (lower is better). This performance is years in the making with an overhaul of the patient triage process, creation of additional chairs for less acute patients, and, most recently the creation of an ED express area on the Mountain View Campus. The ED express has capacity for 6 patients of lower acuity and will allow our teams to provide more efficient care for patients of lower acuity (treat to street).

## **E. Equitable**

- 1. Homeless discharge documentation of providing appropriate clothes.** In Q2 of FY24 documentation of offering weather appropriate clothing to homeless patients prior to discharge has improved from 53% to 69%. The health equity department is partnering with nursing clinical documentation team to reduce the inefficiencies in our EMR build which obfuscate consistent documentation of compliance with our homeless discharge policy.
- 2. Quality Council Health Equity Item Included in Process Improvement Efforts (% of departments).** With the return of our Health Equity manager from a medical leave, the health equity team has been able to coach and support departments to include at least one improvement measure viewed through an equity lens. For the second quarter of FY2024 four of twelve departments reported on a health equity measure during their annual performance improvement report at the monthly Quality Council meeting.
- 3. Sepsis Bundle Compliance by Race.** We continue to track and learn from segregating some of our quality measures by race, whilst optimizing the accuracy of race data we collect from our patients at the time of registration. The quality of 'race' data provided by our patients must improve prior to deducting meaningful information about sepsis bundle compliance by race. That said, as we continue to track this measure, the increase in the denominator over time will render the measures more meaningful.

## **F. Other Measures**

**Patient Experience Measures.** Performance in patient experience is **favorable** to target in our Emergency Department, Maternal Child Health, and Inpatient Units. We continue to exceed our target for our Likelihood to Recommend (LTR) scores across the enterprise due to our continued commitment and focus on our evidence-based best practices. This includes hourly (purposeful) rounding, leader rounding, bedside shift report and enhanced communication using our WeCare practices.

Attachment:

1. STEEEP Dashboard through Q2 of FY2024

## Works Cited

Michael Baldino D.O., M. a. (April 2021). Impact of a Novel Post-Discharge Transitions of Care Clinic on Hospital Readmissions. *Journal of the National Medical Association*, Pages 133-141.

FY24 Quarterly Board Quality Dashboard (STEEP)

Quality Domain	Metric	Past Performance				Baseline	Target	Current Performance		
		FY23 Q1	FY23 Q2	FY23 Q3	FY23 Q4	FY 23	FY 24	FY24 Q1	FY24 Q2	FYTD
Safe Care	HAC Index 2.0 Score	1.358	1.451	1.238	0.861	1.238	1.201	1.130	1.460	1.300
	HAC Component: Cdif Weighted (25%) Rate (per 10,000 Patient Days)	0.627	1.165	0.874	0.629	0.830	0.805	0.649	1.112	0.880
	HAC Component: CAUTI Weighted (25%) Rate (per 1,000 Urinary Catheter Days)	0.136	0.162	0.218	0.177	0.171	0.166	0.356	0.192	0.277
	HAC Component: CLABSI Weighted (25%) Rate (per 1,000 Central Line Days)	0.511	0.000	0.080	0.000	0.154	0.150	0.000	0.075	0.039
	HAC Component: nvHAP Weighted (25%) Rate (per 1000 Patient Days)	0.084	0.124	0.066	0.055	0.082	0.080	0.125	0.081	0.103
	SSI Rate (per 100 surgical procedures) (not part of HAC Index)	0.314	0.552	0.196	0.463	0.380	0.369	0.564	0.301	0.431
Timely	Lab STAT Troponin TAT for ED (received to verification)	93.8%	88.8%	70.9%	78.0%	82.7%	90.0%	84.2%	81.3%	82.7%
	Imaging TAT: ED including Xray (target = % completed ≤ 45 min)	78.4%	78.3%	78.3%	77.0%	78.0%	84.0%	76.3%	76.5%	76.4%
Effective	Risk Adjusted Readmissions Index	1.05	1.18	1.05	1.09	1.09	1.00	1.14	1.13* (Oct-Nov)	1.13* (July-Nov)
	Risk Adjusted Mortality Index	1.03	1.14	1.19	1.14	1.13	1.00	1.00	1.13	1.07
	Risk Adjusted Sepsis Mortality Index	1.02	1.37	1.26	1.15	1.20	1.00	1.07	1.32	1.20
	PC-02 NTSV C-Section	28.8%	24.7%	24.0%	30.2%	27.0%	23.9%	26.6%	23.2%	25.2%
Efficient	Length of Stay O/E	1.19	1.16	1.22	1.19	1.19	1.15	1.19	1.22	1.20
	Median Time from ED Arrival to ED Departure (Enterprise)	174 min	167 min	168 min	164 min	168 min	165 min	157 min	154 min	156 min
Equitable	Homeless Discharge Clothing Documentation Compliance	---	---	---	---	---	100.0%	53.0% (184/347)	69.0% (240/348)	61.0% (424/695)
	Quality Council Health Equity Item Included in PI efforts (% of depts)	---	---	---	---	---	50.0%	0.0% (0/7)	33.3% (4/12)	21.1% (4/19)
	Sepsis Bundle Compliance by Race	Asian	---	---	---	---	---	77.8% (28/36)	75.0%* (12/16) (Oct-Nov)	76.9%* (40/52) (July-Nov)
	Sepsis Bundle Compliance by Race	Hispanic	---	---	---	---	---	93.3% (14/15)	81.3%* (13/16) (Oct-Nov)	87.1%* (27/31) (July-Nov)
	Sepsis Bundle Compliance by Race	White	---	---	---	---	---	86.6% (84/97)	82.8%* (53/64) (Oct-Nov)	85.1%* (137/161) (July-Nov)
	Sepsis Bundle Compliance by Race	Others	---	---	---	---	---	61.1% (11/18)	70.0%* (7/10) (Oct-Nov)	64.3%* (18/28) (July-Nov)
Patient-centered	IP Units Enterprise - HCAHPS Likelihood to Recommend	79.9	78.8	76.6	78.4	78.5	76.4	84.0	80.3	82.1
	ED - Likelihood to Recommend (PG)	70.3	72.3	73.8	70.4	71.7	71.7	77.9	74.5	76.2
	MCH - HCAHPS Likelihood to Recommend	72.3	72.1	83.7	74.0	75.0	75.0	79.7	83.7	81.5

Updated: 01/23/24

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

Legend:

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

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

**El Camino Health Board of Directors  
Board Meeting Memo**

**To:** El Camino Hospital Board of Directors  
**From:** Holly Beeman, MD, MBA, Chief Quality Officer  
**Date:** February 7, 2024  
**Subject:** Quality Committee Follow-Up, HAC Index 2.0 Weighting

**Purpose:**

To approve the change to HAC 2.0 weighting as reviewed and recommended for approval by the Quality Committee.

**Summary:**

**Situation:** The HAC Index 2.0 is a weighted index comprised of 4 individual quality measures, each one a hospital acquired condition. Non-ventilator pneumonia (nvHAP) is one of the 4 measures. We have changed the methodology of identifying nvHAP events to conform with current medical literature and peer-reviewed studies. We were previously over-reporting nvHAP by including non-infectious aspiration pneumonitis in the numerator. With the change in methodology, the baseline for FY23 changed from 112 nvHAP events to 20 nvHAP events.

**Background:** The committee requested that management review the current weighting of each component of the HAC Index 2.0 and consider changing the weighting of the individual measures.

**Assessment:** If a change is made, we recommend the committee consider weighing each measure equally. This will reduce the weight of nvHAP from 35% to 25%. Additionally, it will reduce the weight of C. Diff from 35% to 25%. The rationale supporting this change is that C. Diff rate is multiplied by 10,000 as opposed to all other measures being multiplied by 1,000. A reduction in C. Diff weighting will prevent one individual measure from having a disproportionate impact on the overall index. The two weighting scenarios are illustrated below.

HAC Index 2.0, Weighting Scenarios									
No change							Adjust to equal weighting for each measure		
FY23 Baseline	Numerator	Denominator	Multiplier per National Healthcare Safety Network (NHSN) guidelines *	FY23 Rate	FY24 Weighting	Weighted Rate	Change Weighting	Updated Baseline weighted rate	
CAUTI	# events	# catheter days	x 1,000	0.68	15%	0.103	25%	0.171	
CLABSI	# events	# central line days	x 1,000	0.62	15%	0.093	25%	0.154	
C Diff	# events	# patient days	x 10,000	3.32	35%	1.162	25%	0.830	
nvHAP	# events	# patient days	x 1,000*	0.27	35%	0.096	25%	0.068	
						<b>FY23 Baseline HAC Index</b>	<b>1.453</b>	<b>FY23 Baseline HAC Index</b>	<b>1.224</b>
* nvHAP criteria not defined by NHSN						<b>Target 3% Reduction</b>	<b>1.410</b>	<b>Target 3% Reduction</b>	<b>1.187</b>

**Minutes of the Open Session of the  
El Camino Hospital Board of Directors  
Wednesday, December 6, 2023**

Hyatt Centric-Mountain View | 409 San Antonio Rd, Mountain View, CA 94040 | Cloud 2

**Board Members Present**

**Bob Rebitzer**, Chair  
**Julia E. Miller**,  
 Secretary/Treasurer  
**Lanhee Chen, JD, PhD**  
**Wayne Doiguchi**  
**Carol A. Somersille, MD**  
**George O. Ting, MD**  
**Don Watters**  
**Peter Fung, MD** (arrived at 5:49  
 p.m.)  
**John Zoglin**

**Board Members Absent**

**Jack Po, MD, Ph.D.**, Vice-Chair

**Others Present**

**Dan Woods**, CEO  
**Mark Adams, MD, CMO**  
**Holly Beeman, MD, CQO**  
**Carlos Bohorquez, CFO**  
**Shahab Dadjou**, President, ECHMN  
**Andreu Reall**, VP of Strategy  
**Cheryl Reinking**, CNO  
**Theresa Fuentes**, CLO  
**Deanna Dudley**, CHRO  
**Omar Chughtai**, Chief Growth  
 Officer  
**Deb Muro**, CIO  
**Ken King**, CAO  
 \*\*via teleconference

**Others Present (cont.)**

**Tracy Fowler**, Director,  
 Governance Services  
**Stephanie Iljin**, Manager,  
 Administration  
**Gabriel Fernandez**, Governance  
 Services Coordinator  
**Brian Richards**, Information  
 Technology

Agenda Item	Comments/Discussion	Approvals/ Action
<b>1. 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 5:35 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Chen, Doiguchi, Miller, Rebitzer, Somersille, Ting, Watters, and Zoglin were present constituting a quorum. Director Fung was absent at roll call and joined the meeting at 5:49 pm.	<b>The meeting was called to order at 5:35 p.m.</b>
<b>2. 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.	
<b>3. PUBLIC COMMUNICATION</b>	Chair Rebitzer invited the members of the public to address the Board. No members of the public provided comments during this time.	
<b>4. RECEIVE QUALITY COMMITTEE REPORT</b>	Director Carol Somersille, Chair of the Quality, Patient Care, and Patient Experience Committee, provided a verbal report on the updates from the committee. Director Somersille shared the knowledge she gained from her attendance at the Health Quality Improvement Conference, updates on the reviews of certain Quality measures, and a progress report on Health Equity initiatives the committee is involved with.  <b>Motion:</b> To receive the Quality Committee Report  <b>Movant:</b> Miller <b>Second:</b> Watters <b>Ayes:</b> Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin <b>Noes:</b> None <b>Abstentions:</b> None <b>Absent:</b> Fung, Po	<b>Motion Approved</b>

	<p><b>Recused:</b> None</p>	
<p><b>5. RECESS TO CLOSED SESSION</b></p>	<p>Motion to recess to closed session at 5:47 p.m. pursuant to <i>Health and Safety Code Section 32106(b)</i> for reports and discussion involving healthcare facility trade secrets for discussion of the strategic environment; and <i>Gov't Code Section 54957</i>; and deliberations concerning reports on Medical Staff quality assurance matters.</p> <p><b>Motion:</b> To recess to closed session</p> <p><b>Movant:</b> Ting  <b>Second:</b> Chen  <b>Ayes:</b> Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Fung, Po  <b>Recused:</b> None</p>	<p><b>Recessed to closed session at 5:47 p.m.</b></p>
<p><b>6. AGENDA ITEM 11: CLOSED SESSION REPORT OUT</b></p>	<p>The open session was reconvened at <b>6:13 p.m.</b> by Chair Rebitzer. Agenda Items 6-9 were addressed in closed session.</p> <p>During the closed session, the El Camino Hospital Board of Directors approved: The Credentialing and Privileging Report. By a unanimous vote of all Directors present: Directors Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, and Zoglin</p>	<p><b>Reconvened Open Session at 6:13 p.m.</b></p>
<p><b>7. AGENDA ITEM 12: CONSENT CALENDAR ITEMS</b></p>	<p>Chair Rebitzer asked if any member of the Board wished to raise an item from the consent calendar for discussion. Director Somersille pulled item h) <i>Approve Physician Wellness Policy</i> for further discussion.</p> <p><b>Motion:</b> To approve the consent calendar (not including item h).</p> <p><b>Movant:</b> Chen  <b>Second:</b> Watters  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p> <p><b>Motion:</b> To approve item h) <i>Physician Wellness Policy</i> with the requested revisions</p> <p><b>Movant:</b> Chen  <b>Second:</b> Watters  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p>	<p><b>The consent calendar was approved.</b></p> <p><b>Actions:</b></p> <p><i>Staff to revise item h) Physician Wellness Policy to include 'Medical Professionals'</i></p> <p><i>Staff to confirm that Director Miller's requested revisions have been made to the November 8<sup>th</sup>, 2023 Hospital Board of Directors Open and Closed Session Minutes</i></p>

<p><b>8. AGENDA ITEM 13:                  APPROVE                  AMENDED MOTION                  TO CLARIFY CEO                  BASE SALARY</b></p>	<p><b>Motion:</b> The Amended Motion to approve FY24 CEO Fixed Cash Compensation and Annual Base Salary and Range as disclosed at the meeting.</p> <p><b>Movant:</b> Miller  <b>Second:</b> Doiguchi  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p>	
<p><b>9. AGENDA ITEM 14:                  DIRECTOR MILLER                  ECH FOUNDATION                  LIASON REPORT</b></p>	<p>Director Julia Miller, Liaison to the El Camino Health Foundation, provided on the activity of the Foundation. Director Miller highlighted the Foundation’s initiative surrounding the Orchard Pavilion Donor Wall at the Mountain View campus. Director Miller invited members of the Board to review the materials and consider donating to the initiative.</p>	
<p><b>10. AGENDA ITEM 15:                  BOARD                  ANNOUNCEMENTS</b></p>	<p>Director John Zoglin, Chair of the Ad Hoc Committee, highlighted updates surrounding the process for conducting Board evaluations in advance of the upcoming Board appointments to the El Camino Hospital Board of Directors.</p> <p>Director Peter Fung formally announced the start of his campaign for County Supervisor – District 5. Director Fung thanked the Board of Directors for their support.</p>	
<p><b>11. AGENDA ITEM 16:                  ADJOURNMENT</b></p>	<p><b>Motion:</b> To adjourn at 6:27 p.m.  <b>Movant:</b> Fung  <b>Second:</b> Miller  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p>	<p><b><i>The meeting adjourned at 6:27 p.m.</i></b></p>

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

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Julia Miller, Secretary/Treasurer

**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
BOARD MEETING COVER MEMO**

**To:** El Camino Hospital Board of Directors  
**From:** Tracy Fowler, Director of Governance Services  
**Date:** February 7, 2024  
**Subject:** Appointment of Compliance and Audit Committee Member

**Recommendation(s):**

To appoint Sylvia Fong, to the Compliance and Audit Committee.

**Summary:**

The Compliance and Audit Committee appointed a Recruitment Ad Hoc Committee, comprised of Director Jack Po, MD, CAC Member Lica Hartman and CAC Member Christine Sublett, that was tasked with recruiting new members. Compliance & Privacy Officer, Diane Wigglesworth, worked with Ad Hoc Committee on the recruitment.

The Ad Hoc Committee sought applicants through public advertising, as well as through the Board, Committee and leadership team networks. Their search was focused on the following areas of expertise: healthcare compliance, internal audit, privacy, and risk management. Applicants were reviewed and screened with only two candidates who met the qualifications and in-person meeting requirements. Candidate Sylvia Fong provided the most relevant questionnaire and was interviewed by the Ad Hoc Committee.

At its November 29, 2023 meeting, the Compliance and Audit Committee voted to recommend the Board appoint Ms. Fong to the Committee.

**List of Attachments:**

1. Candidate CV – Sylvia Fong

# Sylvia C. Fong

San Francisco, CA 94114

Results-driven in-house lawyer and business partner with extensive experience and deep understanding of the healthcare industry. Strong interpersonal communicator dedicated to fostering effective teams and robust relationships through effective communication and inclusivity. Proven performance in people and process management, implementing strategy and finding innovative solutions while navigating the gray areas of the law.

## EXPERIENCE

### Alto Pharmacy, San Francisco, CA — *Head of Legal*

January, 2021 - May, 2023

As a member of the executive team, provide legal and compliance counsel on company strategy and operations. Build and manage the legal and compliance functions based on business priorities. Structure and negotiate complex business partnerships; develop data privacy and security program in compliance with HIPAA, HITECH and state privacy laws; oversee corporate governance, financing and capital raises; manage legal operations and general transactional support; manage employment matters, payor and PBM relationships, pharmacy operations compliance, e-commerce, marketing, provider relationships and anti kickback laws, pharmacy licensing, pre-litigation disputes and Product compliance. Hire and manage all outside counsel relationships.

### McKesson Corporation, San Francisco, CA

January, 2013 - January, 2021

*Managing Chief Counsel* - Manage legal function for multibillion dollar hospital and provider customer segments including drug distribution, group purchasing organizations and value added services. Manage 4 attorneys and 3 paralegals. Partner with sophisticated sales, finance and operations executives to strategically structure contracts, resolve issues and manage risk. Structure and negotiate complex transactions. Establish policies and procedures for risk and process alignment across multiple business segments.

*Managing Senior Counsel* - Trusted and sought-after business advisor in matters of complex business transactions and healthcare regulations including discount and personal services antikickback safe harbors, privacy and 340B drug pricing program. Led key legal process improvement initiatives including supply agreement template updates, contract fallback provisions and rebate templates. Led operational policy updates obtaining key business stakeholder buy-in. Hired, trained and managed team of paralegals. Created framework for paralegal review of request for proposal responses and marketing materials. Routinely provide legal advice on antitrust, privacy, marketing, software and consulting services, and government contracting matters.

## SKILLS AND EXPERTISE

Healthcare regulatory

HIPAA, HITECH and privacy

340B pricing program

Pharmacy

Complex transactions

Negotiations

## AWARDS

McKesson's General Counsel Award, 2016

## LANGUAGES

Spanish (fluent)

*Counsel* - Skilled and agile transactional attorney negotiating multimillion dollar wholesale distribution agreements with hospital system, long term care and retail pharmacy customers; advise business clients on applicable regulatory issues, contract interpretation, and reputation risk. Draft and review request for proposal responses.

### **El Camino Health, Mountain View, CA — *Manager, Legal & Contracting Services***

November, 2009 - January, 2013

As the first in-house attorney, advised senior management in matters regarding Stark, Anti-Kickback, False Claims Act, HIPAA, state/federal regulatory requirements and corporate compliance. Draft, negotiate and manage vendor, consultant and physician agreements, clinical trial agreements and business associate agreements. Ensure that all policies, procedures, programs, and contracts of El Camino Health and its affiliates comply with laws and regulations. Advise in local government matters including the California Public Records Act. Manage key public affairs initiatives.

### **Axiom Legal, San Francisco, CA - *Attorney***

February, 2008 - November, 2009

**SanDisk Corporation** - Negotiate and draft resale and distribution agreements focusing on pricing issues, rebates and discounts; assist in revision of global privacy policies; contract review and amendments for sales divisions.

**Cisco Systems** - Support Legal Sales division; manage the Channels Due Diligence program, orchestrating compliance and screening process for over 2000 channel partner and distributors world-wide, working closely with Public Sector Compliance Director to establish internal controls and advise business teams in matters of Foreign Corrupt Practices Act, engaging foreign consultants and agents and other issues involving corporate compliance. Create due diligence training materials and hold training sessions for Legal Sales; draft FCPA corporate policy documents.

## **EDUCATION**

**The George Washington University Law School, Washington, DC — *Juris Doctor, 2006***

**University of California, Berkeley, CA — *Bachelor of Arts, Sociology; Bachelor of Arts, Spanish Language & Literature, 2001***



**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
BOARD MEETING COVER MEMO**

**To:** El Camino Hospital Board of Directors  
**From:** Deanna Dudley, CHRO  
**Date:** February 7, 2024  
**Subject:** Severance Benefits Review

**Purpose:** To summarize ECH's current severance benefits, provide comparative market data, and recommend approval of updated severance period.

**Motion:** To approve an increase for the severance period to 18 months from 12 months for the CEO and to 12 months from 6 months for other executives as recommended by the Executive Compensation Committee.

**Background:**

ECH's compensation philosophy states that the intent is to have an executive benefits package that is market competitive and total remuneration targeted between the market 50<sup>th</sup> and 75<sup>th</sup> percentiles. In support of that philosophy, Mercer's executive benefits review in June 2023 identified the opportunity for ECH to change the Executive Severance Policy:

- Increase severance to 12 months from 6 months (to 18 months from 12 months for CEO)

At the November ECC meeting the Executive Compensation Committee passed a motion recommending the approval of a change to severance benefits by the El Camino Hospital Board.

**Summary:**

All elements of the ECH Executive Severance Policy were found to be aligned with the market except for the duration of the severance period (i.e., how long benefits are paid following an involuntary termination). The severance period for the CEO of ECH is 12 months, whereas 60% of companies have severance periods longer than 12 months for the CEO. The severance period for all other executives at ECH is 6 months, whereas 89% of companies have severance periods longer than 6 months for the CEO's direct reports.

Aside from market benchmarking, the pros / benefits of increasing severance and the cons / risks of increasing severance are laid out in detail and evaluated in the attachment; for review and discussion.

**Attachments:**

1. Severance Benefits Review and Considerations

# Severance Benefits Review and Considerations

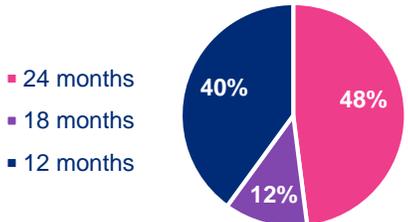
As presented to Executive Compensation Committee on November 20, 2023

Heidi O'Brien  
Rob Kirkpatrick

A business of Marsh McLennan

# Severance Benefits Review and Considerations

- ECH’s compensation philosophy states that the intent is to have a benefits package that is market competitive and total remuneration targeted between the 50<sup>th</sup> and 75<sup>th</sup> percentiles of market data. In support of that philosophy, Mercer’s executive benefits review in June in 2023 identified two opportunities for change:
  - Increase SERP contribution by ~3% of salary (for non-CEO executives)
  - Increase severance to 12 months from 6 months (to 18 months from 12 months for CEO)
- It was determined in the September ECC meeting that the cost associated with increasing SERP contributions could better be spent elsewhere and the possibility of increasing severance should be evaluated in more detail at the November ECC meeting.
- All elements of the ECH executive severance policy were found to be aligned with market except for the duration of the severance period (i.e., how long benefits are paid following an involuntary termination); that is outlined in more detail below.

Level	ECH	Market <sup>1</sup>
<b>CEO</b>	12 months	<p>60% of companies have severance periods &gt; 12 months for the CEO</p>  <ul style="list-style-type: none"> <li>24 months</li> <li>18 months</li> <li>12 months</li> </ul>
<b>All Other Executives</b>	6 months	<p>89% of companies have severance periods &gt; 6 months for the CEO’s direct reports</p>  <ul style="list-style-type: none"> <li>24 months</li> <li>18 months</li> <li>12 months</li> <li>Other</li> </ul>

# Severance Benefits Review and Considerations

## Evaluation and recommendation

### Pros / benefits of increasing severance

- **Talent attraction.** Generally accepted thinking dictates that stronger benefits packages attract higher quality candidates.
- **No cost at implementation or impact to total remuneration.** Severance is paid only in the event of an involuntary termination and is therefore not included in total remuneration calculations.
- **Talent retention.** Additional peace of mind for current and future executives could reduce the chance of voluntary turnover.
- **Market and compensation philosophy alignment.** The proposed change would put ECH's benefit more in line with market median.
- **Addresses a current pain point.** Feedback from ECH executive team indicates dissatisfaction with current benefit.
- **Simple administration.** If ECH moves forward with the enhanced severance period, only updates to the CEO employment agreement and ECH Policy & Procedures document would be needed.

### Cons / risks of increasing severance

- **Quality of applicants.** Possibility that individuals without confidence in their longevity in the role will be attracted to the role due to the stronger safety net.
- **Potentially increased cost.** ECH will incur higher costs (additional time in which severance benefits are paid) if/when there is an involuntary termination.

### Recommendation

**Increase severance period to 18 months from 12 months for the CEO and to 12 months from 6 months for other executives** to align this benefit more closely with ECH's compensation philosophy. The main goal of benefits is to provide financial security and peace of mind, so an enhancement of the terms is a reasonable action to take.

# Appendix

## Full ECH severance policy details<sup>1</sup>

- **Eligibility:** The Chief Executive Officer (“CEO”) of El Camino Hospital (“the Hospital”) and those executives reporting directly to the CEO or COO. Participation in the plan is subject to approval by the Hospital Board of Directors.
- **Policy Summary:** To support the Hospital’s ability to attract and retain executive talent, the Hospital shall provide key executives with a benefits package that is market competitive, compliant, and cost effective. This section outlines the benefits offered to executives in addition to those offered to employees in general.
- **Section D.3.b: Severance Plan**
  - The severance period is up to six months unless otherwise stated in the executive’s employment agreement. Severance will be paid on a bi-weekly basis and will be determined by the executive’s base salary at the time of termination.
  - Severance may be paid if the executive’s employment is terminated by the Hospital without cause or following a material reduction in duties or salary within six months of a change of control. Severance will not be paid when the executive voluntarily resigns or is discharged as described under Human Resources Policies 3.12 and 7.01.
  - In addition to six months’ pay, the executive is eligible for up to six months coverage extension of medical, dental, and vision coverage employer contributions. The executive will contribute to the cost on the same basis as when employed. The Hospital will continue to pay the employer share until such time as the executive fails to pay his or her share of premium, becomes ineligible for continuation under COBRA, obtains other group coverage, or six months (whichever is less).
  - Any obligation of the Hospital to the executive is conditioned, upon the executive signing a release of claims in the form provided by the Hospital (the “Employee Release”) within twenty-one days (or such greater period as the Hospital may specify) following the later of the date on which the executive receives notice of termination of employment or the date the executive receives a copy of the Employee Release and upon the executive not revoking the Employee Release in a timely manner thereafter.
  - Severance benefits are taxed as ordinary income.
  - Severance pay will be offset by any earnings received should the executive gain employment during the severance period. The terminated executive must notify the Hospital upon obtaining other employment and provide evidence of base salary received and benefits eligibility (if continuing benefits) in the new position.



**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
AGENDA ITEM MEMO**

**To:** El Camino Hospital Board of Directors  
**From:** Theresa Fuentes, Chief Legal Officer  
**Date:** February 7, 2024  
**Subject:** Recommendation to Update Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members (“Guidelines”)

**Recommendation(s):** Recommend approval of the proposed updates to the ECHB Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members to ensure it reflects current practices and standards. The Guidelines as proposed will also apply to the El Camino Healthcare District Board (ECHD) upon ECHD approval.

**Motion:** I move to approve the proposed updates to the ECHB G ECHB Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members and recommend that the ECHD Board of Directors

**Background:**

The existing ECHB Guidelines are due for an update, as the current version was last approved June 13, 2018. In addition, the ECHB recently approved the ECHB Code of Conduct, which incorporates the Guidelines. The ECHB requested that the Guidelines be reviewed and updated as well. The ECHB Governance Committee reviewed and recommended ECHB approval.

The El Camino Healthcare District (ECHD) communication guidelines mirror the ECHB guidelines. In order to ensure efficient and consistent communication processes, the Guidelines combine the two separate ECHB and ECHD documents into one document that will apply to both the ECHB and the ECHD. Once approved by the Governance Committee and the ECHB, the Guidelines will be submitted to ECHD for approval.

**Next Steps:**

1. Upon approval by the ECHB, the Guidelines will be presented to the ECHD for approval.
2. Upon approval by the ECHD, the separate ECHD guidelines will be retired.
3. **Governance:** After approval from ECHB and ECHD, the Guidelines will serve as the guidelines for both ECHD and ECHB. This will ensure uniformity in communication guidelines across the two entities.

**Rationale:**

This recommendation will increase efficiency, consistency and clarity for Board members, Advisory Committee members and Staff regarding communication processes. Creating one set of Guidelines for ECHB and ECHD will make it easier for staff and stakeholders to understand and follow the guidelines.

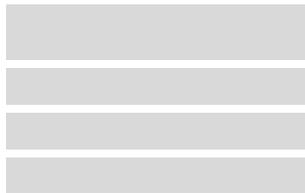
**List of Attachments:**

ECH Governance Committee – Policy Update  
December 12, 2023

1. ECHB and ECHD: Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members – Clean
2. ECHB and ECHD: Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members - Redline  
ECHD: Guidelines for Communication with the CEO and Other El Camino Hospital Staff Members – Current Version

<b>TITLE:</b>	<b>Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members</b>
<b>CATEGORY:</b>	Administrative
<b>ORIGINAL DATE:</b>	<b>January 14, 2015</b>
<b>LAST APPROVAL:</b>	<b>June 13, 2018</b>

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- I. **COVERAGE:** Members of the El Camino Hospital Board of Directors and Advisory Committees and El Camino Healthcare District Board of Directors
- II. **PURPOSE:** To provide an efficient process for individual Board and Advisory Committee members to request information or assistance from Hospital staff relating to agenda items, governance, or interpretations of policy and other board requirements. .
- III. **POLICY STATEMENT:** It is the policy of the El Camino Hospital Board of Directors and the El Camino Healthcare District that staff be available to individual Hospital Board, District Board and Advisory Committee members (collectively “Board members”) to respond to reasonable requests for information or assistance , and that the Board or Committee Chair be kept informed of such requests. This policy shall not apply to requests for staff work on matters that have been approved by a Board or Committee, and the request is made by the Board or Committee Chair on behalf of the Board or Committee. .
- IV. **DEFINITIONS:**  
N/A
- V. **REFERENCES:**  
N/A
- VI. **PROCEDURE:**
  - A. **Communication Generally:** All Board member general requests for information or assistance from Hospital staff shall be as follows:

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*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.*

<b>TITLE:</b>	<b>Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members</b>
<b>CATEGORY:</b>	Administrative
<b>ORIGINAL DATE:</b>	<b>January 14, 2015</b>
<b>LAST APPROVAL:</b>	<b>June 13, 2018</b>

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- a. All communications to the Chief Executive Officer shall be submitted directly to the Chief Executive Officer.
- b. All requests for legal advice and support shall be submitted directly to the Chief Legal Officer. Use of outside counsel requires approval from the Chief Legal Officer or Chief Executive Officer.
- c. Chairs of the Advisory Committees may contact the Executive Sponsor of their assigned Committee directly regarding the business related to the Committee
- d. Routine clerical requests, such as for clarification of meeting dates and locations and access to items in the Board portal, should be directed to the Executive Assistant, Director of Governance Services, or other person assigned to support the Board or Committee.
- e. All other requests **shall be in writing through email to the Director of Governance Services, with a copy to the Board or Committee Chair.**
  - i. The Director of Governance Services shall consult with the Chief Executive Officer and the Chief Legal Officer as appropriate to ensure that the response is consistent with governing documents, policy, and practice.
  - ii. The Director of Governance Services, or designee, shall respond **in writing** to the request, with a copy to the Board or Committee Chair, **within 2 business days**. If additional time is needed for response, the Director of Governance shall respond with an estimate of approximate time for response.
  - iii. The Director of Governance Services, or designee, shall log the request and the response on the Board Information Response log, which shall be available on the Board portal.

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<b>TITLE:</b>	<b>Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members</b>
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- f. In the case of an emergency after business hours or on a holiday or weekend, Board and Advisory Committee members can contact the Administrator on Call (AOC) by calling the Hospital Operator at 650-940-7000 and asking for the AOC.
- g. When acting as a member of the public, and not in their role as a member of the Board, members may interact with Hospital staff directly. For example, if a member is a patient, or has a family member who is a patient, the member should interact with staff as necessary and appropriate related to patient care.

**B. Board or Committee Member Requests for Substantive Staff Work Within the Scope of the Board or Committee:**

- 1. If a request for substantive staff work within the scope of the Board or Committee is made to the CEO by a Board member other than the Chair, the Board member shall communicate that request via e-mail to the CEO, the Board or Committee Chair and the Director of Governance Services. The CEO will evaluate the staff time required to fulfill the request. If the CEO estimates that a request will require more than 2.5 hours of staff work, the CEO will inform the Chair prior to beginning the work. The Chair will either authorize the work or add the request to the agenda for an upcoming Board or Committee meeting.
- 2. The CEO shall not honor requests for staff work on matters that the Board has considered and voted not to approve or pursue.
- 3. The CEO will keep the Board or Committee Chair informed of all requests for staff work from Board members other than the Board or Committee Chair.

**VII. APPROVAL:**

<b>APPROVING COMMITTEES AND AUTHORIZING BODY</b>	<b>APPROVAL DATES</b>
Governance Committee Originating Committee or UPC Committee	12/12/2023

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<b>TITLE:</b>	<b>Guidelines for Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members</b>
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(name of) Medical Committee (if applicable):	N/A
ePolicy Committee:	N/A
Pharmacy and Therapeutics (if applicable):	N/A
Medical Executive Committee:	N/A
Hospital Board of Directors:	[02/07/24?]
District Board of Directors:	[02/13/24]
Historical Approvals:	1/14/15; 6/13/2018

**VIII. ATTACHMENTS:**  
N/A

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Department	Policy Name	Revised?	Doc Type	Notes	Committee Approvals
<b>New Business</b>					
Quality	1. Patient Blood Management Patient-Centered Quality Plan	New	Plan	1. None	<ul style="list-style-type: none"> <li>• Transfusion Safety</li> <li>• ePolicy</li> <li>• MEC</li> </ul>
Wound Care Center	1. Scope of Service – Count Care Center	Revised	Scope of Svc	1. Updated each section	<ul style="list-style-type: none"> <li>• Med Dir</li> <li>• ePolicy</li> <li>• MEC</li> </ul>

**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
BOARD MEETING COVER MEMO**

**To:** El Camino Hospital Board of Directors  
**From:** Julia Miller, Board Member  
**Date:** Board Meeting Date: February 2024  
**Subject:** Report on Educational Activity

**Purpose:** For information/education.

**Summary:** Problems of under staffing and lack of communication. Losing physicians and nurses with some joining unions in a branch of SEIU. These relations must be tightened and strengthened and retention programs for physicians set up. Big work force turnover and shortage. Boards need an assessment and also assess the doctor peer review process. Possible change and restructure of organization.

**Conference Title:** January Leadership Conference

**Sponsoring Organization:** The Governance Institute

**1. Key Educational Points, Lessons Learned:**

**AI:** The session on AI highlighted how much healthcare has already incorporated technology while giving guidance on future impact. Some of the AI examples that were of great interest were the following: assistance in looking at large insurance denials (Cigna denies claims in 2 seconds) and assistance in diagnosing sepsis. AI has already created increased administrative efficiency. Risks must be managed as they can't be avoided and will require governance on multiple engagements and levels.

Book Recommendation: "The Age of AI: Artificial Intelligence and the Future of Humanity" by Jason Thacker.

**Financial Performance:** The critical importance of managing cash in healthcare and its impact on capital markets was emphasized. Boards were advised to concentrate on three key areas: (1) Off-Budget Issues - Boards should address and clarify off-budget challenges to ensure transparency and a comprehensive understanding of financial health. (2) Addressing Underperformance - Any underperformance must be thoroughly explained to the board. This includes providing insights into the reasons behind it and outlining strategies for improvement. (3) Labor Cost and Liquidity - Boards need to scrutinize labor costs, ensuring that they reflect the organization's liquidity. This is vital for maintaining financial stability.

Additionally, the trend of cross-country mergers as a strategy to absorb debt was highlighted. Succession planning was stressed, emphasizing the importance of a roadmap aligning public and corporate missions, including rate negotiation considerations.

Transparency was emphasized in obtaining information from the Quality Committee, even when delivering negative news. Boards were advised that a focus on quality not only enhances patient care but also yields positive financial outcomes. Service line reports, managed by the Chief Quality Officer, were recommended to use a Red/Green/Yellow framework to assess and improve both quality and culture. The ultimate question posed was

whether consumers trust the organization, emphasizing the critical link between quality, trust, and financial success.

**Board Governance and Oversight:** Board responsibilities that were discussed included defining organizational strategy, safeguarding regulatory compliance, promoting transparency, sustaining focus, and reducing both direct and indirect costs. The following topics were discussed : (1) Ethics Committee for Complex Issues – for example – right to die, anti-vaccine movement and workplace violence on the rise, (2) Vigilance Against Intimidation – the board should be informed of all incidents of verbal and physical intimidation on or off campus, (3) Legal Landscape Task Force - Collaboration between doctors and administration in a task force is essential to navigate the complex legal landscape, especially considering the limitations on doctors speaking publicly, (4) Collaborative Board Approach – the board has to work cohesively and remember that collective effort is necessary to achieve goals and address challenges, and (5) Significance of Palliative Care – strong palliative care programs have the potential to add three months or more to life, improve access, and enhance the quality of life. Specialized facilities and furniture are integral components for delivering this essential form of care.

2. Has the conference improved your ability to fulfill your obligations as a member of the ECH Board? If so, how?

Of course.

3. Were there speakers that ECH should consider inviting?  Yes  No

Laura Adams, Senior Advisor at National Academy of Medicine, Lexington, Mass.  
for an AI conversation.

4. Do you recommend this conference to other members of the Board?  Yes  No

Attachment: Board Briefing from The Governance Institute

# Board Briefing

JANUARY 2024



## Highlights from the January 2024 Leadership Conference

*This discussion guide includes key takeaways and questions to consider from the speakers you heard at our January 2024 Leadership Conference in Naples, Florida. Please [let us know](#) how this has enhanced your board education experience and anything more we can do to help you with your next steps.*

Two themes emerged from our January Leadership Conference to kick off this year of board education:

### **Hope is not a strategy! And... It's all about relationships!**

The time has passed for us to hope and pray, wait and see, or wish things would get easier. Change is here and happening all around us, so we need to change or become obsolete. The hard part is: what to change, when to change, how fast to change, and how to pay for it! The good news is that providers still retain the highest level of trust among consumers compared to other entities in healthcare. What we do with that trust in the coming year(s) will be key.

The key question for you as you read this is: What will you do differently as a result of this information?

### **Hope Is Not a Strategy**

For our first theme, speakers updated the audience on financial challenges, systemness, quality, patients' rights, governing AI, transitioning (still!) to value-based care, and the data-driven healthcare future. Here are the takeaways.

#### **Financial Challenges and Systemness**

- Lisa Goldstein emphasized the imperative to preserve cash in order to access it quickly when needed.

- She cited the areas of rating agency focus in 2024: labor strategies, regulation impact, financial improvement, liquidity preservation, and the board's effectiveness in supporting management and succession planning.
- Paul Keckley discussed trends in five zones impacting the U.S. health system: clinical innovations, technology, regulatory constraints, capital markets, and consumers. He cautioned that systemness is the key; it will be increasingly difficult for any healthcare organization to truly thrive independently in the future.

Questions to consider:

- How will your organization be impacted if the future of the industry continues to be defined by outside players?
- Is the innovation of the healthcare industry radical or incremental? What about in your organization?
- In regard to partnerships, what is your core business and where is there a strong consumer need or demand?
- How will your hospital preserve cash in 2024?

### *Quality and Patients' Rights*

Executing consistently high quality across multiple hospitals, all with different sets of challenges, is no easy task. Michael Pugh and representatives from St. Luke's University Health Network in Pennsylvania and Michigan Medicine narrowed down these key ingredients:

- The system CEO must treat quality as the number one priority. Culture is the thing: the CEO and board set the tone for an organizational culture of quality and safety.
- Goals must be aligned and physician and executive incentives should be connected to these goals—a must for goal achievement.
- Teamwork, teamwork, teamwork.
- Measure, measure, measure. (Including outpatient!)
- We need to intentionally hardwire safety/quality in every health profession through education and training.

Board members bring a diverse set of perspectives and may see different things in the data. Asking questions helps underscore board accountability for quality. Require root-cause analyses, listen to patients, and study up: come to board and committee meetings with a strong understanding of the data so the time spent can be on questions and discussion, rather than reviewing reports. Ask your QI Team when you have an adverse event:

- Why did it happen?
- How did it happen?

- What is being done to ensure it won't happen again?

And to round out the conversation:

- Where is the outpatient data? What are we not seeing that we should?
- How strong is the outpatient data?
- How can we improve our outpatient data?

Todd Sagin, M.D., J.D., tackled the difficult topic of patients' rights in today's legal environment. It is becoming increasingly crucial for boards to stay abreast of evolving controversies that politicians and judges act on—*these have direct implications on care decisions for patients that your physicians are having to make right now*. Healthcare workers are five times more likely to experience violence than employees in other industries. Many of these attacks happen on social media over social and political matters.

Questions to consider:

- How will your board facilitate regular and ongoing dialogue with your physician community over changes in legislation and legal rulings?
- How will your board dedicate time to discussing the changing political and legal climate?
- Does your hospital have adequate bandwidth to follow the legal volatility landscape and if not, what steps can be taken to ensure that it does?

## Governing AI

Laura Adams put AI into context for boards. Here is her list of opportunities and cautions:

- Predictive AI can be used for things such as forecasting appointment no-shows, analyzing variation in patient flow, predicting negative outcomes in at-risk patients, and determining the possibility of hospital readmission.
- Unlike predictive AI, generative AI looks for patterns and structures and then creates new content. It can best be used for creative endeavors such as brainstorming various scenarios, creating hypothetical charts, and asking for possible solutions to a problem when you encounter a roadblock.
- Negative consequences of AI include a lack of privacy and patient rights, a widening of the equity divide, deepfakes, and liability issues. (Proceed with caution!)
- We should not train machines to act like humans; rather, we should use machines to do the machine-like actions so that the humans' job is more rewarding and less repetitive/mundane. Use AI to pave the way for physicians to see, hear, and listen to their patients.

It is becoming increasingly crucial for boards to stay abreast of evolving controversies that politicians and judges act on—these have direct implications on care decisions for patients that your physicians are having to make right now.

For now, the most important thing boards can do is read up and ask questions. Most AI applications in healthcare now are administrative; the clinical applications will take more time to figure out.

Questions to consider:

- Is your organization considering implementing the use of AI in the health system and if so, are there low-risk options for getting started?
- How can you help senior leaders prepare for the future of AI in the organization?
- What are some possible tasks throughout your organization that would be made easier with the integration of AI? What are some things that cannot be replaced by AI?

### *Accelerating Value*

Dr. Brian Silverstein focused on the board's job of accelerating value at the right pace for your market. His key takeaways:

- **Change is slow.** Continue to work with your communities to improve overall health on a broader level—moments spent in the healthcare environment are not enough to do this.
- **Location matters.** Life expectancy can be drastically different by zip code. It is important that your board is aware of this and related governance implications.
- **Make technology work for you.** Your EHR may need additional layers of technical capabilities to be useful and efficient for your workforce and patients.

Questions to consider:

- What are our health goals?
- Is digital a separate strategy? (Hint: the answer shouldn't be yes.)
- Are we making the right investments?
- How should we approach performance-based risks?
- From a governance/management perspective, have we set up our organization for success?

### *Data Will Drive the Future*

Tom Koulopoulos drew a compelling picture of how consumers will be using healthcare data in the future, and how technology will alter the healthcare workforce, with knowledge workers and digital workers in an ambient digital ecosystem. The equation to consider is “keep it vs. shred it,” and where/when to partner along the way in order to build a truly integrated delivery system with technology at the center.

While this seems like a distant future state, boards can begin now to pave the way. Tom cited several examples of how today's leaders tend to hang on too tightly to "keeping yesterday alive a little longer." The key now is to work towards an integrated digital strategy that considers how technology impacts every piece of the delivery model, and how to bring disparate technologies together into a unified user experience.

## It's All about Relationships

For our second theme, speakers pinpointed the importance of trust. Ken Hughes said that healthcare is in the "life" business. To "defibrillate" our purpose, we need to invest in customers *and* employees to deliver the experience that is expected by consumers and that is needed to differentiate against disruptors. How is your board and senior leadership thinking about:

- Trust?
- Honesty?
- Authenticity?
- Intimacy?

Often providers talk *at* people rather than engaging in a two-way conversation with the patient as partner. In our lines of work, what are we bringing to the relationship, and how can we do better?

Ryan Donohue said we need to do more with the trust we have with our consumers and patients, because if you aren't actively working to keep and deepen that trust, it leaves a vacuum others (outside disruptors!) will rush to fill.

A lot of it is about telling your story. Are you "innovating quietly"? Do consumers know about what you are doing to improve their experience/health/lives?

Sven Gierlinger continued on the relationship theme comparing patient experience to places like the Ritz-Carlton. While hospitals don't need to become luxury hotels, there are some real-life applications that are relatively simple, low-cost, and make a meaningful impact on patient experience and loyalty:

- Genuine care and comfort should be our highest mission.
- Can we provide personal service?
- How can we fulfill unexpressed wishes and needs?
- Through those things, we can instill wellbeing.

The key takeaways:

- Again, the CEO must lead the charge.
- You need to act and believe that you are in the customer service business.

**A lot of it is about telling your story. Are you "innovating quietly"? Do consumers know about what you are doing to improve their experience/health/lives?**

- Reputation matters.
- Your patient experience strategy must include culture, care delivery, hospitality, and accountability.

Steps to consider:

- 1. Innovate your marketing and public messaging.** It's time to hold the marketing team accountable to a different expectation. Relying on your annual community benefit report to get the message across just isn't going to cut it. Awards and recognitions may not set you apart. How do different demographic populations want to receive your messages and which messages do they need to receive to build and retain trust? Do you have the data you need to do this right?
- 2. This is where boards come in—advocacy.** Build a strategy for telling your organization's story in a way that matters to consumers. Consider who you should be talking to in your community to make the message heard louder and further. Brainstorm ideas to help patients know who to talk to and how to connect with your organization when they need to, via *their* preferred method. Help find ways to reach patients before those patients wonder what to do next.

Gierlinger closed with this question: when you consider all of the information you are tracking about a patient in the EHR, are you including things that are important to them personally, that would be important to translate to their next care setting? How can we do a better job making that connection?

Finally, Tom Koulopoulos reminded us that change is about making decisions. We're setting the bar too low.



**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
BOARD MEETING COVER MEMO**

**To:** El Camino Hospital Board of Directors  
**From:** Carol A. Somersille, M.D., F.A.C.O.G., Board Member  
**Date:** February 7, 2024  
**Subject:** Report on Educational Activity

**Purpose:** For information.

**Summary:** Conference Attendance Focused on Quality and Leadership

**Conference Title:** IHI Conference, December 10-13, 2023

**Sponsoring Organization:** Institute for Healthcare Improvement Forum 2023

**1. Key Educational Points, Lessons Learned:** (Please use as much space as necessary)

- **12/11/2023 “Better Quality Through Better Management” with Sandip Godambe and Robert Lloyd.**

This full day workshop was extremely informative because as leaders, we need to understand data. To understand the data, we were taught how to conceptually and statistically understand the process of the quality measurement journey. Three key components of the journey to better quality are attention to aim, concept and measurement.

AIM delineates the motivation for measuring.

CONCEPT tells where we are on the journey. First there is quality control, then quality assurance once we know it is stable, and then quality improvement if it starts slipping.

MEASUREMENT tools should be chosen that are the best way to understand the data and we must recognize why understanding variations allows us to measure correctly.

- **12/12/2023 “Executive Leadership Summit: Digital Today, Digital Tomorrow” with eleven presenters including Donald Berwick, President Emeritus and Senior Fellow, Institute for Healthcare Improvement.**

This full day workshop examined technology as a catalyst for change. Some take-aways from the presentation are:

- AI adoption should be from the organization as a whole and not from the top down. Improvements are largely dependent upon the social connections to those in leadership. Clinical leadership should be leading the charge but currently administrators are leading the charge.
- The team should be “Affordance Rich” with a mix of people who are passionate, people in authority, people with experience in the issue and its content, people who are affected, and people who can cross coordinate complex communities, all on the journey together.
- We need to embrace the concept of failing fast. Otherwise, the process will gobble up organizational good will.

- **12/13/2023 “Leading for Whole System Quality”**

This was a half day workshop. Key elements such as enabling transparency through shared knowledge to eliminate competing demands were discussed. Our healthcare system does an excellent job of leading through whole system quality. Our strategically

Report on Educational Activity – Dr. Somersille  
February 7, 2024

focused quality journey allows us to deploy integrated quality management. We would benefit from a less reactive and more proactive anticipatory journey.

2. Has the conference improved your ability to fulfill your obligations as a member of the ECH Board? If so, how?

Yes. See the key educational points, lessons learned. I plan to incorporate all.

3. Were there speakers that ECH should consider inviting?  Yes  No

Robert Lloyd, Ph.D., Vice President, Institute for Healthcare Improvement.

4. Do you recommend this conference to other members of the Board?  Yes  No

El Camino Hospital Board												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/9	9/13	10/11	11/8	12/6	JAN	2/7	3/13	4/17	5/8	6/12
<b>STANDARD</b>												
Public Communication		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Committee Reports (Informational and Consent item, unless requested)		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Consent Approvals		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Executive Session		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
CEO Report		✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
<b>COMPLIANCE</b>												
Annual Corporate Compliance Summary					✓							
<b>EXECUTIVE PERFORMANCE</b>												
CEO Assessment Results Discussion			✓									
CEO Performance Evaluation & Compensation				✓								
Executive Incentive Approvals				✓								
<b>FINANCE</b>												
Financials		✓		✓				✓			✓	
Budget Review & Approval												✓
<b>MEDICAL NETWORK</b>												
Bi-Annual Report			✓						✓			
<b>STRATEGY</b>												
Strategy Update, Strategic Vision					✓			✓			✓	
Board Retreat									✓			
<b>QUALITY</b>												
Quality Committee Focused Review			✓		✓			✓			✓	
Medical Staff Report			✓		✓				✓			✓
<b>GOVERNANCE</b>												
Board Self-Assessment & Action Plan										✓		
ECHB Officer Elections (Bi-annual)										✓	✓	
Director, Committee Member, and/or Chair Appointments					✓							✓
Committee Charter Review												✓

*Last Update: 10/19/2023*

## FY24 ECHB MEETING FOLLOW UP ITEMS

<u>Subject</u>	<u>Actions</u>	<u>Notes</u>	<u>Status</u>
<b>December ECHB Meeting</b>			
<b>Quality Report</b>	Future Meeting	Director Somersille requested discussion of the strategic plan with a focus on review of integration of ECHMN quality reporting - legal team to review.	Paced for March 13, 2024 ECHB meeting
<b>Consent Calendar</b>	Off Agenda	<p>Correct November 8<sup>th</sup> meeting minutes: three changes submitted by Director Miller were done prior to the meeting. [Open Minutes Item 6 – change “as” to “and”; Closed Minutes Item 2 – delete “Sobrato”; Closed Minutes signature line – change to Julia Miller]</p> <p>Physician Wellness Policy – adjust the title to include Medical Professionals</p>	<b>Complete</b>
<b>November ECHB Meeting</b>			
<b>Quarterly Financial and Strategic Alignment</b>	Future Meeting	Carlos to present an assessment of the trend in payor mix at the February meeting.	Paced for February 7, 2024 ECHB meeting
<b>Annual Compliance Report</b>	Off Agenda	Dan to set up meeting with Dr. Somersille and stakeholders re: exchange of Quality information	Resolved and Paced for March 13, 2024 ECHB meeting
	Future Meeting	AI Governance needs to be added to pacing plan	Paced for June ECHB meeting
<b>Strategy Update</b>	Future Meeting	Schedule time for discussion of the rapidly changing strategic environment as related to market disruptors and potential impact for our plan.	Paced for February 7, 2024 ECHB meeting
<b>October ECHB Meeting</b>			

<u>Subject</u>	<u>Actions</u>	<u>Notes</u>	<u>Status</u>
<b>Consolidated Financial Report</b>	Next report	Consider a plan for RFP for Auditor – work for Finance Committee and Compliance and Audit Committee	Paced for next report – October 2024
	Future meeting	Plan, proposal, thoughts on how we are accommodating the changes in payor mix and trends in that area. <b>In November meeting this was requested for February agenda.</b>	Paced for February 7, 2024 ECHB meeting
<b>Culture of Safety</b>	Future Meeting	For board retreat, joint education, or conferences: Discuss goal setting and how to balance between stretch goals and goals that are insufficiently aggressive and how to set metrics correctly.	In progress
	Future meeting	Quality Metrics and progress update from discussion on Culture of Safety (Dr. Fung suggested a 5-10 minute presentation from Dr. Adams on the Culture of Safety.)	In progress
<b>Code of Conduct</b>	Next meeting	<ul style="list-style-type: none"> <li>- Previous Board Communication policies</li> <li>- CLO or Board Chair should be able to decide on outside counsel</li> <li>- JM – report out to board does not protect privacy or confidentiality</li> <li>- Lanhee, Don and Theresa to work on final version</li> <li>- Add communication guidelines</li> </ul>	<b>Complete</b> Approved on 11/8/2023.
<b>September ECHB Meeting</b>			
<b>Quality Committee Report</b>	Next Report	Include more information on Patient Experience both at Hospital and ECHMN in next Quality report	Paced for March 13, 2024 ECHB meeting
<b>Closed CEO Report: PERB</b>	ECHMN Board	We need to get more information about our competitors and others in the market. Gather intel on the implications of unionization and share with ECHMN board. ECHMN meeting held on November 8 <sup>th</sup> and Legal will continue to monitor.	Paced for March 13, 2024 ECHB meeting

<u>Subject</u>	<u>Actions</u>	<u>Notes</u>	<u>Status</u>
<b>Closed Consent Calendar: Credentialing</b>	Off Agenda	Legal and Medical Staff looked at what all the California Healthcare Districts are doing. Priya and Julia had further emails on the matter.	<b>Complete</b>
<b>Open Consent Calendar: Code of Conduct</b>	Next Meeting	Share the two changes– definition of act (Section IV.D.Conduct second bullet) and add a final report given to board in closed session (Section IV.G) - with David Reis and bring back to October board meeting. Retaliation should be the new letter H with Questions becoming I – formatting issue. Shared in October and further revisions requested for November meeting.	<b>Complete</b> Approved on 11/8/2023.

**CEO Report**  
**February 7, 2024**  
**Dan Woods, Chief Executive Officer**

## **Finance**

The month ending December 31, 2023, produced strong operating revenue of \$130.9 million which was favorable to budget by \$0.2 million / 0.1% and 9.2% higher than the same period last year. Income from operations of \$18.0 million was favorable to budget by \$6.0 million / 49.3%. Favorable operating income is attributed to management of variable expenses, strong surgical & emergency room volumes and favorable payor mix. Net income of \$69.2 million was favorable to budget by \$54.3 million / 363.8% mainly attributed to higher than budgeted investment income.

YTD FY2024 total operating revenue of \$757.0 million is unfavorable to budget by \$8.1 million / 1.1% and \$49.8 million / 7.0% higher than same period last year. Operating EBIDA of \$123.8 million is favorable to budget by \$6.3 million / 5.4% and higher than the same period last year by \$7.3 million / 6.3%. Initiatives to reduce denials / increase cash collections resulted in a decrease in Net Days in AR from 59.1 in July to 53.6 in December.

## **Operations**

### **Orthopedics**

ECH Orthopedic joint replacement program completed its first case using a new 3D surgical navigation technology, El Camino Health is the first hospital in Northern California to implement the innovation. The device is an augmented-reality navigation software which allows the surgeon to measure and precisely place the artificial hip components while looking at the surgical field through a headset. The software allows for both navigation and enhanced viewing of the bony anatomy based on a pre-op CT scan of the patient, enabling a more accurate and confident procedure, especially in cases with unusual anatomy.

### **Norma Melchor Heart & Vascular Institute**

For 2024, Healthgrades has awarded El Camino Health as:

- 1) America's 100 Best Cardiac Care, and #4 Cardiac Care in California for superior clinical outcomes in heart bypass surgery, coronary interventional procedures, heart attack treatment, heart failure treatment, and heart valve surgery
- 2) America's 100 Best Hospitals for Coronary Intervention Award for superior clinical outcomes in coronary intervention procedures (angioplasty with stent)

### **Women's & Newborn Care**

US News awarded MV "High Performing" status in their Best Maternity Hospital Survey (highest status) for 2024.

### **Scrivner Center for Mental Health & Addiction Services and the Taube Pavilion**

The Scrivner Center for Mental Health & Addiction Services, and the Taube Pavilion, was highlighted in Becker's Hospital Review, as "36 hospitals and health systems with great psychiatry and mental health programs". This recognition is the result of our amazing team of caring experts who provide top-notch specialized care.

### **Nursing**

Our nursing leadership impact continues to go beyond our hospital. We have seven ECH presentations on the agenda for the Annual Association of California Nurse Leaders conference in February. Fourteen of our nurse leaders will be sharing best practices and outcomes they have achieved through their work at ECH.

## **Human Resources**

### **Inclusion, Diversity Equity & Belonging**

Inclusion, Diversity, Equity & Belonging proudly promoted several opportunities for staff to honor Dr. Martin Luther King Jr's legacy with a day of service. In observation of the Martin Luther King Jr. holiday on January 15, staff worked with several nonprofit organizations across the Bay Area to give back to communities. Activities

ranged from prepping produce for the hungry with Martha's Kitchen in San Jose to garden maintenance at East Palo Alto Charter School. Opportunities to volunteer in Oakland and San Francisco were also provided to staff.

#### **Engagement and Safety Pulse Survey:**

Forty departments were selected to participate in the Engagement and Safety Pulse Survey. Over half of the departments made significant improvements compared to last Spring's survey. The next survey is scheduled for April 2024.

#### **Information Services**

ECH completed its annual HIPAA Cybersecurity Risk Analysis confirming El Camino Health meets HIPAA security requirements by demonstrating cybersecurity practice and procedure standards.

ECHMN is in the top 10% percentile of all Epic organizations for MyChart patient activation at 76% improving 5 percentage points from 71% last April. With implementation of "Enhanced Open Scheduling" workflows, patient self-scheduling of appointments on-line has increased to 18.6% from 13.8% in the last 6 months.

#### **Corporate Health Services**

Concern is developing a program to support residents in several of the healthcare organizations we support. We have created a panel of mental health providers who specialize in working with physicians. We are contracting with an innovative, evidence-based program that is self-paced to address depression and anxiety. This is in line with our goal to expand the choice to receive emotional support.

The South Asian Heart Center is now featured on the Santa Clara County Website as a Diabetes Prevention Program Provider.

#### **Foundation**

In December, El Camino Health Foundation secured \$451,928 in donations. The Foundation has raised a total of \$5,483,797 in the first half of FY 2024, which is 55% of the fiscal year fundraising goal.

The Foundation received six major gifts in December totaling \$201,603. Two of the major gifts were from first time donors. One of the returning donors was Santa Clara Sporting Club, which has been contributing annually to the Free Mammogram Program for 16 years. This latest gift brings their total contribution to \$615,200. Last year, the Free Mammogram Program underwrote 50 diagnostic mammograms, 40 diagnostic breast ultrasounds, and 19 breast biopsies for women in need.

#### **Auxiliary**

The Auxiliary donated 3,376 volunteer hours for the month of December. This brings our combined hours for FY23 to 23,055. This is the equivalent of 11 people working for a full year. We continue to be grateful to the excellent work done by our Auxiliary team.

# A13a. DRAFT 2023-12-06 ECHB Minutes (Open)

**Minutes of the Open Session of the  
El Camino Hospital Board of Directors  
Wednesday, December 6, 2023**

Hyatt Centric-Mountain View | 409 San Antonio Rd, Mountain View, CA 94040 | Cloud 2

**Board Members Present**

**Bob Rebitzer**, Chair  
**Julia E. Miller**,  
Secretary/Treasurer  
**Lanhee Chen, JD, PhD**  
**Wayne Doiguchi**  
**Carol A. Somersille, MD**  
**George O. Ting, MD**  
**Don Watters**  
**Peter Fung, MD** (arrived at 5:49  
p.m.)  
**John Zoglin**

**Board Members Absent**

**Jack Po, MD, Ph.D.**, Vice-Chair

**Others Present**

**Dan Woods**, CEO  
**Mark Adams, MD, CMO**  
**Holly Beeman, MD, CQO**  
**Carlos Bohorquez, CFO**  
**Shahab Dadjou**, President, ECHMN  
**Andreu Reall**, VP of Strategy  
**Cheryl Reinking**, CNO  
**Theresa Fuentes**, CLO  
**Deanna Dudley**, CHRO  
**Omar Chughtai**, Chief Growth  
Officer  
**Deb Muro**, CIO  
**Ken King**, CAO  
*\*\*via teleconference*

**Others Present (cont.)**

**Tracy Fowler**, Director,  
Governance Services  
**Stephanie Iljin**, Manager,  
Administration  
**Gabriel Fernandez**, Governance  
Services Coordinator  
**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 5:35 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Chen, Doiguchi, Miller, Rebitzer, Somersille, Ting, Watters, and Zoglin were present constituting a quorum. Director Fung was absent at roll call and joined the meeting at 5:49 pm.	<b>The meeting was called to order at 5:35 p.m.</b>
2. <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.	
3. <b>PUBLIC COMMUNICATION</b>	Chair Rebitzer invited the members of the public to address the Board. No members of the public provided comments during this time.	
4. <b>RECEIVE QUALITY COMMITTEE REPORT</b>	Director Carol Somersille, Chair of the Quality, Patient Care, and Patient Experience Committee, provided a verbal report on the updates from the committee. Director Somersille shared the knowledge she gained from her attendance at the Health Quality Improvement Conference, updates on the reviews of certain Quality measures, and a progress report on Health Equity initiatives the committee is involved with.  <b>Motion:</b> To receive the Quality Committee Report  <b>Movant:</b> Miller <b>Second:</b> Watters <b>Ayes:</b> Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin <b>Noes:</b> None <b>Abstentions:</b> None <b>Absent:</b> Fung, Po	<b>Motion Approved</b>

	<p><b>Recused:</b> None</p>	
<p><b>5. RECESS TO CLOSED SESSION</b></p>	<p>Motion to recess to closed session at 5:47 p.m. pursuant to <i>Health and Safety Code Section 32106(b)</i> for reports and discussion involving healthcare facility trade secrets for discussion of the strategic environment; and <i>Gov't Code Section 54957</i>; and deliberations concerning reports on Medical Staff quality assurance matters.</p> <p><b>Motion:</b> To recess to closed session</p> <p><b>Movant:</b> Ting  <b>Second:</b> Chen  <b>Ayes:</b> Chen, Doiguchi, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Fung, Po  <b>Recused:</b> None</p>	<p><b>Recessed to closed session at 5:47 p.m.</b></p>
<p><b>6. AGENDA ITEM 11: CLOSED SESSION REPORT OUT</b></p>	<p>The open session was reconvened at <b>6:13 p.m.</b> by Chair Rebitzer. Agenda Items 6-9 were addressed in closed session.</p> <p>During the closed session, the El Camino Hospital Board of Directors approved: The Credentialing and Privileging Report. By a unanimous vote of all Directors present: Directors Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, and Zoglin</p>	<p><b>Reconvened Open Session at 6:13 p.m.</b></p>
<p><b>7. AGENDA ITEM 12: CONSENT CALENDAR ITEMS</b></p>	<p>Chair Rebitzer asked if any member of the Board wished to raise an item from the consent calendar for discussion. Director Somersille pulled item h) <i>Approve Physician Wellness Policy</i> for further discussion.</p> <p><b>Motion:</b> To approve the consent calendar (not including item h).</p> <p><b>Movant:</b> Chen  <b>Second:</b> Watters  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p> <p><b>Motion:</b> To approve item h) <i>Physician Wellness Policy</i> with the requested revisions</p> <p><b>Movant:</b> Chen  <b>Second:</b> Watters  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p>	<p><b>The consent calendar was approved.</b></p> <p><b>Actions:</b></p> <p><i>Staff to revise item h) Physician Wellness Policy to include 'Medical Professionals'</i></p> <p><i>Staff to confirm that Director Miller's requested revisions have been made to the November 8<sup>th</sup>, 2023 Hospital Board of Directors Open and Closed Session Minutes</i></p>

<p><b>8. AGENDA ITEM 13:                  APPROVE                  AMENDED MOTION                  TO CLARIFY CEO                  BASE SALARY</b></p>	<p><b>Motion:</b> The Amended Motion to approve FY24 CEO Fixed Cash Compensation and Annual Base Salary and Range as disclosed at the meeting.</p> <p><b>Movant:</b> Miller  <b>Second:</b> Doiguchi  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p>	
<p><b>9. AGENDA ITEM 14:                  DIRECTOR MILLER                  ECH FOUNDATION                  LIASON REPORT</b></p>	<p>Director Julia Miller, Liaison to the El Camino Health Foundation, provided on the activity of the Foundation. Director Miller highlighted the Foundation’s initiative surrounding the Orchard Pavilion Donor Wall at the Mountain View campus. Director Miller invited members of the Board to review the materials and consider donating to the initiative.</p>	
<p><b>10. AGENDA ITEM 15:                  BOARD                  ANNOUNCEMENTS</b></p>	<p>Director John Zoglin, Chair of the Ad Hoc Committee, highlighted updates surrounding the process for conducting Board evaluations in advance of the upcoming Board appointments to the El Camino Hospital Board of Directors.</p> <p>Director Peter Fung formally announced the start of his campaign for County Supervisor – District 5. Director Fung thanked the Board of Directors for their support.</p>	
<p><b>11. AGENDA ITEM 16:                  ADJOURNMENT</b></p>	<p><b>Motion:</b> To adjourn at 6:27 p.m.  <b>Movant:</b> Fung  <b>Second:</b> Miller  <b>Ayes:</b> Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin  <b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Po  <b>Recused:</b> None</p>	<p><b><i>The meeting adjourned at 6:27 p.m.</i></b></p>

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

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Julia Miller, Secretary/Treasurer

## **A13e2. Communication with the CEO and Staff (2018.06.13) \_Combined Redline**

**TITLE:** Guidelines for **Board and Committee Member Communication with the CEO and Other El Camino Hospital Staff Members**

**CATEGORY:** Administrative

**ORIGINAL DATE:** **January 14, 2015**

**LAST APPROVAL:** **June 13, 2018**

**TYPE:**  Policy  Protocol  Scope of Service/ADT  
 Procedure  Standardized Process/Procedure

**SUB-CATEGORY:** *Board*

**OFFICE OF ORIGIN:** **Administration**

**ORIGINAL DATE:** **January 14, 2015**

- I. **COVERAGE:** Members of the El Camino Hospital Board of Directors and Advisory Committees and El Camino Healthcare District Board of Directors
  
- II. **PURPOSE:** To provide an efficient process for individual Board and Advisory Committee members to request ~~or share~~ information or assistance from Hospital staff relating to agenda items, governance, or interpretations of policy and other board requirements, and for Board members to request and obtain staff assistance with research or projects.
  
- III. **POLICY STATEMENT:** It is the policy of the El Camino Hospital Board of Directors and the El Camino Healthcare District that staff be available to ~~(1) individual Hospital Board, District Board, and Advisory Committee members~~ (collectively "Board members") to respond to pursuant to reasonable requests to obtain for information or assistance or share information and (2) to individual Board members for assistance with research or projects, and that the Board or Committee Chair be kept informed of such requests. This policy shall not apply to requests for staff work on matters that have been approved by a Board or Committee, and the request is made by the Board or Committee Chair on behalf of the Board or a Board Advisory Committee, made by the Committee or the Committee Chair.
  
- IV. **DEFINITIONS:**  
N/A
  
- V. **REFERENCES:**  
N/A

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<b>TITLE:</b>	<b>Guidelines for <u>Board and Committee Member</u> Communication with the CEO and Other El Camino Hospital Staff Members</b>
<b>CATEGORY:</b>	Administrative
<b><u>ORIGINAL DATE:</u></b>	<b><u>January 14, 2015</u></b>
<b><u>LAST LAST</u></b>	
<b>APPROVAL:</b>	<b>June 13, 2018</b>

## VI. **PROCEDURE:**

- A. Communication Generally: All Board member general requests for information or assistance from Hospital staff shall be as follows:
- a. All communications to the Chief Executive Officer shall be submitted directly to the Chief Executive Officer via email.
  - b. All requests for legal advice and support shall be submitted directly to the Chief Legal Officer. Use of outside counsel requires approval from the Chief Legal Officer or Chief Executive Officer.
  - c. Chairs of the Advisory Committees may contact the Executive Sponsor of their assigned Committee directly regarding the business related to the Committee.
  - d. Routine clerical requests, such as for clarification of meeting dates and locations and access to items in the Board portal, should be directed to the Executive Assistant, Director of Governance Services, or other person assigned to support the Board or Committee.
  - e. All other requests shall be in writing through email to the Director of Governance Services, with a copy to the Board or Committee Chair.
    - i. The Director of Governance Services shall consult with the Chief Executive Officer and the Chief Legal Officer as appropriate to ensure that the response is consistent with governing documents, policy, and practice.
    - ii. The Director of Governance Services, or designee, shall respond in writing to the request, with a copy to the Board or Committee Chair, within 2 business days. If additional time is needed for response, the Director of Governance shall respond with an estimate of approximate time for response.

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<b>LAST LAST APPROVAL:</b>	<b>June 13, 2018</b>

iii. The Director of Governance Services, or designee, shall log the request and the response on the Board Information Response log, which shall be available on the Board portal.

f. In the case of an emergency after business hours or on a holiday or weekend, Board and Advisory Committee members can contact the Administrator on Call (AOC) by calling the House Supervisor at (650) 336-4933 Hospital Operator at 650-940-7000 and asking for the AOC.

g. When acting as a member of the public, and not in their role as a member of the Board, members may interact with Hospital staff directly. For example, if a member is a patient, or has a family member who is a patient, the member should interact with staff as necessary and appropriate related to patient care.

~~The Director of Governance Services or, in the prolonged absence of the Director of Governance Services, a specific designee, shall serve as the first and primary point of contact between the Board and Advisory Committee Members and staff.~~

~~—The Director of Governance Services, when at all possible, is expected to (1) return phone calls and e-mails within 2 business days and (2) notify Board and Advisory Committee Members in advance of planned absences greater than two business days. Exceptions include:~~

~~0. Board Members may contact the CEO directly with the Board Chair on copy. Regarding substantive matters related to committee work, Advisory Committee Members may contact their Committee Chair directly.~~

~~0. For routine clerical matters, the Board and Advisory Committee members should first contact the Board Services Coordinator, or the~~

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<b><u>LAST LAST APPROVAL:</u></b>	<b>June 13, 2018</b>

- ~~Executive Assistant who supports their assigned Board Advisory Committee, but may always refer a matter to the Director of Governance Services at their discretion.~~
- ~~1. Chairs of the Advisory Committees may contact the Executive Sponsor of their assigned Committee directly regarding the business related to the Committee.~~
  - ~~1. To schedule an 1:1 appointment with the CEO, Board members should contact the El Camino Hospital employee who manages the CEO's calendar, but may always refer a matter to the Director of Governance Services at their discretion.~~

~~In the case of an extreme emergency after business hours or on a holiday or weekend, Board and Advisory Committee members should contact the Administrator on Call (AOC) by calling the House Supervisor at (650) 336-4933. Contact information for the AOC will also be maintained in the Board Portal.~~
  - ~~1. When acting as a member of the public, and not in their role as a member of the Board or an Advisory Committee, Board and Advisory Committee members may interact with Hospital staff directly. For example, if a member is a patient, or has a family member who is a patient, the Board member should interact with staff as necessary and appropriate related to patient care.~~

**B. Board or Committee Member Requests for Substantive Staff Work Within the Scope of the Board or Committee:**

1. If a request for substantive staff work within the scope of the Board or Committee is made to the CEO by a Board member other than the Board Chair, the Board member shall communicate that request via e-mail to the CEO, the Board or Committee Chair and the Director of Governance Services, and the Board Chair. The CEO will evaluate the staff time required to fulfill the request. If the CEO estimates that a request will require more than 2.5 hours of staff work, the CEO will inform the Board Chair prior to beginning the work. The Chair will either authorize the work or add the request to the agenda for an upcoming Board or

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<b><u>LAST</u></b>	
<b><u>LAST</u></b>	
<b>APPROVAL:</b>	<b>June 13, 2018</b>

~~Committee meeting, the next meeting. Each Board member may make one such request between Board meetings.~~  
~~— If a request for staff work on an item is made to the CEO by two or more Board members, those Board members shall communicate that request via email to both the CEO, the Board Chair and the Director of Governance Services, and the Board Chair. The CEO shall evaluate the staff time required to comply with the request. If the CEO estimates that a request will require more than 5 hours of staff work, the CEO will inform the Board Chair prior to beginning the work. The Chair will either authorize the work or agendaize the topic for the next meeting. Each Board member may initiate one such request between Board meetings.~~

2. The CEO shall not honor requests for staff work ~~from individual or groups of two Board members~~ on matters that the Board has considered and voted not to approve or pursue.

3. The CEO will keep the Board or Committee Chair informed ~~in regards to~~ of all requests for staff work from Board members other than the Board or Committee Chair.

**VII. APPROVAL:**

APPROVING COMMITTEES AND AUTHORIZING BODY	APPROVAL DATES
<u>Governance Committee</u> Originating Committee or UPC Committee	<u>12/12/2023</u> <del>N/A</del>
(name of) Medical Committee (if applicable):	N/A
ePolicy Committee:	N/A
Pharmacy and Therapeutics (if applicable):	N/A
Medical Executive Committee:	N/A
<u>Hospital</u> Board of Directors:	<del>February date</del> <u>02/07/24?</u> <del>16/13/2018</del>

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**TITLE:** Guidelines for **Board and Committee Member**  
Communication with the CEO and Other El Camino Hospital  
Staff Members

**CATEGORY:** Administrative

**ORIGINAL DATE:** January 14, 2015

**LAST  
LAST  
APPROVAL:** June 13, 2018

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District Board of Directors:	<del>February date</del> 2/13/24
Historical Approvals:	1/14/15; 6/13/2018

**VIII. ATTACHMENTS:**  
N/A

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# **A13f2. Patient Blood Management Patient-Centered Quality Plan-History**



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

Owner Jeong Chae:  
 Patient Blood Management Programs Manager  
 Area Quality  
 Document Type Plan

## Patient Blood Management Patient-Centered Quality Plan

### PROGRAM OVERVIEW:

El Camino Health (ECH) is a 454 bed and nonprofit care organization with hospital campuses in Mountain View, California and Los Gatos, California. Our hospitals have served communities in the South San Francisco Bay Area for over 60 years. ECH is mission-driven to provide the best care to its patients. This quality plan is an effort in extending this care philosophy to the hospital's Patient Blood Management (PBM) program.

There is an increasing awareness of the limited clinical efficacy of blood, an increasing concern regarding its safety, dwindling blood supply and rising costs of blood products. The practice of transfusion medicine now emphasizes the judicious use of transfusion, only when clinically indicated. ECH's patient blood management program is seen as a solution to these problems.

Since July 2014, ECH has been actively involved in a Patient Blood Management (PBM) initiative to promote advancements in transfusion practice. The main areas of implementation included establishing evidence-based transfusion guidelines, reviewing the appropriateness of each transfusion with practitioner feedback, providing ongoing clinical education, creating PBM dashboards, and distributing an analytic blood utilization report. ECH's PBM program has been adopted across medical specialties and we are anticipating a continuous advancement in coming years.

### VISION FOR QUALITY:

The promotion of safe, high quality management and use of blood and blood products is a primary objective of the PBM program. Statements in the Joint Commission (TJC) and the Association for the Advancement of Blood and Biotherapies (AABB)'s PBM standards outline the expectations of healthcare

organizations with regard to the responsible, sustainable and appropriate use of blood and blood products.

ECH's PBM program improves patient outcomes by ensuring that the focus of patient's medical and surgical management is on optimizing and conserving the patient's own blood. PBM sets the standard of ECH's care applied by all clinicians for patients facing a medical or surgical intervention who are at risk of blood loss, bleeding, coagulopathy or may require a blood product as part of their treatment, recognizing that there may be more appropriate ways of using and administering blood and blood products to manage disorders.

## **PRINCIPLES OF PATIENT BLOOD MANAGEMENT:**

PBM views a patient's own blood as a valuable and unique resource that should be conserved and managed appropriately. This recognizes that for many patients the best and safest blood is their own circulating blood. Appropriate patient management requires a patient's blood (circulatory system) to be considered in the same way as the management of all other body systems.

### **A. Reducing inappropriate use**

Appropriate use of blood products within a blood management framework would mean that red blood cell (RBC) transfusions would be characterized as "appropriate" on the basis of a pre-transfusion hemoglobin, could be rendered unnecessary if a patient's iron deficiency is treated and patients are allowed adequate time to generate their own red cells and hemoglobin in preference to transplanting another person's red blood cells.

ECH's PBM is a multidisciplinary, evidence-based approach to optimizing the care of patients and represents best practice for transfusion medicine. Appropriate use of blood and blood products should therefore take into account a patient's modifiable risk factors that may reduce the use of transfusion as a treatment option.

### **B. Partnering with patients**

The Standard aims to ensure that patients (and surrogates) are engaged in decisions about their care management and, if they chose to receive blood and blood products, they do so appropriately and safely. Information should be provided to patients about optimizing their own blood, PBM strategies and the potential need for blood and blood products, including all treatment options, risks and benefits.

When discussing PBM with patients, it is important to:

1. Ensure that the information is current, and that clinicians have ready access to it.
2. Provide information in a format that is easy to understand and able to be adapted to level of health literacy.
3. Honor an adult patient who has capacity to make medical decisions (or their designated surrogate decision maker) to refuse blood product and review non-blood medical alternatives and treat the patient without using allogeneic blood.

ECH's PBM supports clinicians to communicate with patients and surrogates to respect the

patient's values and preferences along with an appropriate informed consent process.

## **PBM PROGRAM IMPLEMENTATION:**

### **A. Dissemination of evidence-based transfusion guidelines**

Effective implementation of comprehensive transfusion guidelines is a key element in a successful patient blood management program. These guidelines establish a standard of care within the organization for clinical transfusion decisions. ECH's transfusion guidelines are developed and written by a multidisciplinary group of clinicians based on a review of the literature including national or specialty-specific physician practice guidelines. They are evaluated by the hospital's Transfusion Safety Committee and Medical Executive Committee (MEC) to ensure that the guidelines are followed.

Transfusion clinical practice guidelines include:

1. Hemoglobin level of 7 g/dL or less as a transfusion trigger (except acute massive hemorrhage)
2. Single unit transfusion: One unit of blood can be ordered at a time for stable patients who are not actively bleeding; a second unit may be added after reassessing the patient
3. CPOE will allow single unit of RBC transfusion and block additional RBC transfusion orders for the period of one hour from the time of previous single unit transfusion order entry
4. In order to place more than one unit of RBC, the ordering physician must check at least one of the options from the exclusion criteria
5. Hemoglobin level of 8 g/dL or less as a trigger in cardiovascular disease or a post-operative patient
6. Specific Platelets Guideline by platelet count threshold and clinical indication (Prophylactic use, Peri-procedural use, and Therapeutic Use of Platelets)

These guidelines were embedded in the hospital's clinical policy and the Computerized Physician Order Entry (CPOE) system. They are also disseminated throughout various communication channels both verbally and via reports. The chair of the Transfusion Safety Committee (a medical director of PBM) and program manager of PBM visit various physician specialties, groups, departments, and committee meetings to present the new guidelines and their specific outcomes data.

### **B. Provider-specific peer review of transfusions**

Concurrent review of transfusion orders is done by the PBM Program Manager on a daily basis. It has been the most effective tool to evaluate whether hospital transfusion guidelines are being followed by each ordering physician and mid-level clinician. Determination of appropriateness is based on medical condition, evidence-based transfusion guidelines, and adequate and appropriate clinical documentation regarding the decision for transfusion. Each week, collected review cases are sent to the chair of the Transfusion Safety Committee for further review. The results of transfusion review are communicated to the ordering provider and the chief of the service or department. The reviewed cases are entered into the Peer

Review data base under the file titled: blood transfusion - outside guidelines. This data is used for education and is also reviewed as a part of the Ongoing Professional Practice Evaluation (OPPE) process.

**C. Computerized Physician Order Entry (CPOE) with clinical decision support**

Implementation of the guidelines and assurance that the guidelines are being followed can be accomplished through incorporation of the guidelines into the hospital's blood and blood component ordering process. In our current computer based ordering system, physicians must choose the clinical indication for transfusion from a list and fill out required fields or order detail. The indicated reason for transfusion as part of the ordering process has facilitated transfusion utilization review.

As a part of effective Clinical Decision Support System (CDSS), most recent laboratory values are available in the order set screen. Evidence-based Transfusion guidelines for each category of blood products are available in the order set via hyperlink.

Currently, single unit transfusion is set up as a default for the non-emergent medical patient. Transfusion of a second unit should only be given if the symptoms of anemia have not resolved. This strategy ensures the patient receives the correct response and reduces the risk associate with repeat transfusions. CPOE allows single unit of RBC transfusion and blocks additional RBC transfusion orders for the period of one hour from the time of previous single unit transfusion order entry. In order to place more than one unit of RBC, the ordering physician must check at least one of the options from the exclusion criteria: Patient is actively bleeding and/or patient is in the operating/procedural room. Any other clinical reason for placing more than one unit order must be entered in the transfusion order set.

**D. Patient blood management–related metrics and analytic dashboards**

PBM-related metrics and blood usage are collated and itemized for each clinical specialty to allow identification of potential areas for improvement due to overutilization. These data are analyzed to identify the physician group, department or committee, and individual clinician. Patient blood management related metrics include single unit RBC transfusion episodes, indications for blood product use with mean pre-transfusion levels, and blood product use that falls outside of transfusion guidelines. As a result, a monitoring and feedback system has been established as a standardized format. Next, data analytic software, Tableau, is utilized to generate specialty and physician specific analytic reports. The data is then distributed to key shareholders including heads of the departments and the Medical Director of Quality and Patient Safety on a monthly or quarterly basis.

**E. Ongoing Professional Practice Evaluation (OPPE)**

ECH has been able to collect meaningful transfusion-related data, and provide that data to individual practitioners through OPPEs. In coordination with peer review coordinators, 2 transfusion metrics have been included in the physician OPPE report since October 2017. The practitioner's average transfusion hemoglobin level and the average number of transfused units are compared to other physicians within the same specialty. In addition, the outlier cases that are entered into the clinical effectiveness data base will be added to the OPPE report as an additional metric for the evaluation of transfusion practices. The positive outcome is that most practitioners will make the needed changes when presented with data showing they are not performing to the same level as their peers.

**F. Tracer Audit and Analytic Report on Transfusion Nursing Documentation**

Through tracer audit activity, nurses will be educated and encouraged to closely monitor the patient and document all required fields, including vital signs before, during, and after the transfusion. Unit and individual specific Tableau report will clearly highlight the areas where there is need for greater improvement, including names of nurses who report higher noncompliance rate. The analytic data are disseminated through nursing managers and directors. It is encouraged to share the data with nursing staffs to understand the current status of noncompliance and need of improvement.

**G. Development of a protocol to check Type and Screen prior to elective surgery**

Beginning an elective high blood loss surgery without confirming the availability of a patient's specific blood type is a safety concern. ECH endeavors to ensure that compatible blood is available since about 3% of specimens have a serologic finding that requires further investigation, causing a potential delay. Development of a formal protocol to have blood testing completed (when ordered) prior to potential high blood loss elective surgery may optimize management of blood resources and maximize patient safety.

An internal audit showed that the rate of same-day type and screen (T&S) was high even though this increases the chances of delayed surgery for compatible blood. A small portion of the population had a T&S between one and sixteen days prior to surgery. More than half of the cases had no T&S. For example, out of 371 cases of elective orthopedic surgeries, the percentage of T&S on the same day of surgery was 33.4% (124 cases) and only 14.2% had a T&S done before the surgery day.

ECH has initiated a systematic pre-admission screening protocol. Based on a review of research articles and clinical guidelines by healthcare organizations, universal pre-admission T&S enabled hospitals to identify patients with a positive screen and to prepare matched blood. An extended specimen policy was implemented allowing for antibody screen results to be valid for up to 30 days. PBM's medical director has communicated with surgeons and finalized a list of high blood loss elective surgeries. ECH's Pre Admission Services (PAS) team will place an order for T&S and other needed preoperative tests and call patients to be tested as early as 14 days prior to surgery. This preoperative screening practice will minimize delays in transfusions and ensure sufficient time to correct a patient's anemia.

**H. Ongoing education**

ECH has been continuously seeking educational outreach to clinical staff to reinforce evidence-based transfusion guidelines and share the department specific analytic data at group meetings. Various communication tools are utilized to provide PBM reminders, such as a letter from the office of the Chief Medical Officer, physician newsletters, displays in physician lounges, pocket-size cards for clinicians regarding guidelines, and poster presentations.

For nursing, PBM modules are incorporated into mandated annual nursing education. The main focus is highlighting the importance of assessing patient's clinical symptoms and hemodynamic instability instead of depending on arbitrary laboratory values. Also, nurses are encouraged to implement restricted diagnostic phlebotomy by minimizing frequency of sampling, utilizing pediatric size blood collection tubes, and utilizing point of care testing for frequently needed chemistry tests such as potassium levels for post-operative cardiac surgery cases.

Additionally, ECH hosted a PBM Clinical Conference to introduce the medical staff and other

clinicians to the most up to date clinical evidence related to transfusion practice. For example, on May 17, 2018, two PBM leaders from the nation's first two organizations (Johns Hopkins and Georgetown University Hospitals) – who are recipients of PBM certification from TJC and the AABB, provided excellent presentations for clinicians. They described the recommended indications for blood transfusion according to the latest randomized trials and society guidelines and five specific methods of blood conservation to reduce blood use, enhance patient safety, and reduce cost. During FY 2019, another PBM conference (April 17, 2019) and PBM awareness week (November 5-9, 2018) are planned. Irwin Gross, MD, a nationally recognized speaker and published author in Patient Blood Management and Transfusion Safety provided an education on the topic of care of the surgical patient through effective PBM application. More recent clinical educational event was inviting Aryeh Shander, MD who is the Executive Medical Director of The Institute for Patient Blood Management and Bloodless Medicine and Surgery at Englewood Hospital, and Past -President of the Society for the Advancement of Patient Blood Management in January 2022. He provided a timely education on the topic of pre-operative anemia management and how to improving outcomes in the pre-surgical patient population. These conferences have increased the awareness of PBM as a patient-centric and evidence-based practice.

**I. TJC/AABB PBM certification**

The natural next step in our PBM effort is obtaining Joint Commission Certification for our program. The certification process will provide a knowledgeable third party review on our processes and practices. This will ensure that we make continuous quality improvements in PBM. In October 2021, ECH has successfully finished re-certification survey by TJC and AABB and recognized as a certified PBM organization.

## **PROGRAM STRUCTURE AND ACCOUNTABILITY:**

The overall organizational structure is depicted below.



PY

**The Medical Director of PBM** provides oversight for the enterprise quality in patient care by promoting system-wide patient blood management function through appropriate and safe fresh blood product administration throughout ECH. This position is a specialist role which provides an effective clinical function in improving patient outcomes. The position holder influences the practice of nursing, medical/clinicians, laboratory and allied health disciplines in PBM both within and external to the health service. Areas of accountability will include the provision of leadership, clinical standard setting and monitoring, policy development, and change management. This position ensures that all steps necessary to embed PBM as a standard of care in ECH in question are accomplished.

The medical director's responsibilities include:

- A. Provides leadership, direction and overall clinical management of the PBM program
- B. Chairs a hospital based multidisciplinary Transfusion Safety Committee to advance and embed PBM as a standard of care
- C. Responsible for reporting on program performance to the clinical staff, hospital administration
- D. Works closely with the PBM program manager regarding the dissemination and creation of PBM throughout the hospital, being a resource and leader
- E. Ensures the development of educational programs and resources about PBM for all clinical and non-clinical staff, including orientation for new staff
- F. Provides regular reports (eg. quarterly, biannual, annual) regarding program performance to clinical staff, hospital administration
- G. Works closely with the Transfusion Medicine Director regarding transfusion usage data, and assures regulatory requirements in the areas pertaining to transfusion and PBM are satisfied
- H. Assists in the development and or reorganization of patient flow for the outpatient/inpatient assessment of iron deficiency (with or without anemia) in the perioperative/medical setting
  - I. Assists in strategies to reduce blood loss (including iatrogenic) for all patients
- J. Liaises with other department heads and hospital committees on issues relevant to the PBM program
- K. Helps develop a mechanism of action / plan with the executive medical staff; regarding identifying transfusion outliers by specialty and individually, with follow through action in that plan.
- L. Ensures the development and communication of best practice guidelines to secure consistent, equitable and quality outcomes are achieved across the Patient Blood Management Program
- M. Monitors, analyses and reports on adherence to the best practice guidelines and performance standards
- N. Develops, refines and communicates operational plans resulting from treatment protocols and clinical pathways, and regularly reviews PBM policies, procedures and protocols
- O. Assists in the development, maintenance and monitoring of data to determine cost reduction and cost avoidance as it relates to transfusion of blood products and anemia care products
- P. Monitors and analyses trends for continuous improvement of the Program and proposes
- Q. Represents the ECH's PBM Program at relevant conferences, events, boards and committees
- R. Ensure enhancement of blood conservation through the utilization of product alternatives by developing and providing education to medical staff and other appropriate clinicians on current technology including (but not limited to): autologous cell salvage, bio-friendly cardiac bypass circuits, and pharmacologic agents which reduce bleeding and stimulate blood cell production

**Patient Blood Management Program Manager** acts as the liaison within the hospital environment to ensure that blood management and transfusion related activities are conducted in the safest possible manner, meet or exceed all existing safety and regulatory requirements, and are within established guidelines. The position is responsible for the development and effective coordination of the PBM and processes to assure that all transfusion related activities are conducted in the safest possible manner

and meet or exceed all existing safety and regulatory requirements. Patient Blood Management Program Manager collaborates with all levels of clinical and medical personnel to evaluate transfusion management strategies and offer recommendations for improvement. In addition, Patient Blood Management Program Manager assists in establishing policies, protocols and procedures to support PBM and utilizations that meet regulatory standards and guidelines related to evidence-based transfusion medicine practices. Establishes a process to track, audit and analyze key performance metrics and offers recommendations to address areas of concern to improve safety and treatment efficacy, and to reduce costs. Patient Blood Management Program Manager serves as a resource to nurses, medical staff and laboratory staff related to blood management and administration, transfusion related safety issues, and this includes the preparation and presentation of education materials to accomplish this task.

Patient Blood Management Program Manager's responsibilities include:

- A. Serves as resource to physicians, nursing and laboratory staff relating to blood utilization and transfusion procedures.
- B. Develops and monitors a blood product utilization program to ensure that appropriate products are requested and used and that wastage is minimal.
- C. Conducts prospective and retrospective audits on the utilization of blood and blood products and brings utilization issues to the attention of the Quality and Transfusion Service Medical Directors and the Transfusion Safety Committee.
- D. Promotes benchmarking and evidence-based practice in the appropriate transfusion of blood, blood products and their alternatives.
- E. Responds to concerns and requests for assistance to ensure compliance with established guidelines and policies pertaining to blood component utilization, administration and documentation.
- F. Conducts investigations of errors, deviations, and near-miss events that involve blood component administration that occur outside of the laboratory.
- G. Reviews and investigates transfusion reactions and reports to the Manager, Medical Director and Transfusion Committee and where appropriate recommends changes to current practices.
- H. Leads hospital's Transfusion Committee meetings together with the Transfusion Service Medical Director and PBM Medical Director.
- I. Works collaboratively with the Laboratory Manager, Technical Specialist and Blood Transfusion staff to provide input to procedures and policies relating to transfusions.
- J. Participates as a member of hospital committees requiring Transfusion Medicine input such as new product evaluation and nursing procedures.
- K. Provides education to physicians, clinical laboratory scientists, and nursing personnel on appropriate use of blood, blood products, and blood transfusion devices and other related information.
- L. Arranges and facilitates multidisciplinary workgroups as needed to ensure the coordination of blood management services and resources.
- M. Maintains professional growth and development in the field of blood management through an

ongoing process of formal and informal.

- N. Assists with hospital Clinical Quality Outcomes monitoring projects as assigned.
- O. Conducts Patient Blood Management audit and provides performance measure reports and analysis to Transfusion Safety Committee. Facilitates pathology review of transfusion service reports.

**Transfusion Safety Committee** is a multidisciplinary group that has the overall responsibility to maintain safe hospital transfusion practice. Its role is pivotal in ensuring appropriate blood utilization and that best practice standards are followed. This committee reports to the Medical Executive Committee of ECH.

Transfusion safety committee's roles include:

- A. Developing systems for the implementation of PBM guidelines and standards within the hospital – defining blood transfusion policies
- B. Monitor the implementation of evidence-based guidelines in the hospital and take appropriate action to overcome any factors that may be hindering their effective implementation
- C. Liaison with blood transfusion services to ensure availability of required blood and blood components
- D. Training and assessment for all staff in the hospital that are involved in the blood transfusion process
- E. Monitoring the usage of blood and blood components within the hospital and contribute to benchmarking against others
- F. Reducing blood component loss due to time expiry and other wastage reasons – linking into clinical areas where clinical wastage is deemed high
- G. Monitoring, reporting and investigating transfusion adverse events and near misses and using these experiences to promote learning
- H. Ensure a cycle of clinical audits to check transfusion practice and safety and compliance to PBM standards
- I. Reduce the number of incidents in which an inappropriate dose of component is given to a patient
- J. Disseminating transfusion related information to users including changes to national guidance, audit results and examples of good practice
- K. Implementing PBM initiatives – reviewing transfusion alternatives and making recommendations of their use
- L. Reviewing if recall and other quality manual processes work as intended

#### **Attachments – Clinical Practice Guidelines and Procedures related to PBM**

- Att A [Administration of Blood and Blood Products in the Neonate](#)
- Att B [Adult Transfusion Guidelines](#)
- Att C [Emergency Blood Release to the NICU](#)
- Att D [Management of Patient Receiving Blood and Blood Products](#)

- Att E [Management of Patient Who Refuses Blood Products](#)
- Att F [Management of the Obstetric Patient Who Refuses Blood Products](#)
- Att G [Massive Transfusion & Emergency Release Protocol \(MTP\)](#)
- Att H [Pre Admission Services \(PAS\) Management of Patient](#)
- Att I [Preadmission Procedure for Blood Bank Services](#)

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## Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Interim Regulatory Accreditation and Licensing Con [PS]	12/2023
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
Transfusion Safety Committee	Jeong Chae: Patient Blood Management Programs Manager	10/2023
	Jeong Chae: Patient Blood Management Programs Manager	10/2023

## History

**Created by Santos, Patrick: Policy and Procedure Coordinator** on 10/2/2023, 2:02PM EDT

**Last Approved by Chae, Jeong: Patient Blood Management Programs Manager** on 10/2/2023, 2:06PM EDT

**Last Approved by Chae, Jeong: Patient Blood Management Programs Manager** on 10/2/2023, 2:09PM EDT

**Comment by Chae, Jeong: Patient Blood Management Programs Manager** on 10/2/2023, 2:16PM EDT

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Transfusion Safety Committee - approved on 9/25/2023

**Last Approved by Santos, Patrick: Policy and Procedure Coordinator** on 10/16/2023, 9:49AM EDT

ePolicy 10/13/23

**Last Approved by Coston, Michael: Interim Regulatory Accreditation and Licensing Con** on 12/18/2023, 3:53PM EST

MEC 11/16/23

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## **A13f3. Scope of Service - Wound Care Center**



Origination	09/2017
Last Approved	N/A
Effective	Upon Approval
Last Revised	01/2024
Next Review	3 years after approval

Owner	Pat Forsberg: Interim Clinical Mgr
Area	Scopes of Service
Document Types	Scope of Service/ADT

## Scope of Service - Wound Care Center

### A. Types and Ages of Patient Served

The Wound Care Center (WCC) is an outpatient department of El Camino Hospital (ECH). The WCC provides comprehensive and coordinated wound care to outpatient adults eighteen years of age and older. WCC focuses on the assessment and treatment of adults with the goal of optimizing complex wound healing in adults of all ages. Types of patients served are described in the scope and complexity of services offered below.

### B. Assessment Methods

Patient assessment and care is provided by physicians, Wound Ostomy Certified Nurses (WOCNs) registered nurses and licensed vocational nurses as appropriate and according to their scope of practice. ~~Physicians and/or~~ The Clinical Manager (RN) provide direct supervision to the registered nurses ~~and~~, licensed vocational nurse, and medical assistant in the provision of patient care.

### C. Scope and Complexity of Services Offered

The WCC is located at 2660 Grant Road, Suite F, Mountain View, California. The WCC operating hours are Monday - Friday from 8 am to 5:30 pm. WCC facility is not open on weekends or holidays recognized by El Camino Hospital. Physicians are not available after the WCC operating hours and patients are instructed to contact their primary MD if needed during those hours or to go to the Emergency Room if in need of urgent attention

The WCC has exam rooms for clinical examinations and moderate to complex procedures. ~~The WCC clinical schedule and patient records are maintained in an electronic health record by trained staff.~~

The following services are provided:

- Comprehensive wound assessment for etiology and characterization of wounds
- Appropriate tissue debridement if needed
- Application of suction devices, compression devices/dressings or therapeutic tissue substitutes when indicated
- Prescribing of oral medications, topical treatments and dressing protocols and referral for diagnostic testing and procedures when appropriate

Patient care Each room is given as directed and prescribed by the physician. The medical staff working in the WCC will have hospital privileges on file in the ECH Medical Staff Office. Staff communicates specific patient needs and coordinates treatment and plan of care equipped with referring and consultative physicians the necessary supplies with sharps and topical medications secured in the rooms in a locked medication cart. Services and treatments provided according to department specific procedures and guidelines and ECH policies and procedures.

#### D. **Staffing/Staff Mix**

A Clinical Manager (RN) oversees the clinical operations of the Wound Care Center and reports to the Department Director and the Medical Directors. Physicians provide direct care and assessment with the assistance of an RN and/or LVN. WCC staffing will be determined by patient volume and patient needs.

The competency of the staff is evaluated through observation of performance and skills competency validation. Staff education and training is provided to assist in the achievement of performance standards.

#### E. **Requirements for Staff**

- All staff must complete specific orientation.
- The Health Stream safety series as well as Safety/Emergency policies and procedures are reviewed annually by all staff.
- All clinical staff members are required to be Basic Life Support certified.
- All clinical staff will be licensed according to ECH policies and procedures and by the State of California.

#### F. **Level of Service Provided**

The level of service is consistent with ambulatory wound care and treatment. The WCC is designed to advocate for and support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a caring and enduring partnership between the care team, patients and the patient's family.

#### G. **Standards of Practice**

WCC is governed by state regulations as outlined in Title 22, the Center for Medicare/Medicaid Services.

- : Dirty instruments are removed from the exam room after the patient visit and sprayed with enzymatic cleaner in the dirty utility room and placed in the red bin for collection
  - : Topical medications are labeled with the date opened and date to be discarded
  - : The WCC will follow the pharmacy policy multidose medications, by discarding at 28 days
- A. The WCC clinical schedule and patient records are maintained in an electronic health record by trained staff.

The following services are provided:

- : Comprehensive wound assessment for etiology and characterization of wounds
- : Appropriate tissue debridement as indicated
- : Application of suction devices, compression devices/dressings or therapeutic tissue substitutes when indicated
- : Product samples are not allowed in the WCC
- : Prescribing of oral medications, topical treatments and dressing protocols and referral for diagnostic testing and procedures when appropriate

Patient care is given as directed and prescribed by the physician. The medical staff working in the WCC will have hospital privileges on file in the ECH Medical Staff Office. Staff communicates specific patient needs and coordinates treatment and plan of care with referring and consultative physicians. Services and treatments provided according to department specific procedures and guidelines and ECH policies and procedures.

**B. Staffing/Staff Mix**

A Clinical Manager (RN) oversees the clinical operations of the Wound Care Center and reports to the Department Director and the Medical Directors. Physicians provide direct care and assessment with the assistance of the WOCN and/or LVN. WCC staffing will be determined by patient volume and patient needs.

The competency of the staff is evaluated through observation of performance and skills competency validation. Staff education and training is provided to assist in the achievement of performance standards.

**C. Requirements for Staff**

- : All staff must complete specific orientation.
- : The Health Stream safety series as well as Safety/Emergency policies and procedures are reviewed annually by all staff.
- : Specific competencies related to wound care are included in the required Health Stream modules
- : All clinical staff members are required to be Basic Life Support certified.
- : All clinical staff will be licensed according to ECH policies and procedures and by the State of California.

**D. Level of Service Provided**

The level of service is consistent with ambulatory wound care and treatment. The WCC is designed to advocate for and support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a caring and enduring partnership between the care team, patients and the patient's family.

**E. Standards of Practice**

WCC is governed by state regulations as outlined in Title 22, the Center for Medicare/Medicaid Services, and The Joint Commission.

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

## Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	01/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2024
Department Medical Director or Director for non-clinical Departments	Pat Forsberg: Interim Clinical Mgr	12/2023
	Pat Forsberg: Interim Clinical Mgr	12/2023

## History

**Edited by Forsberg, Pat: Interim Clinical Mgr** on 10/4/2023, 1:50PM EDT

- Added WOCN certification for the registered nurses.
- Added Medical Assistant to the care team.
- Removed physicians as providing supervision for the registered nurses.
- Changed the hours of operation from 8-5 to 8-4:30.

Added that sharps and topical medications are secured in the exam rooms.  
Added The Joint Commission as another governing body.

**Administrator override by Santos, Patrick: Policy and Procedure Coordinator** on 11/30/2023, 5:25PM EST

Updated title and ownership (per email request from Ann Aquino).

**Last Approved by Aquino, Ann: Associate Chief Nursing Officer-Los Gatos** on 12/5/2023, 3:58PM EST

**Draft saved by Forsberg, Pat: Interim Clinical Mgr** on 12/28/2023, 2:44PM EST

**Edited by Forsberg, Pat: Interim Clinical Mgr** on 12/28/2023, 2:45PM EST

Added medication labeling and expiration dates  
Added handling of dirty sterile instruments  
Added that we do not allow samples in the WCC

**Last Approved by Forsberg, Pat: Interim Clinical Mgr** on 12/28/2023, 2:45PM EST

**Last Approved by Forsberg, Pat: Interim Clinical Mgr** on 12/28/2023, 2:46PM EST

Approve additions

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Minor formatting correction; will re-format entire doc before publishing.

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ePolicy 1/12/24

**Last Approved by Coston, Michael: Director Quality and Public Reporting** on 1/31/2024, 11:40AM EST

MEC 1/25/24