QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING

Wednesday, October 25, 2023
5:00pm-7:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session:  HCP Conference Center, see above address

Members of the public may also participate at the following ZOOM Meeting Link:¹
https://alamedahealthsystem.zoom.us/j/9361457125?pwd=aUF4anZlK01JRklVMzZvQVY5NTdOZz09

Meeting ID: 936 145 7125
Password: 20200513

One tap mobile
+14086380968,,9361457125# or
+13462487799,,9361457125#

Dial by your location
+1 408 638 0968 US (San Jose)
+1 346 248 7799 US (Houston)
+1 646 518 9805 US (New York)

Find your local number: https://alamedahealthsystem.zoom.us/u/aeojyFgeyI

COMMITTEE MEMBERS
Kinkini Banerjee  Taft Bhuket, MD, Chair
Jennifer Esteen  David Sayen

NON-VOTING MEMBERS
Chief of Staff – AHS Medical Staff
Chief of Staff - AH Medical Staff

¹ Log into the meeting at www.zoom.com. You will be directed to download the meeting app (free) if you have not used ZOOM previously. ZOOM meetings may be accessed on computers and portable devices.

NOTE: In the event that a quorum of the Board of Trustees participates on this Committee, the meeting is noticed as a Special Meeting of the Board of Trustees; however, no final Board of Trustees action can be taken.
QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING AGENDA

SPECIAL NOTE: The governor-declared state of emergency that altered public meeting protocols during the Covid pandemic has been lifted. All Alameda Health System Board of Trustees meetings and Board of Trustees Committee meetings will be held in accordance with current Brown Act requirements. As a result, our meetings will be held via a hybrid of in-person and remote access.

The public is invited to attend the meetings in person or observe and participate in the meeting via the Zoom link above.

Public Comment Instructions
If you attend the meeting in person and wish to address the Board or Committee regarding an item on the agenda or in their purview, please complete a Speaker Card available near the entrance. If you need assistance, please see the Clerk of the Board.

If you attend the meeting remotely and wish to address the Board of Trustees or Committee regarding an item on the agenda or in their purview, send an email to cob@alamedahealthsystem.org PRIOR TO THE START OF THE MEETING. Your comment will be heard at the appropriate time. During the meeting, public comment requests may be submitted to the ZOOM meeting host or the Clerk of the Board, but requests must be submitted prior to the beginning of the public speaker time for that item.

Each speaker, whether in person or remote, will be allotted between one and three minutes to speak, depending on the number of speakers present.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT: Non-Agenda Items

Public comment on each Action or Report/Discussion/Information item may take place after the staff presentation and prior to Committee action or discussion. To provide comment remotely, follow the “Public Comment Instructions” above. The Committee does not vote on Report/Discussion/Information items.

A. REPORT/DISCUSSION: QPSC Chair (estimated 10 min)
   Taft Bhuket, MD, Trustee

B. ACTION: Consent Agenda (estimated 10 min)

Public comment on all Consent Agenda items may be heard prior to the Committee’s vote. To provide comment remotely, follow the “Public Comment Instructions” above. The Committee does not deliberate on Consent Agenda items. Any member of the public or the Committee may request that a Consent Agenda item get pulled from the Consent Agenda for deliberation and to be voted on separately from the Consent Agenda.
B1. Approval of the Minutes of the September 27, 2023 Quality Professional Services Committee Meeting

B2. Policies and Procedures

Recommendation to the Board of Trustees for approval of the policies listed below.

System Wide Policies
• Targeted Temperature Management Policy – TTM CONTROLLED SUBSTANCE MANAGEMENT
• GME - CLINICAL AND EDUCATIONAL WORK HOURS
• GME - KAISER OAKLAND/HIGHLAND OB/GYN RESIDENCY AHS COMMUNITY HOSPITALS
• GME - PROGRAM CLOSURE AND REDUCTION POLICY
• GME - RESTRICTIVE COVENANT POLICY
• Infusion Pump Policy
  BLOOD_PRODUCT_ADMINISTRATION_(TRANSFUSION)_(33465_-1)
• AHS Code Status Policy
• Comfort Care Policy (CARE OF THE PATIENT AND FAMILY TRANSITIONING TO COMFORT CARE)
• Utilization Management Committee Plan
• Visiting Policy

B3. Medical Staff Policies

Recommendation to the Board of Trustees for approval of the policy listed below.

• Medical Staff Department Structure and Divisions

B4. Revised Privilege Form

• Addiction Medicine Multifacility

Recommendation: Motion to Approve

END OF CONSENT AGENDA

Public comment on each Report/Discussion/Information item may take place after the staff presentation and prior to Committee discussion. To provide comment remotely, follow the “Public Comment Instructions” above. The Committee does not vote on Report/Discussion/Information items.

C. REPORT/DISCUSSION: Medical Staff Reports (estimated 20 min)
- AHS Medical Staff: Lan Na Lee, MD (Chief of Medical Staff)
  Abid Mogannam, MD (SLH Leadership Committee Chair)
- AH Medical Staff: Nikita Joshi, MD (Chief of Medical Staff)
D. REPORT/DISCUSSION: Quality Reports (estimated 10 min)

D1. Regulatory Affairs, Patient Safety, TNM Dashboard
    Ana Torres, Vice President, Quality

D2. Post Acute
    Richard Espinoza, Chief Operating Officer, Post Acute

E. REPORT/DISCUSSION: AHS Quality Retreat Update (estimated 20 min)
    Felicia Tornabene, MD, Chief Medical Officer
    Ana Torres, Vice President, Quality
    Annette Johnson, Quality Analytics and PI, Director

F. REPORT/DISCUSSION: Patient Safety Annual Report (estimated 20 min)
    Darshawn Grewal, Patient Safety Director

G. INFORMATION: Planning Calendar/Issue Tracking (estimated 1-2 min)
    Taft Bhuket, MD, Chair

H. CLOSED SESSION (estimated 20 min)

Public comment on Closed Session items may take place prior to the Board adjourning to the Closed Session. To provide comment remotely, follow the “Public Comment Instructions” above. An announcement of any action taken during the Closed Session will take place prior to the end of the Open Session.

H1. Consideration of Confidential Medical Staff Credentialing Reports
    Chief of Staff, AHS Medical Staff
    Chief of Staff, AH Medical Staff

H2. Regulatory Affairs, Risk Management, Patient Safety
    [Health and Safety Code 101850(ai) (1)]

(Reconvene to Open Session)

OPEN SESSION

I. REPORT: Legal Counsel’s Report on Action Taken in Closed Session
    Ahmad Azizi, General Counsel

ADJOURNMENT

ADDENDUM ONE: ABCs of Communication

ADDENDUM TWO: Committee Charter

Our Mission
Caring, Healing, Teaching, Serving All
Strategic Vision
AHS will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities.

Values
Compassion, Commitment, Teamwork, Excellence, Integrity, and Respect.

Meeting Procedures
All items appearing on the agenda are subject to action by the Board of Trustees. Staff recommendations are subject to action and change by the Board of Trustees.

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here: http://www.alamedahealthsystem.org/meeting-agendas-and-minutes/. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.

Disability Access
The Meeting Rooms are wheelchair accessible. Assistive listening devices are available upon request at the Clerk of the Board's Office. To request accommodation or assistance to participate in the meeting, please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to perfumes and various other chemical-based scented products. Please help us to accommodate these individuals.

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.
Approval of the Minutes of the September 27, 2023
Quality Professional Services Committee Meeting
QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING
Thursday, September 28, 2023
5:00pm-7:00pm

Conference Center at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session: HCP Conference Center, see above address
Teleconference Locations:
710 E Street, Eureka, CA 05501
3112 Gibbons Drive, Alameda CA, 94501

COMMITTEE MEMBERS
Kinkini Banerjee  Taft Bhuket, MD, Chair
Jennifer Esteen  David Sayen

NON-VOTING MEMBERS
Chief of Staff – AHS Medical Staff
Chief of Staff - AH Medical Staff

QUALITY PROFESSIONAL SERVICES COMMITTEE MEETING MINUTES

THE MEETING WAS CALLED TO ORDER AT 5:03 pm

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT: Kinkini Banerjee, Taft Bhuket, MD, David Sayen

ABSENT: Jennifer Esteen (Excused)

Trustee Bhuket announced that this special meeting of the committee was called to hear the credentialling reports because the regularly scheduled meeting the day prior was cancelled due to lack of a quorum.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT: Non-Agenda Items: None

Mr. Azizi said the Quality Professional Services Committee would meet in Closed Session to consider the items as set forth in the agenda.

NOTE: In the event that a quorum of the Board of Trustees participates on this Committee, the meeting is noticed as a Special Meeting of the Board of Trustees; however, no final Board of Trustees action can be taken.
A. CLOSED SESSION

A1. Consideration of Confidential Medical Staff Credentialing Reports
   Chief of Staff, AHS Medical Staff
   Chief of Staff, AH Medical Staff

(Reconvene to Open Session)

OPEN SESSION

B. REPORT: Legal Counsel's Report on Action Taken in Closed Session
   Ahmad Azizi, General Counsel

   Mr. Azizi reported that the Committee met in Closed Session and considered credentialing reports for each of the medical staffs and approved credentials/privileges for fully qualified practitioners recommended by the medical staffs.

ADJOURNMENT: 5:15pm

This is to certify that the foregoing is a true and correct copy of the minutes of the Quality Professional Services Committee meeting of September 28, 2023, as approved by the Quality Professional Services Committee on October 25, 2023:

Ronna Jojola Gonsalves
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: 

Ahmad Azizi
General Counsel
Policies and Procedures
# Alameda Health System Policies and Procedures

## CPC Executive Summary to AHS and AH Medical Executive Committee(s) - October 2023

**Chair:** Dr. Bullard and Theresa Cooper

<table>
<thead>
<tr>
<th>TOPIC or TITLE OF POLICY</th>
<th>Document Owners</th>
<th>Summary of Changes</th>
<th>Last Approved Date</th>
<th>Next review date after BOT approval</th>
<th>Purpose</th>
<th>History of Review Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS System Wide Policies &amp; Procedures</td>
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<tr>
<td>Targeted Temperature Management Policy – TTM</td>
<td>Dr. Tyronda Elliott</td>
<td>• Revised</td>
<td>10/2025</td>
<td>• CPC 10/05/2023</td>
<td>AHS and AH MEC 10/18/23</td>
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This policy is titled "CODE STATUS & POLST: PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT" and is meant to replace the following current policies:
- POLST: PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT
- PERIOPERATIVE DNR
<table>
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<tr>
<td>(CARE OF THE PATIENT AND FAMILY TRANSITIONING TO COMFORT CARE)</td>
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<td>• It accompanies a revised comfort care order set that was recently approved by MEC, approved version attached.</td>
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<td></td>
<td></td>
<td>• This policy replaces the following policies, which should be retired:</td>
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<td></td>
<td></td>
<td>◦ Care of the Imminently Dying Patient (AHS)</td>
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<td></td>
<td></td>
<td>◦ CITY OF ALAMEDA HEALTH CARE DISTRICT ADMINISTRATIVE POLICY &amp; PROCEDURE No. 25: WITHHOLDING/WITHDRAWING LIFE-SUSTAINING TREATMENT</td>
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<tr>
<td>Utilization Management Committee Plan</td>
<td>Dr. Hena Borneo</td>
<td>• Revised</td>
<td>10/2025</td>
<td>10/2025</td>
<td></td>
<td>CPC 10/05/2023 AHS and AH MEC 10/18/23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Approved by the Utilization Management Committee on Monday, September 25, 2023.</td>
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<tr>
<td>Visiting Policy</td>
<td>Theresa Cooper</td>
<td>• Revised</td>
<td>10/2025</td>
<td>10/2025</td>
<td></td>
<td>CPC 10/05/2023 AHS and AH MEC 10/18/23</td>
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</tbody>
</table>
Targeted Temperature Management Policy

Effective Date 11/01/23  System Date Approved TBD  
Document Owner Chief Nursing Executive, Clinical Nurse Specialist, Critical Care  Date Revised 09/2023  
Category Medical Staff, Clinical  Next Scheduled Review  
Executive Responsible CNO

Printed copies are for reference only. Please refer to electronic copy for the latest version.

1.0 PURPOSE
To outline targeted temperature management (TTM previously therapeutic hypothermia) for patients who have suffered cardiac arrest and severe acute brain injuries complicated by elevated intracranial pressure (ICP).

2.0 DEFINITIONS
2.1 Initial Cooling Phase: Period of time from initiation of cooling until the patient reaches the ordered target temperature. For cardiac arrest patients, this phase occurs immediately after sustained return of spontaneous circulation (ROSC). The target temperature is 36.0°C (or as ordered by physician).

2.2 Maintenance Cooling Phase: Period of time spent maintaining the initial target temperature. For cardiac arrest patients, this phase lasts for 24 hours after reaching the target temperature goal. Maintenance phase for ischemic brain injury and intracranial pressure (ICP) management may vary.

2.3 Rewarming Phase: Period of time when the patient undergoes controlled rewarming from the target temperature to normothermia (defined as 36.5°C). Rewarming should occur at a rate of 0.1- 0.25°C per hour until normothermia is achieved.

2.4 Active Fever Avoidance Phase: Period of time from the end of the rewarming phase until an additional 48 hours. For cardiac arrest patients, this
phase begins 24 hours after the maintenance phase of targeted temperature management and ends 72 hours after the maintenance phase of targeted temperature management.

3.0 INDICATIONS
3.1 Cardiac arrest with persistent coma or severe altered mental status as evidenced by no response to commands or pain, and where blood pressure can be maintained at least SBP 90 mmHg even if fluids/vasopressors are required.
3.2 Selected patients with increased intracranial pressure due to severe acute brain injury

4.0 RELATIVE CONTRAINDICATIONS (consult with Attending physician)
4.1 Any other known reversible reasons for coma (sedating medications etc.)
4.2 Patient has a code status or an advance directive prohibiting invasive interventions.
4.3 Known terminal or debilitating illness preceding arrest (e.g. advanced cancer, severe dementia, persistent vegetative state or coma)
4.4 Severe coagulopathy or bleeding disorder which may be worsened by hypothermia to 36°C or cooler.
4.5 Pregnancy

5.0 CRITICAL ELEMENTS:
5.1 Rapid initiation of cooling to goal temperature with passive cooling (surface cooling), active cooling (cold intravenous (IV) fluids or gastric lavage with cold saline) or endovascular cooling (see page 7 for ZOLL Thermoguard).
5.2 Prevent shivering.
5.3 Monitor for side effects including hypokalemia, hyperglycemia, hypotension, bradycardia, and coagulopathy during cooling and rewarming phases.
5.4 Provide controlled rewarming (follow physician order and may utilize cooling console to provide controlled rewarm) with fever prevention and avoidance.

6.0 PROCEDURE - TARGETED TEMPERATURE MANAGEMENT

<table>
<thead>
<tr>
<th>INITIAL COOLING PHASE</th>
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</thead>
<tbody>
<tr>
<td><strong>Initiation of Therapy:</strong> Physicians</td>
</tr>
<tr>
<td>1. <strong>Emergency department:</strong> For out of hospital cardiac arrest, targeted temperature management (TTM) should be started urgently in the ED</td>
</tr>
</tbody>
</table>
under the direction of the ED Attending physician.

2. **Catheterization Lab**: TTM may be initiated in the cardiac catheterization lab under the direction of the cardiologist.

3. **For all inpatient arrests**: TTM should start upon immediate arrival to ICU under direction of the Attending physician. Formal Intensivist consultation should be obtained in all cases as soon as possible regardless of time of day.

4. TTM orders should be placed via the TTM order set in Epic.

5. Neurology consult: Neurology consult is to be obtained on all cases. **Do not delay initiation of TTM pending this neurological assessment.**

### Initiation & Maintenance of Therapy: Nursing

<table>
<thead>
<tr>
<th>Key Points</th>
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</thead>
<tbody>
<tr>
<td>1. A physician order is required to initiate targeted temperature management.</td>
</tr>
<tr>
<td>2. Insert esophageal probe (or use bladder probe if esophageal probe contraindicated).</td>
</tr>
<tr>
<td>3. Initiate surface cooling as quickly as possible even if endovascular cooling is planned.</td>
</tr>
<tr>
<td>4. IV infusion of iced normal saline may be ordered to facilitate rapid cooling.</td>
</tr>
<tr>
<td>5. Gastric lavage with iced normal saline may be ordered to facilitate rapid cooling.</td>
</tr>
<tr>
<td>6. See page 7 for target temperature management utilizing the ZOLL</td>
</tr>
</tbody>
</table>

Esophageal or bladder temperature monitoring is most practical & accurate method to continuously monitor core body temperature. Rectal temperatures lag behind core temperature changes by up to 1.5°C per hour. If a bladder temperature is used, measurement may be dependent on adequate urine output.
Thermoguard endovascular catheter system.

7. Monitor the patient's temperature continuously and record the patient's temperature every 1 hour.
   a. Target temperature is 36°C for post cardiac arrest patients unless otherwise specified by the physician.
   b. Target temperature to be specified by the treating neurologist for brain injury patients.

Notify physician if goal temperature not achieved within 2 hours of initiating therapy.

<table>
<thead>
<tr>
<th>SHIVERING MANAGEMENT</th>
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<tbody>
<tr>
<td>1. Assess for subtle signs of shivering (goose bumps, chest, and axillary or upper arm muscles) and more overt signs of shivering using the Bedside Shivering Assessment Scale (BSAS). Intervene early before shivering progresses to rigors.</td>
</tr>
<tr>
<td>2. Notify physician if BSAS is equal to 2 or greater.</td>
</tr>
<tr>
<td>3. Administer medications for shivering prevention (all medications require physician order)</td>
</tr>
<tr>
<td>a. First line medications include analgesics and sedatives.</td>
</tr>
<tr>
<td>b. PRN medications may include meperidine, paralytics, buspirone and/or dexmedetomidine.</td>
</tr>
<tr>
<td>4. Only for patients being cooled via endovascular catheter: Surface techniques to prevent shivering include placing warming blankets over entire body and/or applying socks and mittens.</td>
</tr>
</tbody>
</table>

Bedside Shivering Assessment Scale (BSAS):

1. None: no shivering noted on palpation of the masseter, neck, or chest wall
2. Mild: shivering localized to the neck and/or thorax only
3. Moderate: shivering involves gross movement of the upper extremities (in addition to the neck and thorax)
4. Severe: shivering involves gross movements of the trunk, upper and lower extremities.

Shivering must be prevented because it slows the cooling process, increases oxygen consumption, metabolic demands, and ICP. Surface re-warming techniques suppress shivering receptors. Analgesics and sedatives with a physician order are often required to prevent shivering.
5. If continuous paralytic drip is ordered, train of four (TOF) should be used for titration and assessment of effectiveness. Follow the neuromuscular blockade order set in Epic.

<table>
<thead>
<tr>
<th>MONITORING/MANAGEMENT DURING INITIAL &amp; MAINTENANCE COOLING PHASES</th>
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</thead>
<tbody>
<tr>
<td><strong>Hypotension</strong></td>
</tr>
<tr>
<td>1. Monitor vital signs every 15 minutes during initial cooling, then every 1 hour during maintenance phase.</td>
</tr>
<tr>
<td>2. Maintain target mean arterial blood pressure (MAP) per physician order.</td>
</tr>
<tr>
<td><strong>Arrhythmias</strong></td>
</tr>
<tr>
<td>1. Continuously monitor ECG and core temperature.</td>
</tr>
<tr>
<td>2. Monitor blood pressure at a frequency defined per unit protocol or continuously.</td>
</tr>
<tr>
<td>3. Report bradycardia (heart rate &lt; 60 bpm) with hypotension or arrhythmias.</td>
</tr>
<tr>
<td>4. Monitor CK/troponin per physician order.</td>
</tr>
<tr>
<td><strong>Electrolytes/ Glucose imbalance</strong></td>
</tr>
<tr>
<td>1. Monitor basic metabolic panel, magnesium, calcium, phosphate, and arterial blood gas (ABG) every 6 hours (physician order required).</td>
</tr>
<tr>
<td>2. Monitor point-of-care testing (POCT) glucose every 1 hour (physician order required).</td>
</tr>
<tr>
<td><strong>Bleeding</strong></td>
</tr>
<tr>
<td>1. Monitor for signs and symptoms of bleeding (hematoma, blood in the urine, gastric drainage, and puncture sites).</td>
</tr>
<tr>
<td>2. Monitor PT, PTT, platelet count, fibrinogen, and CBC every 6 hours per physician order.</td>
</tr>
<tr>
<td><strong>Skin Breakdown</strong></td>
</tr>
<tr>
<td>Disease process, medications and cold-induced diuresis may lower blood pressure. Low cardiac output may occur due to vasoconstriction and myocardial muscle depressant.</td>
</tr>
<tr>
<td>Bradycardia is common during therapy and may be well tolerated. Refractory, lethal arrhythmias may occur with over-cooling.</td>
</tr>
<tr>
<td>Cooling causes intracellular shifts of potassium, magnesium, calcium, and phosphate result in abnormally low serum levels of these electrolytes. Potassium is replaced cautiously due to potential for hyperkalemia during re-warming phase.</td>
</tr>
<tr>
<td>Mild hypothermia physiologically suppresses insulin release and can cause insulin resistance.</td>
</tr>
<tr>
<td>Coagulopathy may occur during hypothermia. Peripheral vasoconstriction places patients at risk for skin breakdown. Blistering has also occurred in edematous patients with tight surface pads.</td>
</tr>
<tr>
<td>Mild hypothermia suppresses white blood cell production and impairs neutrophil and macrophage function. Fever as sign of infection may not be present during hypothermia.</td>
</tr>
</tbody>
</table>
1. Initiate pressure ulcer prevention.
2. Place on low air mattress.
3. Place heel protectors.
4. Apply eye lubricant to eyes every 6 hours.
5. Remove surface pads every 8 hours and assess skin.

**Gastroparesis**
1. Note presence of bowel sounds, abdominal exam every 8 hours.

**VTE Prevention**
1. Anticoagulants and/or intermittent pneumatic compression devices per physician order.

Decreased gastric motility results from mild hypothermia. Feeding may be delayed until the rewarming phase.

Increased risk factors for venous stasis, increased blood viscosity from hypothermia and bed rest.

### REWARMING & ACTIVE FEVER AVOIDANCE PHASES

1. **Start to wean sedation (and paralysis, if applicable) after the patient has been in the maintenance phase for 24 hours (or as ordered by physician).**

2. **Stop potassium and insulin infusions 6 hours, per physician order, prior to rewarming.**

3. **Obtain basic metabolic panel every 6-12 hours (physician order required).**

4. **Begin controlled rewarming to a target temperature of 36.5°C at a rate of 0.1 - 0.25°C per hour.** This can be achieved by turning off the cooling device, raising the ventilator and/or room temperature, or covering the patient in a warm blanket. Do not use a warming blanket unless these measures do not result in a sustained temperature >36.5°C.

5. **Monitor for increased ICP while rewarming brain injury patients. For patients with intracranial pressure monitoring, if ICP increases, stop re-warming, and notify**

Hypotension may occur secondary to vasodilation.

Insulin resistance resolves and insulin requirements decrease.

Monitor for hyperkalemia as shifts in potassium can occur during rewarming.

Fevers must be strictly avoided for at least 72 hours in any patient with acute brain injury including hypoxic/anoxic brain injury from cardiac arrest. Too-rapid rewarming and rebound hyperthermia can be injurious to the brain.

The ZOLL Thermoguard endovascular catheter will need to be programmed every hour to a specified temperature (using the specified rate of rewarming) to actively re-warm patients.
neurosurgeon immediately. Anticipate re-cooling patient.

6. Monitor for rebound hyperthermia after rewarming is completed and normothermia is attained. Maintain normothermia with cooling pads for at least 48 hours after rewarming. **If the patient's temperature rises to 37.5°C or higher, resume TTM to goal temperature 36.5°C and notify the physician.**

### ENDOVASCULAR CATHETER (ZOLL THERMOGUARD) FOR TEMPERATURE MANAGEMENT

<table>
<thead>
<tr>
<th>1.</th>
<th>Follow quick set-up instructions on console (see references for link to video for set-up and disconnect instructions).</th>
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<tbody>
<tr>
<td>2.</td>
<td>Obtain a chest X-ray following placement of the catheter in the internal jugular or subclavian veins to confirm correct positioning, but do NOT delay initiation of passive or active cooling therapy pending results. In addition, do not infuse IV medications via the catheter until radiographic confirmation has been obtained. Femoral placement does not require imaging for confirmation, though all venous ports should draw back blood and should flush easily.</td>
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<tr>
<td>3.</td>
<td>Discontinue the passive and active cooling efforts once the endovascular cooling therapy has been successfully initiated.</td>
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<tr>
<td>4.</td>
<td>ZOLL Thermoguard endovascular catheters are magnetic resonance imaging (MRI) safe. Additional ports not used for cooling can be utilized as a standard central line including medication delivery, blood draw, and central venous pressure monitoring. However, they are not power ports and cannot be used for contrast administration.</td>
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<tr>
<td>5.</td>
<td>Follow patient care as outlined in surface cooling as above.</td>
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External cooling should be initiated immediately as per the above standard protocol pending evaluation for endovascular cooling.

Placement of ZOLL Thermoguard endovascular catheters will be inserted by experienced physicians.

The Quattro™ lower-body catheter is for femoral vein use and approved for a dwell time of 4 days. The Solex7™ upper-body catheters are for internal jugular or subclavian veins and are approved for a dwell time of 7 days for fever control and 4 days for cardiac and neurosurgery uses.

Equipment required for insertion:
- a. ZOLL Thermoguard console
- b. Startup kit
- c. Catheter
- d. 250 mL saline bag
- e. Patient temperature probe
6. Avoid interrupting therapy. When disconnection is absolutely necessary, place console in standby but do not turn off console (saves programmed settings). Disconnect the catheter from the console. Connect two free ends of console and two free ends of console tubing.

7. Follow central line policy for catheter care.

8. If a femoral vein is accessed, assess circulation in the lower extremity after the catheter is placed and every 4 hours throughout the treatment.

9. ZOLL Thermoguard 24-hour clinical support is available at 877-225-7487.

**Removal:**
Trained ICU RNs or MDs may remove this catheter. Wait until the patient's temperature is normothermic to prevent increased bleeding. Catheter balloons must be deflated prior to removal.
References:


TGXP System Setup https://youtu.be/va0aakGzNMo
PURPOSE
Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each training program must have a program-specific policy addressing clinical and educational work hours and a work hour tracking system that are in compliance with both ACGME requirements and Alameda Health System GME policies. It is the responsibility of the house staff to ensure that they are in compliance with their program’s policy and will be disciplined if they fail to do so. Accurate reporting is considered part of the ACGME “professionalism” competency.

POLICY
Clinical Experience and Educational Work Hours: All clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities and scheduled academic activities such as conferences. Work hours do not include reading and preparation time spent away from the work site.

DEFINITION
1. House Staff/Officer: An Intern or Resident in a training program.

2. Moonlighting: Voluntary, compensated and medically-related work performed inside/outside the institution where the resident is in training or at any of its related participating sites.

3. New Innovation: work hour tracking system in compliance with ACGME requirements and AHS’s policies.
PROCEDURE

1. Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home and all moonlighting.

2. House staff should have eight hours off between scheduled clinical work and education periods; there may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.

3. House staff must have at least 14 hours free of clinical and educational work after 24 hours of in-house call.

4. House staff must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.

5. Clinical and educational work periods for resident must not exceed 24 hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education.

6. In rare circumstances, after handing off all other responsibilities, a house staff may elect to remain or return to the clinical site in the following circumstances:
   a. To continue to provide care to a single severely ill or unstable patient
   b. Humanistic attention to the needs of a patient or family
   c. To attend unique educational events

   These additional hours of care or education will be counted toward the 80-hour weekly limit.

7. Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. The maximum number of consecutive weeks of night float, and the maximum number of months of night float per year may be further specified by each ACGME Review Committee.

8. House staff must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period).

9. Time spent on patient care activities by house staff on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of clinical work and education when averaged over four weeks. At-home call must not be as frequent or taxing as to preclude rest or reasonable personal time for each house staff.
10. House staff are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.

11. Moonlighting must not interfere with the ability of the house staff to achieve the goals and objectives of the educational program, and must not interfere with the resident’s fitness for work nor compromise patient safety.

12. Time spent by residents in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit.

13. PGY-1 residents are not permitted to moonlight.

A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and education work hours to individual programs based on a sound educational rationale.

REFERENCES


APPROVALS

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PURPOSE
To define the parameters of the professional graduate education program provided through the Kaiser Oakland sponsored Highland Site OB/GYN residency program, and the accompanying patient care activities that occur during the rotations at Highland Hospital, San Leandro Hospital and Alameda Hospital.

POLICY
1. Participants of the program will adhere to all facility policies.

2. The Attending is the initial contact, and ongoing primary contact, for all patient care provided by this service.

3. Attendings are the only individuals that may supervise the trainees.

4. All patient care performed by the trainee will occur under direct supervision of the attending.
   a. Within the parameters of this policy, the supervising Attending makes the decision about each Trainee’s progressive involvement in specific patient care activities.

5. Attendings and Trainees must inform each patient of their respective roles in that patient’s care, when providing direct patient care.

6. Trainees will be PGY2, PGY3 or PGY4 level.

7. Trainees will be on-site as needed only.
   a. The Attending will initiate contact with trainee when services are needed in the operating room or perioperatively.

8. All trainee entries into the medical record must be signed with the inclusion of the trainee’s level. (i.e.: PGY2, PGY3 or PGY4).

9. All trainee patient care orders, or other entries in the patient’s medical record, must be co-signed by the Attending before considered actionable.
**SCOPE**

To describe the roles, responsibilities, and patient care activities of the participants of the graduate education program. This policy applies to all stakeholders affected by the Kaiser Oakland Highland OB/GYN residency program at Highland hospital, San Leandro Hospital and Alameda Hospital.

The Kaiser Oakland Highland OB/GYN program maintains the same governance structure, including program director, at all affiliated clinical sites within Alameda Health System. The scope of this policy does not include the governance structure, or the program rules that apply to all trainees, at all AHS clinical sites.

**DEFINITIONS**

A. **Attending:** Highland OB/GYN faculty members, who are licensed independent practitioners with appropriate clinical privileges at the facility

B. **Trainees:** Resident physicians working under the supervision of the Attending

C. **Direct Supervision:** the supervising physician is physically present with the trainee and patient.

**REFERENCES**

1. Affiliation Agreement Between the Kaiser Oakland and Alameda County Medical Center
2. Joint Commission Standard MS.04.01.01 – GRADUATE MEDICAL EDUCATION PROGRAMS
3. ACGME Common Program Requirements
4. ACGME OB/GYN Program Requirements
## APPROVALS

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PROGRAM CLOSURE AND REDUCTION POLICY

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PURPOSE
The ACGME Institutional Requirements require the sponsoring institution to have a written policy that addresses a reduction in size or closure of a residency/fellowship program or closure of institution. This process needs to be done in a way that minimizes the impact on trainees.

POLICY
The closure or reduction of a residency or fellowship program may occur for a number of reasons such as loss of program or institution accreditation or loss of patient revenue. AHS has no reason to believe such a program or institution closure or loss of accreditation will occur. However, in view of the remote possibility, the following policy is promulgated.

PROCEDURE
In case of a closure, reduction or loss of accreditation, AHS will make every effort to provide house staff with treatment equal to that provided to other staff affected by the event. This will include notification to the Graduate Medical Education Committee (GMEC), the program directors and the house staff of a projected closing at as early a date as possible.

The GMEC are responsible for oversight and must review and approve all requests to close a residency or fellowship program.

AHS will make every effort to allow house staff in the program to complete their education at AHS and the affiliated hospitals. If possible, payment of stipends and benefits will continue to the conclusion of the current letter of appointment.

If any house staff is displaced by the closure or reduction of the program, AHS will assist them in enrolling in an ACGME-accredited program(s) in which they can continue their graduate medical education.
Provision will also be made for the proper disposition of house staff education records, including appropriate notification to licensure and specialty boards. AHS will also inform house staff of adverse accreditation actions taken by ACGME in a reasonable period of time after the action is taken.

REFERENCES

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RESTRICTIVE COVENANT POLICY

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PURPOSE
The use of Restrictive Covenants may not be included in ACGME-accredited residency and fellowship program trainee agreements at Alameda Health System.

POLICY
1. ACGME specifically prohibits the use of Restrictive Covenants in trainee agreements.

2. Alameda Health System-Highland Hospital, as a Sponsoring Institution, does not require a resident to sign a Restrictive Covenant, nor any of its ACGME-accredited training programs.

DEFINITIONS
Restrictive covenants refer to contractual agreements that attempt to restrict an employee or owner's post-employment activities so as to limit his/her ability to compete. They are often signed in conjunction with physician employment contracts, or when a physician joins a practice group as an owner.

REFERENCES
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INFUSION PUMP POLICY

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POLICY
All licensed personnel who utilize infusion pumps within Alameda Health System will receive theory and hands on training for infusion pumps used in their departments during orientation and on implementation of any new infusion pump devices. Infusion pumps will be used as indicated per manufacturer guidelines.

PURPOSE
To outline requirements for infusion pump training and utilization.

SCOPE
This policy applies to all personnel who use infusion pumps such as Licensed Vocational Nurses with IV Certification, Registered Nurses, Anesthesiologists and Certified Registered Nurse Anesthetists, etc.

DEFINITIONS
Infusion Pump: Mechanical device utilized for controlled intravenous or subcutaneous delivery of fluid, blood and blood products, medication, parenteral nutrition or the enteral administration of enteral feeding products and water.

Patient Controlled Analgesia (PCA): Patient self-administration of intravenous opioids/narcotics for pain control via an infusion pump. Examples of infusion pumps used for PCA include Alaris PCA Pump.

Smart Pump: A mechanical device with advanced safety technology, comprehensive drug library and a system of alerts and safeguards to prevent errors related to infusion. Example: Alaris Pump
**Syringe Pump**: Mechanical device utilized for controlled intravenous delivery of small volumes of fluid, blood and blood products, and medication, e.g. Alaris Syringe Pump.

**Master Drug Library (MDL)** - contains defined drug infusion parameters such as commonly used concentrations and dosing limits, hard and soft limits.

**Dose Error Reduction Software (DERS)** - A customized software program in the infusion device that reduces the risk of infusion related errors by incorporating hard and soft limits, multiple drug dose modes and starting dose rates and concentrations, each customized in a master drug library.

**Basic Mode**
The use of the pump without using a drug specific library for the infusion of a medication.

**Hard & Soft Limits**
- Lower Hard Limit (LHL): the lower limit that cannot be overridden.
- Lower Soft Limit (LSL): the lower limit that can be overridden.
- Upper Soft Limit (USL): the upper limit that can be overridden.
- Upper Hard Limit (UHL): the upper limit that cannot be overridden.

**PROCESS**

**Training**:
1. Upon initial hire each personnel will receive theoretical and hands-on return demonstration training on the infusion pumps used in their departments.
2. Every personnel will receive training updates as required for practice changes and updates with relation to infusion pump devices.
3. Copies of competency checklists or quizzes are to be kept in the employee file.
4. Training will be updated as needed to address medication safety needs.

**Infusion Pumps will be utilized for:**
1. Intravenous delivery of fluid, blood and blood products and medication via central venous access devices, e.g., subclavian, femoral, implanted ports, PICCs.
2. Intravenous delivery of Total Nutrient Additive (TNA) and Lipid Solutions.
3. Intravenous delivery of vasoactive medication.
4. Any fluid, blood and blood product or medication requiring controlled infusion rates or programs.

**The Nurse is responsible for:**
1. Selection of the appropriate infusion pump based on fluid, blood/blood product, medication, parenteral or enteral product to be administered.
2. The safe programming of the infusion pump, including utilization of drug library if applicable to the pump utilized.
3. Referring to AHS approved electronic drug information for detailed information related to administration of any medication being infused.
4. Determining fluid and medication compatibility prior to infusing concurrently.
5. Performing independent double checks of programming as per the IV Medication Policies or as required by department or institution specific policy (e.g. high risk medication, PCA, Independent Double Check Policy).

6. Monitoring and documenting the infusion and patient’s response and expected outcome before, during and after infusions. Refer to Mosby for information related to monitoring patients receiving intravenous, subcutaneous or enteral administration.

7. Monitoring pain, sedation and respiratory status of patient during opioid administration.

8. Recording administration of medication and assessment of patient’s response to therapy on the appropriate patient health record form.

9. Notifying the receiving unit when transferring a patient of the need for an infusion pump.

10. Reporting any fluid or medication near misses or actual errors using the Midas Safety Alert System.

11. Removing malfunctioning pumps from service placing a out of service “orange tag” and entering details of the issue and contact information on the tag and notifying Biomedical Engineering, through a work order

Infusion Pump Cleaning, Maintenance and Repair:
1. Nursing shall wipe down the pump to disinfect and remove gross contaminant and visibly soiled debris from the pump before storing in the dirty/soiled utility room.
2. Routine pick up of the pumps from the dirty utility/soiled area is done by the Agiliti personnel at all sites.
3. Routine maintenance of infusion pumps shall be managed by the Biomed Department.

Adverse Events and Near Misses
1. In the case of an adverse event or near miss due to a problem with the infusion pump, the pump, tubing, IV bags and medications and any other accessories used should be sequestered together in a red bag and held by a department charge nurse or leader for Agiliti personnel to pick up
2. A Safety Alert will be submitted with the details of the event including serial #, Agiliti Asset number and any patient harm.

Smart Pump Utilization: The following applies to the utilization of the Smart Pump.
1. Prior to Utilization of the Smart Pump and at each shift handover:
   a. The Nurse is responsible for checking the preventative maintenance tag which will be located on the side of the pump.
   b. If the pump does not have the appropriate preventative maintenance Sticker, the Nurse is responsible for obtaining another pump with the correct PM sticker and removing the pump with the incorrect PM sticker from service and attaching an orange out of order tag on the device.
   c. A service ticket should be placed through the Agiliti portal for the same.
   d. The pump removed from service will be picked up by Agiliti personnel and sent to Biomed for maintenance.
2. Dose Error Reduction Software and Drug Library Compliance:
   a. The Smart Pumps are programmed with a Master Drug Library (MDL) and Dose Error Reduction Software (DERS) that has been vetted and reviewed by System P&T for best practice and safety to reduce the potential for medication error.
b. Drug names, concentrations, upper and lower limits are all preprogrammed for safety in the MDL.

c. These drugs are sorted into the various “care areas” that would commonly require them for specific patient populations, e.g., critical care, Emergency Department is an expectation that Nurses are compliant with usage of the DERS and MDL when using the Infusion Pump.

d. Nurses should primarily access the “Care Area” appropriate to the unit that they are working on.
i. If the drug does not appear in the library for the care area in which they work, they will switch care areas in order to administer.

3. Basic Mode:
a. Prior to running any medication or solution in basic mode the nurse must verify that the drug is not in the MDL.
b. Once the drug is confirmed that it is not available in the MDL, the Nurse must get authorization from the charge nurse to use basic mode and an independent double check must be completed for any high-risk drugs prior to initiating the infusion.
c. Following the initiation of administration of any drug in basic mode the form Drug Library Feedback Change Request Form (See Appendix B) must be completed by the Nurse and nurse manager for the area and forwarded to Pharmacy.
d. The Medication Safety Committee will assess compliance with MDL and DERS, and the use of Basic Mode is monitored on a quarterly basis.
e. Trends and recommendations from this review of DERS and MDL compliance and use of Basic Mode will inform drug library updates and will be reported by the Medication Safety Committee, System Pharmacy and Therapeutics Committee (P&T) and through to the Clinical Practice Committee.

4. Soft limits:
a. May be exceeded by selecting “yes” to override the alert.
b. During the infusion, the dose or rate that is outside the soft limits will be displayed in red font on the pump screen.
c. If a soft limit is hit when programming a medication ordered on an approved Preprinted Order Set, the physician does not need to be notified.
d. If a soft limit is hit when programming a medication ordered that is not on an order set, the ordering physician shall be notified by the assigned nurse.
e. Documentation should occur of the override on the Medication Administration Record (MAR).

5. Hard limits:
a. May not be exceeded unless the ordering physician is contacted to provide a rationale for exceeding the hard limit.
b. The nurse must document in MAR provider’s name and rational for hard limit override.
c. Exceeding the hard limit requires the infusion to be given in Basic Mode.

Continuous Quality Improvement (CQI) and MDL Updates

1. The Medication Error Reduction Team (MERT) is responsible for monitoring usage of the DERS, MDL update recommendations, use of Basic Mode, soft and hard limit and doses reviews in the CQI reports.

Any requests to change the MDL shall be submitted to pharmacy through completion of Drug
Library Feedback Change Request Form and will be reviewed by the Medication Error Reduction Team (MERT). Updates to the MDL must be developed for each medication or fluid with consultation from pharmacy, nurse leader, as well as the physician chief or designate of the department who will be utilizing that medication or fluid in the MDL.

2. A communication and education plan must be developed and accompany all proposed MDL updates.

3. Once approval is received the Medication Error Reduction Team (MERT) will communicate the changes to System P&T.

4. The upload of the new version of the MDL shall be done at a time agreed upon by Clinical Practice Committee.

5. Activation of an updated MDL on the pump configured to the network occurs automatically. This ensures that pumps within the fleet have the most clinically current information. The wireless pump automatically searches for updates, downloads and installs the MDL when powered on before programming, after the infusion is cleared, during sleep mode when powered off and plugged in.

REFERENCES

1. Manufacture’s Reference Manual: Directions for Use: Alaris System (with Alaris PC Unit, Model 8015)

2. ISMP Proceedings from the ISMP Summit on the Use of Smart Infusion Pumps: Guidelines for Safe Implementation and Use 2009

APPROVALS

<table>
<thead>
<tr>
<th>Department</th>
<th>System</th>
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<th>AHS/Highland/John George/San Leandro</th>
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Data Set Change Request and Reporting Form.

This form is to be completed in detail and submitted to Pharmacy.

Request Infusion Pump:
- □ Alaris Pump
- □ CME
- □ NICU

Request Type: Please check all that apply.
- □ Request for Drug/Fluid addition
- □ Request to delete a drug/fluid for Guardrails
- □ Request to change Guardrails limits
- □ Report an issue

Drug/Medication Information:
1. *Medication Name* (generic): ____________________________

2. *Medication Name* (Brand): ____________________________

3. *Flow*: Is this a continuous or intermittent IV medication?
   - □ Continuous
   - □ Intermittent

4. *Concentration*: List the product strength and bag volumes if known:
   ___________________________________________________________________

5. *Route*: What is the usual route of administration?
   - □ Central
   - □ Peripheral
   - □ Both

6. Dosage: Usual doses and infusion rates at which this medication is administered.
   ___________________________________________________________________

7. *Profile*: Pump Profile Change is requested on:
   - □ Critical Care
   - □ Med Surg
   - □ Oncology
   - □ Special Care
   - □ NICU

8. *Protocols*: Will different dosing protocols be needed? (if Yes, specify protocols)
   ___________________________________________________________________

9. *Policy and Procedure*: Any change or impact to Policy and Procedures?
   - □ Yes
   - □ No
10. Reason why this change is needed?

_____________________________________________________________________________________

Printed Name of Requestor                                      Date
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PURPOSE

The purpose of this policy is to define the processes by which Alameda Health System (AHS) clinicians should establish, document, and follow code status orders. These orders define the overall focus of care and specific treatments that should or should not be provided in the event of a patient’s cardiopulmonary arrest or other clinical deterioration such as respiratory failure, hypotension, or tachycardia. This policy covers orders placed in all AHS care settings: inpatient, perioperative, emergency department, and ambulatory, as well as the use of Physician Orders for Life Sustaining Treatment (POLST) forms, which are required for AHS provider-ordered code statuses to be followed outside of AHS facilities by emergency responders.

POLICY STATEMENT

All patients have the right, through their own statements or those of their surrogates, to accept or refuse medical treatments offered by their medical providers, including cardiopulmonary resuscitation and other life-sustaining therapies such as mechanical ventilation, cardioversion, non-invasive positive airway pressure, vasopressors, blood transfusions, and antibiotics.

Every patient who is admitted to an AHS facility should have a discussion with their admitting provider to establish their preferences around resuscitation and other life-sustaining therapies.

DEFINITIONS

AHS Code Status Order: The provider order that guides care for a patient while at AHS facilities in the event of cardiopulmonary arrest or other clinical deterioration such as respiratory failure, hypotension, tachycardia. Once an AHS provider has discussed code status with a patient or their surrogate and ordered a code status, the ordered code status will remain active upon changes in patient location (e.g. presentation to the emergency department, hospital admission or discharge), to alert providers in these locations of the last stated patient preferences. The code status should be revisited upon presentation of a patient to a new setting or when the patient’s clinical status changes.

Advance Directive: A legal form in which patients who currently have capacity can state their preferences for care in the future, including overall focus of care under certain circumstances, and specific preferences for use of life sustaining therapies such as resuscitation, mechanical ventilation, and feeding tubes/artificial nutrition. May also include a section to legally designate a decision-maker, Designated Power of Attorney for Health Care (DPOA), though a DPOA and Advance Directive can be completed separately. In contrast to the POLST form, the Advance Directive is not a medical order and informs but does not specify treatments to be provided at a certain moment. All patients should be encouraged to complete an Advance Directive or update it if they have not recently reviewed it.

Verbal Designation of Surrogate Decision Maker: A patient’s verbal designation of an adult surrogate decision maker to make health care decisions on the patient’s behalf. This designation is made personally by the patient to the supervising health care provider. The designation of a surrogate decision maker should be promptly recorded in the patient’s medical record. Unless the
patient specifies a shorter period, the verbal designation is effective only during the course of the treatment or illness, or during the patient’s stay in the healthcare facility when the verbal designation is made, or for 60 days, whichever period is shorter. If the patient has designated an agent under a power of attorney for healthcare, the verbally appointed surrogate decision maker has priority over the agent during the period the verbal designation is effective.¹

**Durable Power of Attorney for Healthcare:** A legal form, completed by a patient who has capacity to designate someone to make medical decisions on their behalf. This form is often part of a written Advance Directive or may be completed on its own.

**Surrogate Decision-Maker:** An adult who can make decisions on behalf of a patient when the patient lack capacity. A surrogate may be designed by the patient through a Durable Power of Attorney, or verbally designated by a patient who has capacity to their attending physician (see Verbal Designation of a Surrogate Decision Maker). If a patient does not have capacity, then the patients’ clinicians work with people who know the patient to determine the best surrogate decision-maker or group of surrogate decision-makers.

**Physician Orders for Life Sustaining Treatment (POLST) Form:** The POLST is a medical order, designed for use with people who have serious illness or frailty, for patients or surrogates and providers to communicate the patient’s preferences for overall focus of care and the use of specific life sustaining therapies including resuscitation, mechanical ventilation, and feeding tubes/artificial nutrition. It is portable, valid throughout the state of California and is honored across institutions and with emergency responders, to ensure that a patient’s stated preferences are followed. In contrast to an Advance Directive, the POLST form applies to current not future care. The POLST is informed by a written Advance Directive as well as patient or surrogate preferences for care stated verbally to clinicians and surrogate knowledge of patient preferences, goals, and values.

¹ See California Probate Code § 4711.
PROCEDURE

I. CODE STATUS ORDERS IN AHS ACUTE CARE HOSPITALS

1. At presentation to the emergency department or for hospital admission, patients or their surrogates should be asked:

   a. Whether the patient has a completed Advance Directive or POLST form (if yes, these should be obtained and scanned into the AHS electronic health record)

   b. Whether the patient has previously stated any preferences to avoid resuscitation or a trial of life sustaining therapies including mechanical ventilation

   c. Who the patient’s surrogate is, should they not be able to make decisions about their medical care at some point during the episode of care.

2. The emergency department or hospital admitting provider should order an AHS code status based on the above information and a discussion with the patient if they have capacity or their surrogate if they do not have capacity.

   a. Prior to discussing code status with the patient or surrogate, admitting providers should review the Advance Care Planning Navigator section of the electronic health record to identify preexisting Advance Directive or POLST forms, prior code status orders, surrogate decision-maker, and Advance Care Planning notes from other clinicians, to find any relevant information that may inform the code status discussion.

   b. For patients who are generally healthy, who are unlikely to develop cardiopulmonary arrest or respiratory failure, and who would be expected to have good outcomes from resuscitation, code status discussions may be brief.

   c. Patients who are frail or have a serious illness such as cancer or advanced dementia or organ failure, are more likely to develop cardiopulmonary arrest, and less likely to have good outcomes from resuscitation. Code status discussions for these patients, when possible, should be more in depth, including a discussion of the patient’s prognosis and expected outcomes of resuscitation, and overall goals and values.

      i. If it is not clinically feasible to have an in-depth discussion of goals of care at admission, the code status should be placed based on currently known preferences, and a goals of care discussion should be planned for the future.

   d. In addition to ordering the appropriate AHS code status order (see APPENDIX, AHS CODE STATUS ORDERS), the admitting provider should update the Advance Care Planning (ACP) Navigator section of the electronic health record with the following information, so that it will be viewable to other clinicians.

      i. Designation of the patient’s primary and secondary surrogate decision makers, who should be contacted for any future code status discussions if the patient does not have capacity.
ii. An Advance Care Planning note, briefly documenting who the code status was discussed with (patient, or surrogate name and contact info), and the rationale for the code status order.

e. Code status may be discussed by resident physicians, Advance Practice Providers, and/or consulting providers and ordered by resident physicians, Advance Practice Providers, or Attending physicians. Attending physicians are ultimately responsible for the patient’s code status and should verify that it is correct within 24 hours of any updates.

3. For patients who have a “DNR” code status, nurses should apply a bracelet to indicate this status, to ensure that the code status is immediately view-able in an emergency.

a. Nurses should check the code status each shift and should check the patient’s wrists to ensure that the bracelet status is correct. See appendix for full list of AHS code statuses and which should have bracelet applied.

4. For patients who have a “DNR” code status, the discharging provider should complete a POLST form (see procedure following) so that the patient preferences will be honored by clinicians outside of AHS. The POLST form should be scanned into the electronic health record and the original must accompany the patient.

5. During hospital or emergency department stays, the code status should be revised if/when the patient’s clinical status changes, especially if the patient is not expected to have good outcomes from resuscitation and mechanical ventilation.

a. Any changes in code status should be accompanied by an Advance Care Planning note, briefly documenting who the code status change was discussed with (patient, or surrogate name and contact info), and the rationale for the code status change.

6. For patients who lack capacity to discuss code status with providers, and for whom a surrogate is not readily available, a social work consult should be ordered for assistance in identifying an appropriate surrogate.

a. If there are no pre-existing code status orders, POLST forms, or Advance Care Planning notes available to sufficiently inform a code status order, the patient should remain FULL CODE until a surrogate is available to discuss the code status with or the patient regains capacity. If there is a clearly stated prior code status order or POLST form, this order should be followed until the patient regains capacity or a surrogate is identified, unless there is sufficient reason to doubt the validity of the prior order or POLST, e.g. an Advance Care Planning note or statement to a provider that the patient had a different preference.

b. If a surrogate is not readily identified, the social worker will follow the “HEALTH CARE DECISION FOR INCAPACITATED UNREPRESENTED PATIENTS” policy to identify a surrogate. If no surrogate is identified and significant medical decisions are required, the social worker should convene an Interdisciplinary Team (IDT) meeting to discuss the patient’s status, medical treatment options including code status and use of life sustaining therapies and advise the patient’s attending physician on the
care plan. Until the IDT can provide guidance, patients who lack capacity and a surrogate should remain FULL CODE / FULL TREATMENT, unless a previous verbal or written Advance Directive discussion or a POLST form suggests the patient had previously requested a different status. Though the IDT can advise on AHS code status, emergency responders may be reluctant to follow a POLST form that lacks a patient or surrogate signature.
II. CODE STATUS ORDERS IN THE PERIOPERATIVE SETTING

Patients who have a code status other than FULL CODE who are undergoing interventions that require anesthetic management are entitled to an individualized discussion and determination of what their code status should be, when possible, prior to undergoing anesthesia. Anesthesia may cause hypotension and decrease respiratory drive and resuscitation in this context may be more effective that in non-perioperative settings. Thus, in the perioperative setting, it may be reasonable to reverse previously placed limitations on resuscitation or other life sustaining therapies.

For example, a patient who has a DO NOT RESUSCITATE code status might choose to change their code status to FULL CODE during the perioperative period, which usually includes pre-op holding, the OR, and the PACU or immediate post-op ICU period. After that period, the code status can be reverted back to DO NOT RESUSCITATE.

The Anesthesia Department will note any referral of a patient on DNR status and will ensure that the current status is communicated to all involved providers throughout the perioperative period. In the case of any patient, who has been designated DNR at any time preoperatively, it must be clearly stated at the end of the anesthetist's preoperative note (using the .ACP dotphrase so the discussion will be included as an Advance Care Planning Note) whether:

1. The patient has agreed to suspension of DNR status (all resuscitative measures will be employed in the operating room and PACU).

   OR

2. The patient wishes DNR status continued into the perioperative setting. In this case there must be a clear discussion of the intervention to be withheld in the operating room and under what circumstances specifically they are to be withheld.

Unless a pre-operative discussion has documented a plan to limit resuscitation in the OR, all patients are to be granted the benefit of resuscitative efforts in the event of a cardiac arrest regardless of the underlying disease and circumstances. If no individual plan has been discussed and documented, DNR status will be suspended for the perioperative period.
III. AHS CODE STATUS ORDERS IN THE OUTPATIENT SETTING

Though code status orders are most relevant in the inpatient and emergency settings because patient’s outpatient clinicians are more likely to know them well and have a trusting relationship, ambulatory providers are encouraged to discuss code status and place code status orders, especially for patients who are frail or have a serious illness such as cancer or advanced dementia.

1. For patients anticipated to have a FULL CODE status on presentation to the emergency department or hospital, it is not expected that that an outpatient provider will enter a code status order.
   a. In the outpatient setting, especially for patients who are generally healthy, the focus of any Advance Care Planning discussions should be: identifying a surrogate decision-maker, identifying and documenting goals and values in an Advance Care Planning note, completing an Advance Directive, and sharing goals and values and the Advance Directive with surrogate decision-makers.

2. For patients who are frail or have a serious illness such as cancer or advanced dementia, outpatient providers are encouraged to discuss prognosis, goals, values, and preferences, and to enter a code status order, when they have discussed code status with the patient or their surrogate. This order will ensure that providers caring for the patient in the emergency department or hospital will be alerted to the patient’s stated preferences.

3. In addition to ordering the appropriate AHS code status order (see APPENDIX, AHS CODE STATUS ORDERS), the outpatient provider should update the Advance Care Planning (ACP) Navigator section of the electronic health record with following information, so that it will be viewable to other clinicians.
   a. Designation of the patient’s surrogate-decision-maker, and alternate if any, who should be contacted for any future code status discussions if the patient does not have capacity.
   b. An Advance Care Planning note, briefly documenting who the code status was discussed with (patient, or surrogate name and contact info), and the rationale for the code status order.
   c. Complete a POLST form (see procedure following) so that the patients preferences will be honored by clinicians outside of AHS.
IV. CODE STATUS ORDERS IN AHS POST-ACUTE FACILITIES

Post-acute units at AHS routinely use the POLST form for all patients. The AHS code status in post-acute units should always align with the most recent POLST form for the patient.

V. PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

To ensure that patient preferences stated to AHS providers are followed by emergency responders outside of AHS facilities, when a “Do Not Attempt Resuscitation/DNR” code status is placed, the provider and patient or surrogate should also complete a POLST form before the patient’s discharge from an AHS inpatient facility. To facilitate honoring of patient preferences stated on POLST forms and to AHS clinicians, the AHS code status orders mirror the options in the POLST form to the greatest extent possible.

Background

1. The POLST form:
   a. Is a standardized form that is brightly pink colored and clearly identifiable;2
   b. Can be revised or revoked by an individual with decision-making capacity at any time;
   c. Is legally sufficient and recognized as a physician order;
   d. Is recognized and honored across treatment settings and institutions;
   e. Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction or any other sanction to a healthcare provider who relies in good faith on the request and honors a POLST;
   f. Should be available to all providers to complete with their patients at AHS facilities.

2. All patients who prefer any “DNR” code status should have a completed and valid POLST form to honor a patient’s code status outside of AHS facilities.

3. A health care provider is required to treat a patient in accordance with a completed POLST form. As outlined in the following procedures, the physician will review the POLST and incorporate the content of the POLST into the care and treatment plan of the patient.

2 Wausau Pulsar Pink paper (65 lb. paper stock recommended) is the color used for the POLST form. It is important to use this specific color of pink paper so that the form can be photocopied and faxed. Although Pulsar Pink is the recognized and recommended color, the form remains valid if another color paper is used. A photocopy of the form is also valid. The official POLST form for California is approved by the Emergency Medical Services Authority and can be downloaded and printed from the California POLST website: https://capolst.org/.
a. If the POLST form indicates treatment preferences that the patient’s providers feel are medically ineffective health care or health care contrary to generally accepted health care standards, palliative care and/or ethics consultations can assist in making a plan of care that best aligns with the patient’s goals and values.

4. A legally recognized health care decision maker may execute, revise or revoke the POLST form for a patient only if the patient lacks decision-making capacity.

5. While a health care provider such as a nurse or social worker can explain the POLST form to the patient and/or the patient’s legally recognized health care decision maker, the provider (physician, nurse practitioner, or physician assistant) is responsible for discussing the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity the patient’s legally recognized health care decision maker.

6. Once the POLST form is completed, it must be signed by the patient, or if the patient lacks decision-making capacity the patient’s legally recognized health care decision maker, AND a provider (physician, nurse practitioner, or physician assistant) who is caring for the patient.

Procedure

1. Patient in Emergency Department and/or Admitted with a Completed POLST Form

   a. During the initial patient assessment, document the existence of the POLST form and confirm with the patient, if possible, or if the patient lacks decision-making capacity the patient’s legally recognized health care decision maker, that the POLST form in hand has not been voided or superseded by a subsequent POLST form.

   b. A nurse or designated staff member will communicate to the emergency department provider or inpatient provider as appropriate existence of the POLST.

      i. The POLST form should be copied and scanned into the Advance Care Planning section of the electronic health record. The ORIGINAL POLST form should be kept in the patient’s paper chart while they are hospitalized.

      ii. When the patient is discharged, the most recent ORIGINAL POLST should stay with them; the patient’s nurse should ensure this.

         a. POLST orders will be followed by healthcare providers as a valid physician order until a more recent hospital order is provided. To inform the AHS code status order, the provider evaluates the patient and reviews the POLST form and any other information available about the patient’s preferences, such as Advance Directive documents, prior code status orders, and Advance Care Planning notes from other clinicians. Based on this information together and a discussion with the patient or surrogate, the provider selects and orders the appropriate AHS code.

         i. If the most recent valid POLST conflicts with the patient’s current preferences, as stated by the patient or their surrogate, then the most recent preferences should be
followed. Any deviation from the POLST and its rationale should be documented in an Advance Care Planning note in the electronic health record.

b. If the code status is revised during the hospitalization, and the POLST is not accurate, it should be revised before discharge (see below).

2. Completing a POLST Form with the Patient

a. Patients who have a “DNR” code status outside of an acute care hospital should have a POLST form completed to ensure that their preferences are honored by clinicians outside of AHS.

   i. If the patient is inpatient and being discharged, the discharging provider should complete the POLST.

   ii. For patients in post-acute facilities, POLST forms are completed at admission.

   iii. For outpatients, any provider that places an outpatient code status order should also complete a POLST form.

b. The provider and the patient, or if the patient lacks decision-making capacity the patient’s legally recognized health care decision maker, complete the POLST form, together.

   i. The provider should discuss treatment options with the patient or legally recognized health care decision maker. The discussion should include information about the patient’s advance directive (if any) or other statements the patient has made regarding his/her wishes for end-of-life care and treatments. The benefits, burdens, efficacy and appropriateness of treatment and medical interventions should be discussed by the provider with the patient and/or the patient’s legally recognized health care decision maker.

c. A health care provider such as a nurse or social worker can explain the POLST form to the patient and/or the patient’s legally recognized health care decision maker, however, the provider is responsible for discussing treatment options with the patient or the patient’s legally recognized health care decision maker.

d. The above-described discussions should be documented in the electronic health record, in an Advance Care Planning note, and dated and timed. In addition the patient’s surrogate decision-maker, who would be able to revise the POLST if needed, if any, should be designated in the Advance Care Planning section.

e. The POLST form is to be completed based on the patient’s expressed treatment preferences and medical condition. If the patient lacks decision-making capacity and the POLST form is completed with the patient’s legally recognized health care decision maker, it must be consistent with the known desires of and in the best interest of the patient.
f. In order to be valid, the POLST must be signed by a physician, and by the patient, or if the patient lacks decision-making capacity, the legally recognized health care decision maker.

i. If the patient is physically unable to read or sign the POLST form but has capacity to discuss and choose among the POLST options, the provider can explain and read the POLST form options and allow the patient to choose among them. A witness, who may be member of the care team that is not the provider signing the POLST, should be present for the conversation and signature process and sign the POLST form as a witness.

1. If possible, the patient should make a mark on the form, even if it is not legible.

2. If the patient cannot make a mark on the form, the provider and witness should each document in the electronic health record in Advance Care Planning notes that the patient could not sign but that verbal consent was obtained. However, emergency responders may be reluctant to follow a form that lacks a patient or surrogate signature.

ii. A patient who has capacity may also verbally delegate authority for signing the POLST to their legal Power of Attorney and then the Power of Attorney may sign the form. The provider should document in an Advance Care Planning note in the electronic health record describing the POLST signing that the patient’s Power of Attorney to sign for them.

iii. If the surrogate is signing the POLST form and is unable to come to the hospital to sign the form, the surrogate signature may be obtained via fax or email. The telephone conversation with the surrogate about the POLST should have a witness present, and the provider and witness should document the discussion and POLST choices in an Advance Care Planning note in the electronic health record. The witness may be a member of the care team that is not the provider signing the POLST.

1. If the surrogate cannot come to the hospital and cannot access email or fax, the POLST form may be completed with a witness and provider signature documenting a telephone conversation, however emergency responders may be reluctant to follow a form that lacks a patient or surrogate signature. The POLST form with the surrogate signature should be obtained as soon as possible.

g. Once the POLST form is completed, a copy should be made and scanned into the Advance Care Planning section of the electronic health record. The ORIGINAL POLST form stays with the patient.

3. Reviewing/Revising a POLST Form

a. Discussions about revising or revoking the POLST should be documented in the Advance Care Planning section of the electronic health record. This documentation should include the essence of the conversation and the parties involved in the discussion.
b. At any time the provider and patient, or if the patient lacks decision-making capacity the patient’s legally recognized health care decision maker, together, may review or revise the POLST consistent with the patient’s most recently expressed wishes. In the case of a patient who lacks decision-making capacity, the provider and the patient’s legally recognized health care decision maker may revise the POLST, as long as it is consistent with the known desires of and in the best interest of the patient.

c. During the acute care admission, care conferences and/or discharge planning, it is recommended that the provider team review the POLST when there is substantial change in the patient’s health status, medical condition or when the patient’s treatment preferences change.

d. If the current POLST is no longer valid due to a patient changing his/her treatment preferences, or if a change in the patient’s health status or medical condition warrant a change in the POLST, the POLST can be voided. To void a POLST, the patient or their legally recognized decision maker should draw a line through Sections A through D and write “VOID” in large letters and sign and date this line.

e. If a new POLST is completed, a copy of the original POLST marked “VOID” (that is signed and dated) should be kept in the medical record directly behind the current POLST. A copy of the revised POLST should scanned into the Advance Care Planning section of the electronic health record.
VI. CONFLICT RESOLUTION

If there are any conflicts or ethical concerns between patients or surrogates and clinicians, or among family member surrogates about the AHS code status or POLST order, appropriate hospital resources should be used to resolve them; e.g., Social Work consult, Palliative Care consult, Bioethics committee, care conference, legal/risk management and/or other administrative and medical staff resources.

1. If there is disagreement among the patient’s family about who should be the patient’s surrogate, a social work consult should be obtained to assist in identifying whether there is a Designated Power of Attorney for Health Care (DPOA) or other legally binding surrogate decision-maker. Social work consult may also help families to work together to make surrogate decisions for patients.

2. During conflict resolution, consideration should always be given to; a) the attending physician’s assessment of the patient’s current health status and the medical indications for care or treatment; b) the determination by the physician as to whether the care or treatment preferred by the patient or surrogate is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the patient’s most recently expressed preferences for treatment and the patient’s treatment goals.

3. A health care provider may decline to comply with a patient or surrogate’s health care instruction or decision for reason of conscience (Probate Code Section 4734(a)) or where a health care instruction or decision requires medically ineffective health care or health care contrary to generally accepted health care standards (Probate Code Section 4735). A provider that declines to comply with a patient or surrogate’s health care instruction or decision must do all of the following³:

   a. Promptly inform the patient, if possible, and any person authorized to make health care decisions for the patient.

   b. Unless the patient or person authorized to make decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in transfer of the patient to another provider or institution that is willing to comply with the instruction or decision.

   c. Provide continuing care to the patient until transfer can be accomplished or until it appears that transfer cannot be accomplished.

   d. In all cases, appropriate pain relief and other palliative care must be continued.

³ These procedures are required under Probate Code Section 4736.
### APPENDIX: AHS CODE STATUS ORDERS

|-------------------------------------------------|---------------------|-----------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| FULL CODE / FULL TREATMENT (POLST option)       | Yes                 | Yes             | No                                | • CPR and Code Blue Response. Attempt Resuscitation.  
• Prolong life by all medically effective means: intubation, mechanical ventilation, vasopressors, cardioversion, ICU.                  |
| DNR / FULL TREATMENT (POLST option)             | Yes                 | Yes             | Yes                               | • No CPR/chest compressions  
• If patient has no pulse and is not breathing: Allow Natural Death.  
• If patient has a pulse or is breathing: Prolong life by all medically effective means.  
  Code blue, intubation, mechanical ventilation, vasopressors, cardioversion.                                      |
| DNR/ SELECTIVE TREATMENT (POLST option)         | No                  | Yes             | Yes                               | • No CPR. No Code Blue. Do not intubate.  
• Avoid burdensome measures.  
• May offer non-invasive positive airway pressure, high flow nasal cannula oxygen, vasopressors.  
• Use basic medical treatments as indicated: antibiotics, IV fluids, transfusions.                                        |
| DNR/ COMFORT CARE (POLST option)                | No                  | Yes [for symptom management] | Yes                               | • No CPR. No Code Blue. Do not intubate.  
• Primary goal is maximizing comfort with medication, oxygen, suctioning, manual treatment of airway obstruction.  
• Life prolonging therapies should not be escalated and may be withdrawn per comfort care orders.                          |
| LIMITED CODE Only an Acute Care Hospital Order (Not a POLST Option, and not available in outpatient or post-acute setting) | Yes                 | Yes             | No                                | • CPR and Code Blue Response. Provide specific interventions as selected by the ordering provider.  
• Use this code status for combinations of interventions that are NOT available on the POLST form, such as “no” to intubation and “yes” to defibrillation, chest compressions, and antiarrhythmic medications, e.g. for treatment of pulseless ventricular arrhythmias.  
• Residents should with an attending physician prior to ordering to ensure combination of treatments is medically appropriate.  
• At discharge from acute care hospital stay, status must be updated to an option that is available on the POLST form. |
REFERENCES

3. California POLST website: https://capolst.org/
4. California POLST Form: Effective 4/1/2017
5. California Probate Code §§4643;4785;4786; 4711

APPROVALS

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Notes:

1. This policy incorporates content from the following policy, which should be retired after the approval of this policy:
   - POLST: PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT
   - PERIOPERATIVE DNR

2. There are 2 old Alameda Health Care District policies which related to the content of this policy. This policy has been designed to address all the issues those policies do, and those should be retired:
   - DO NOT RESUSCITATE (DNR)
   - WITHHOLDING/WITHDRAWING LIFE-SUSTAINING TREATMENT (forthcoming “Comfort Care” policy will also address some of this content)
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PURPOSE
The purpose of this policy is to define the processes by which Alameda Health System (AHS) clinicians should prepare for and care for patients and families when the patient is transitioning to comfort care, including the withholding and withdrawal of life-prolonging therapies.

POLICY STATEMENT
When a patient, through their own statements, or those of their surrogates, chooses to receive comfort care, their clinicians should: ensure that the patient’s physical symptoms are assessed and managed; respond to emotional, cultural, spiritual, psychosocial, and practical needs of the patient and family; avoid adding or escalating any therapies that will prolong the dying process without providing any benefit to patient comfort.

DEFINITIONS

Comfort care: Under this status, the primary goal is maximizing comfort by managing bothersome physical symptoms and responding to the emotional, cultural, spiritual, psychosocial, and practical needs of the patient and family. Life prolonging therapies are not added or escalated and may be withdrawn. Comfort care is most often selected by or for patients who are imminently dying, who are on life-sustaining therapies that they prefer not to continue, or who have a serious illness and only a period of weeks to months to live. However, any patient who has capacity or their surrogate may choose this care focus.

Family: For the purposes of this policy, the term “family” refers to the people who are defined as family by the patient, or the care team if the patient cannot. This may include relatives as well as friends, neighbors, or others who have a relationship with the patient and are thus impacted by their serious illness.

Goals of care discussion: The process by which clinicians work with patients or their surrogates to determine the overall focus of a patient’s care and the specific treatments that will be provided. Goals of care discussion should address: the patient’s prognosis; the patient’s goals, values, preferences, and priorities; a recommendation from the patient’s clinician about the overall care focus on specific treatments that will best achieve the patient's goals, given their prognosis.

- Goals of care discussions should be tailored for the patient and surrogate decision-making preferences and the amount of information they prefer to receive.
  - E.g. patients may delegate decision-making to a surrogate, even if they have capacity.
  - Patients or families should be asked how much they want to know about prognosis, and these preferences should be respected to the degree possible while still obtaining informed consent.

Hospice: All patients who are on comfort care who are expected to leave the hospital should be referred to hospice. Hospice is a model and philosophy of care that provides palliative care to patients with life-limiting illness while focusing on palliating patients' pain and other symptoms, attending to their and their family/loved one's emotional and spiritual needs, and providing support for their caregivers.

- Hospice can be provided at home or in skilled nursing facilities.
• Social work and care management can determine how hospice services can be covered by patient’s insurance or charity care.
• Hospice is not currently available for inpatients at Alameda Health System acute care hospitals; this policy guides the provision of comparable care in this setting.

Palliative care: Palliative care focuses on the expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. It attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness.
• Palliative care principles and practices should be provided by all clinicians caring for all patients who have serious illnesses in any setting, including patients whose primary goal is comfort, as well as those whose primary goal is life-prolongation. All patients who are receiving comfort care should receive palliative care but not all patients who require palliative care are on comfort care.
  o For patients, families, and clinicians who need additional support, specialty consultations from clinicians who have additional training and certification in palliative care are available at all Alameda Health System acute care hospitals.
  o Consultation from the palliative care service is not required for transition to comfort care but is encouraged when primary providers/teams require additional guidance for complicated patients.

PROCEDURE

A goals of care discussion to determine goals, preferences, and needs of the patient and family precedes the transition to comfort care. The patient or their surrogate and the patient’s attending physician must approve the plan to transition to comfort care.
• For patients who do not have capacity or an identified surrogate, the process outlined in the “HEALTH CARE DECISION FOR INCAPACITATED UNREPRESENTED PATIENTS” policy can be used to determine whether comfort care is appropriate.
• If questions or conflict arises among the patient, surrogate(s) and/or and clinicians about whether or not comfort care is appropriate, hospital resources can be used to resolve them; e.g., Social Work consult, Palliative Care consult, Bioethics committee, care conference, legal/risk management and/or other administrative and medical staff resources.

I. DESIGN OF THE COMFORT CARE PLAN

To design the comfort care plan, consider each treatment that the patient is currently receiving or treatments that may be indicated and determine whether they should be part of the comfort care plan. The specific plan should be discussed with the patient or the surrogate and the attending physician for approval prior to implementation. Input from other clinicians caring for the patient member is encouraged, and all clinicians caring for the patient should be advised of the plan. Specific points to consider in designing the comfort care plan include:
• The primary goal of the patient’s comfort and how specific treatments will support or detract from those goals.
Oxygen, antibiotics, medications, transfusions, and artificial nutrition or hydration might contribute to a patient’s comfort for some patients and may be appropriate for a patient receiving comfort care.

Some treatments that are invasive, e.g. thoracentesis or paracentesis, may be provided if the intention of the treatment is to promote comfort.

Life-sustaining therapies that the patient is receiving may be stopped or continued upon transition to comfort care based on the established goals of care. See following section on “Life-sustaining therapies”.

- The goals, preferences, and priorities of the patient and family identified as part of or after the goals of care discussion and consideration of how specific treatments will support or detract from those goals.
- Likely complications and/or symptoms (e.g. bleeding, respiratory distress), that may arise as the comfort care plan is implemented and how these will be managed.
- Expected prognosis and location of death: Estimate the likely prognosis once the comfort care plan is implemented, to determine whether disposition planning is needed.

**LIFE-SUSTAINING THERAPIES**

A. After transition to comfort care, treatments that have the sole purpose of prolonging life will not be added. This includes mechanical ventilation, non-invasive positive airway pressure, high flow nasal cannula oxygen, dialysis, and vasopressors.

B. For patients who are receiving life-sustaining therapies prior to the transition to comfort care, the treatments may be either stopped or continued but not escalated, based on patient and family goals, preferences, and priorities.

1. For example, a patient who is wanting more time in order to see a family member who is traveling to see them before they die might have a ventilator or high flow nasal cannula oxygen continued until the family arrives, while being on comfort care status.

2. Some patients or families may never feel comfortable withdrawing a life sustaining therapy such as a ventilator or artificial nutrition or hydration. Comfort care can still be initiated while these treatments are continued, with the understanding that:
   - The support from life sustaining therapies will not be increased if the patient worsens and other life sustaining treatments will not be added if the patient worsens clinically. Medications will be used to maintain comfort, e.g. if breathing gets worse.
   - Some therapies may need to be stopped if they are harming the patient or the patient is not tolerating them (e.g. artificial nutrition causing volume overload, respiratory distress, swelling, or high residuals because body is not processing it).

C. For patients in the ICU or step-down unit who are receiving life sustaining therapies, such as mechanical ventilation, non-invasive positive airway pressure, high flow nasal cannula oxygen, or vasopressors, an interdisciplinary huddle must precede transition to comfort care. This huddle may also be appropriate for other patients.

1. See APPENDIX, “Huddle Checklist: Transition to Comfort Care for Patients Receiving Life Sustaining Therapies.”

2. The clinician huddle MUST include the primary attending/team, the primary nurse and, if patient is receiving high-flow oxygen, non-invasive positive airway pressure, or high flow nasal cannula oxygen, the respiratory care services.
3. Others should be included as indicated based on patient and family need, e.g. critical care consulting provider, charge nurse, pharmacist, chaplain, social worker, and/or palliative care consultant.

4. The huddle discussion should include:
   a. The patient’s expected prognosis after transition to comfort care and expected place of death (usually ICU vs. hospital floor; if life-sustaining therapies are withdrawn, survival to hospital discharge is rare.).
   b. The values, goals, preferences, and needs of the patient and family.
   c. Plan for which interventions will be limited or withdrawn and the sequence of withdrawal of vasopressors, inotropes, dialysis, mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen, etc.
   d. Plan for non-pharmacological intervention and medications to be used to maintain patient comfort, based on review of analgesia and sedation usage over the past 24 hours.
   e. Plan for complications that may arise, e.g. bleeding in/around the airway, difficult to manage symptoms, patients who cannot be extubated due to upper GI or pulmonary hemorrhage, severe pulmonary edema, or mass compressing the airway

5. During the huddle, designate a team member to review with the patient and/or family the plan for transition to comfort care and the expected trajectory.

6. If a significant amount of time elapses after the huddle before comfort care is initiated, if shifts have changed, or if the patient’s status or family needs have changed, consider revisiting the huddle to make sure all are clear about the plan.
II. SUPPORT OF THE PATIENT AND FAMILY

1. **Screen for and Address Patient & Family Needs**: Prior to the initiation of and throughout comfort care, the care team should screen the patient and family for emotional, cultural, spiritual, psychosocial, and practical needs and address identified needs.
   a. Elicit and address concerns and worries about the dying process or treatment plan.
   b. Inquire about any traditions, cultural or religious rites, or other things that should be done during the dying process or after death.
   c. Consult Spiritual Care for patients or families who are experiencing emotional or spiritual distress, regardless of their religious or spiritual background. Spiritual care services are available at all Alameda Health System acute care hospitals.

2. **Provide Anticipatory Guidance**: Prior to the initiation of and throughout time on comfort care, anticipatory guidance should be provided to the patient and the family regarding what to expect, including how long the patient is likely to live and changes that may occur in the dying process.
   a. Clarify to patients and families that on comfort care, the patient’s nursing and medical team will not be monitoring and responding to changes in vital signs with the goal of preventing the patient’s death. The focus of monitoring and intervention is to ensure distressing symptoms are identified and treated.
   b. Discuss the anticipated location of death with the patient or the family.
      i. When the patient is expected to die in the hospital, patients and families should be advised of this, including any transitions of care within the hospital that are expected to occur, e.g. patients transitioned to comfort care in the ICU will be moved to a room on the step down or med surg unit if their prognosis is expected to be more than hours and their symptoms are well-managed.
      ii. When the patient or family is expected to remain stable for hospital discharge, the patient and family should be advised of this and hospice recommended for patient symptom management and family support. Social work and care management can assist in planning the location for discharge e.g. home versus skilled nursing facility as well as coordinate the transition to hospice, if planned.
   c. Prepare the family for the normal physiologic and cognitive changes that occur during the dying process.
      i. These changes can be distressing for the family to witness. They are usually not distressing for the patient.
      ii. Refusal of foods and fluids is a normal phase of dying. Dehydration rarely leads to patient discomfort and may be protective; ongoing hydration may be harmful and increase patient distress.
      iii. Most patients become less responsive or unresponsive as part of the dying process.
      iv. Noisy breath sounds associated with inability to clear excessive respiratory secretions are a common change.
      v. Altered breathing patterns at the end of life are normal and do not imply distress due to dyspnea.
      vi. Reassure that comfort measures will be given to minimize discomfort including sedatives and analgesics, but that the doses of medications used for symptom control are much lower than doses that would hasten death.
3. **Prepare the Patient’s Room and Liberalize Visitation:** Optimize the physical environment for patient and family comfort, creating a calm and private environment.
   a. Move the patient to a private room as soon as possible. Provide additional chairs, tissues, and water for family comfort.
   b. Place a RED BUTTERFLY sign on the patient door to cue all staff that the patient is on comfort care and to respect the need for privacy and quiet.
   c. Expand visitation for families and pets. Encourage and facilitate inclusion of family who cannot visit in person using technology such as Zoom or Face Time.
   d. Support the family to participate in the patient’s care and create a nourishing environment by encouraging them to:
      i. Talk to and touch the patient. A familiar voice, touch, and music may have a calming presence.
      ii. Bring in stories, photos, and music as other ways of connecting to and nourishing their loved one.
      iii. Participate in bathing, feeding, mouth care.
      iv. Bring in favorite or culturally appropriate foods for themselves and the patient, as they are safely able to take food or fluid by mouth.

4. **Plan Post-Mortem Care:** For patients who are expected to die in the hospital.
   i. Provide information about the post-mortem procedures which are followed at each hospital.
   ii. Make a plan to honor any post-mortem requests from the family, e.g. change of clothing, bathing, leaving the body undisturbed for a period of time.
   iii. If the cause of death is suspected to be unnatural, e.g. accident, homicide, suicide, advise the family that the coroner may require a post-mortem examination.
   iv. Provide grief packets to family as available at each hospital.
   v. Consult spiritual care for family anticipatory grief or post-mortem support.
III. WITHDRAWING LIFE-SUSTAINING THERAPIES

MECHANICAL VENTILATION

- The respiratory care practitioner will coordinate all changes to ventilator support with the primary nurse and the ICU service. If the patient does not appear comfortable in the judgment of both clinicians, the change will be deferred and additional medication or nonpharmacologic comfort measures provided.
- The respiratory care practitioner and the nurse will reassess after an appropriate interval and may proceed with weaning if the patient appears comfortable.

For patients receiving neuromuscular blocking agents (NMBAs):

- NMBAs must be discontinued prior to initiation of comfort care. The respiratory care practitioner and ICU provider will assess the level of spontaneous respiratory effort using data from the ventilator and physical exam. Train-of-four (TOF) monitoring is available as an adjunctive tool. There are no conclusive data on superiority of TOF versus other methods of determining return of spontaneous respiratory effort prior to terminal withdrawal of mechanical ventilation. In rare cases, NMB cessation has required administration of a reversal agent by the ICU Attending.

Discontinuation process:
1. Ensure adequate sedation prior to and during weaning of ventilation.
2. Adjust all alarms to minimum settings, disabling them where possible.
3. Reduce FiO2 to 0.21 and PEEP to zero in a gradual, stepwise fashion (length of time this will take depends on the current level of support and the patient's response to weaning).
4. Wean respiratory rate to backup rate of 4 and/or PS to 5 cm H2O.
5. When the patient is comfortable on a backup rate of 4 and/or PS of 5 cm H2O, extubate to room air, nasal cannula, or place the patient on room air cool aerosol T-piece. See below for discussion of extubation considerations.

Extubation considerations:

- The provider will discuss the ventilator withdrawal options with the family prior to writing comfort care orders.
- Patients with certain clinical conditions - for example, upper GI or pulmonary hemorrhage, severe pulmonary edema, or mass compressing the airway - are not candidates for extubation. This should be discussed in the huddle and the rationale for not extubating communicated to the patient and/or family.
- Consider performing a leak test prior to extubation for patients with head and/or neck swelling
- Some families may have a preference for or against extubation.

NONINVASIVE POSITIVE PRESSURE VENTILATION (NIPPV)

The principles of discontinuation of NIPPV are similar to those involved in discontinuing invasive mechanical ventilation. The respiratory therapist will coordinate all changes to NIPPV settings with the primary nurse and ICU service. If the patient does not appear comfortable in the judgment of both the nurse and respiratory therapist, the change will be deferred and additional medication or nonpharmacologic comfort measures provided. The respiratory therapist and nurse
will reassess after an appropriate interval and may proceed with weaning if the patient appears comfortable. This gradual reduction of support allows time to control dyspnea through medication administration.

**Discontinuation process:**
1. Ensure adequate comfort and sedation for patient prior to and during weaning of settings
2. Adjust all alarms to minimum settings, disabling where possible
3. Reduce FIO2 with goal to reach 0.21
4. Slowly reduce IPAP and EPAP concurrently with goal to reach IPAP 4 and EPAP 4, with backup rate of 4
5. When patient is comfortable on these settings:
   Place patient on room air
   **OR**
   Nasal cannula with oxygen @___LPM.

**HIGH FLOW NASAL CANNULA (HFNC)**
- The respiratory therapist will coordinate all changes to HFNC with the primary nurse. If the patient does not appear comfortable in the judgment of both clinicians, the change will be deferred and additional medication or nonpharmacologic comfort measures provided.
- The respiratory therapist and nurse will reassess after an appropriate interval and may proceed with weaning if the patient appears comfortable.
- Weaning continues in this stepwise fashion by down-titrating liter flow until the patient is on room air.
- Patients must be on a stable liter flow for HFNC will not be initiated after the transition to comfort care and the flow rate will not be increased.
IV. MEDICAL TEAM RESPONSIBILITIES

The medical team/provider should follow these steps to transition the patient’s care to comfort care.

1. Document in an Advance Care Planning Note (can use the .ACP dotphrase to insert into another note) in the electronic health record: the discussion leading to comfort care and which interventions will be continued and which will be stopped; if any treatments are to be continued, include the rationale for continuing them. Advise the patient’s nurse and other relevant clinicians (e.g. respiratory therapy) of the planned change in status.

2. Update the code status to “DNR Comfort Care”.
   • For patients who are expected to leave the hospital: Complete a POLST form with the patient or family for “Do Not Attempt Resuscitation/DNR and Comfort-Focused Treatment” to ensure that the resuscitation preference is honored outside of the hospital, during transport, and future care. See “CODE STATUS & POLST: PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT” policy.

3. If a patient has an implantable cardioverter-defibrillator (ICD), call the device company representative and request to turn off tachyarrhythmia therapy function.
   • If the patient is imminently dying, place an order for the nurse to place a magnet over the device.

4. Discontinue all active orders that may conflict with comfort care or are unnecessary including:
   • Devices: SCD’s, NG tube, feeding tube, restraints, BP cuff; PEG tube may be maintained to use for administering medications.
   • Fluids: decrease IVF rate to TKO. Minimize IV fluids for patient comfort and to minimize secretions.
   • Tube feeding: unless otherwise discussed with family, artificial nutrition is generally stopped on comfort care
   • IVs: maintain IV for patients with symptom distress, others can be kept comfortable with sublingual medications
   • Foley catheters: may be maintained especially in patients near end of life for comfort
   • Labs
   • Medications: only continue medications that minimize symptoms or contribute to comfort; this should include medications being used to manage symptomatic medical programs, e.g. heart failure, seizures.
   • Monitoring: pulse oximetry, telemetry, POCT finger sticks, weights
   • Precautions: e.g. neutropenia precautions
   • Treatments: enteral nutrition, TPN, antibiotics, blood transfusions
   • Vitals: Symptom-focused vitals are included the comfort care order set

5. Place the “AHS INPATIENT COMFORT CARE ORDER SET” to guide nursing and respiratory care and symptom management.
   a. For patients receiving significant support from mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen: If any these interventions will be withdrawn, boluses and an infusion of opioid and possibly benzodiazepine should be ordered.
   b. Consult Palliative Care Service if needed, for:
i. Physical symptoms that are refractory to initial management as outlined in this policy and the comfort-care order set, or symptoms that are expected to become difficult to manage, e.g. due to complicated withdrawal of life-sustaining therapies.

ii. Complicated emotional, cultural, spiritual, psychosocial, and practical needs of the patient or family.

iii. Questions around prognosis and discharge planning for patients on comfort care.

iv. When the patient’s primary clinicians have any questions about the comfort care transition.

c. For patients who are expected to leave the hospital, place an order for hospice care.

i. Social work and case management will work with the family on discharge planning, discharge location, and hospice enrollment. For patients with complex medical needs for whom discharge to hospice is planned, a verbal handoff should be arranged with the Hospice Medical Director and/or Admissions Nurse.

V. NURSING TEAM RESPONSIBILITIES

The nursing team should follow these steps to transition the patient’s care to comfort care.

1. Review the plan for comfort care, including rationale for which treatments will be continued and which will be stopped, in the Advance Care Planning Note in the Advance Care Tab in the electronic health record and/or participate in the interdisciplinary huddle.
   - A huddle must precede transition to comfort care for patients in the ICU or step-down unit who are receiving life sustaining therapies, such as mechanical ventilation, non-invasive positive airway pressure, high flow nasal cannula oxygen, or vasopressors.

2. For patients who are intubated in the ICU, confirm with the Donor Network West that the patient is not a candidate for organ donation before beginning the process of ventilator withdrawal.

3. Confirm that the code status has been updated to “DNR Comfort Care”; contact the provider if not. Confirm that the patient has an “Allow Natural Death (AND)” bracelet in place.

4. Confirm that the provider has discontinued all active orders that may conflict with comfort care or are unnecessary, including:
   - Devices: SCD’s, NG tube, feeding tube, restraints, BP cuff; PEG tube may be maintained to use for administering medications.
   - Fluids: decrease IVF rate to TKO. Minimize IV fluids for patient comfort and to minimize secretions.
   - Tube feeding: unless otherwise discussed with family, artificial nutrition is generally stopped on comfort care.
   - IVs: maintain IV for patients with symptom distress, others can be kept comfortable with sublingual medications.
   - Foley catheters: may be maintained especially in patients near end of life for comfort.
   - Labs
   - Medications: only continue medications that contribute to comfort.
   - Monitoring: pulse oximetry, telemetry, POCT finger sticks, weights.
   - Precautions: e.g. neutropenia precautions.
   - Treatments: enteral nutrition, TPN, antibiotics, blood transfusions
   - Vitals: Symptom-focused vitals are included the comfort care order set.
5. Confirm that provider has placed the “AHS INPATIENT COMFORT CARE ORDER SET” and ordered appropriate medications for common end of life symptoms; contact provider if not.
   - For patients receiving significant support from mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen and if these interventions will be withdrawn, a bolus and infusion of opioid and possibly benzodiazepine should be ordered.

6. Discontinue monitoring and treatments per orders.
   a. Check if patient has an AICD in place, and if so, ensure that measures have been taken to deactivate it or place a magnet for imminently dying patient.
   b. Discontinue cardiac monitoring and continuous pulse oximetry (CPO).
      - Exception: patients on high-flow nasal cannula who are alert must have CPO in place as safeguard against accidental dislodgement leading to acute dyspnea and rapid demise. The purpose of CPO in this case is not flow titration but detection of device dislodgement; as such, the HFNC order might reference a low O2 sat such as 80%. The response to an O2 sat below this threshold is not provider notification but immediately checking the patient.

7. Provide vigilant symptom assessment: every hour until symptoms are well controlled, then every two hours and as needed. See details in “PROCEDURE: SYMPTOM ASSESSMENT AND MANAGEMENT” section below. Notify provider for any new or uncontrolled distressing symptoms.
   - Activate the Rapid Response team on the step down or medical surgical unit for patients with difficult to control symptoms or for patients from whom life sustaining therapies, such as mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen, are being withdrawn.

8. Diet: Generally, patients should be allowed to eat as desired when on comfort care; maintain nutrition as a social, pleasurable, and comfortable experience for as long as the patient wants to eat.
   a. Diet that is full liquid (ice cream, Jello) often more palatable and easier to swallow than clears
   b. Formal swallow evaluation is not indicated on comfort care, but primary nurse should assess for risk of choking or frank aspiration which could lead to overt distress and adjust what is provided accordingly; educate family about any dietary restrictions.

9. Provide frequent mouth care with swabs, small sips of liquids, or ice chips and moisturizing lip treatment at least every shift and more often as needed.

10. For patients who are not imminently dying, reposition as usual, premedicating as needed. For patients who are imminently dying, repositioning may be tailored to patient comfort.

11. Provide palliative wound care; focus shifts from wound healing to management of wound-related symptoms for comfort, dignity, and quality of life.

12. Documentation:
   - Symptom assessment using reliable assessment methods and validated assessment tools see “SYMPTOM ASSESSMENT AND MANAGEMENT” section below
   - Administration of medication or other nonpharmacologic interventions
   - Response to medication or other nonpharmacologic interventions
   - Communication with covering providers for unresolved symptoms
VI. RESPIRATORY THERAPY TEAM RESPONSIBILITIES

The respiratory team/therapist should follow these steps to transition the patient’s care to comfort care.

1. Review the plan for comfort care per the Advance Care Planning Note in the Advance Care Tab in the electronic health record and/or participate in the interdisciplinary huddle. The huddle must precede transition to comfort care.

2. If orders indicate to wean mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen, confirm that the code status has been updated to “DNR Comfort Care” before decreasing support; contact provider if not.

3. Coordinate changes to mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen with the patient’s nurse, so that opioid and benzodiazepine medications can be adjusted during weaning to maintain patient comfort. Refer to WITHDRAWING LIFE SUSTAINING THERAPIES section above.

4. For patients who will continue mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen on comfort care, support from these interventions should not be increased or titrated based on oxygen saturation. The patient’s nurse will provide opioid and benzodiazepine medications as needed to maintain patient comfort.
VII. SYMPTOM ASSESSMENT AND MANAGEMENT

Resources:
- **Rapid Response Team:** Though Code Blue is not called for patients receiving comfort care, the Rapid Response Team can support the primary nurse in managing difficult to control symptoms and/or symptoms during withdrawal of oxygen and/or non-invasive positive airway pressure.
- **Palliative Care Consult:** Available at all acute care hospitals for assistance in managing refractory symptoms. For patients for whom symptoms are refractory to management e.g. pain with opioids even after repeated titration, it is appropriate to offer sedation to lessen awareness of the symptom. Palliative care consultation can assist with planning and implementation.

GENERAL CONCEPTS

1. Patients on comfort care require careful symptom assessment and management.
   a. In lieu of vital signs, symptom monitoring is the focus on comfort care.
   b. The following symptoms should be assessed every hour until well controlled and then every two hours and as needed: pain, dyspnea, respiratory rate, anxiety, agitation and secretions.
   c. In addition, assessments should be done to ensure regular bowel movements (every 3 days is goal), absence of nausea and vomiting, and screening for delirium (each shift).
   a. Enteral (for patients able to take PO or who have PEG tube) or sublingual (for patients who are unable to swallow) route is preferred for patients who are not in acute symptom distress.
      i. An enteral or sublingual route will facilitate transition to discharge for patients who are not expected to die in the hospital and receive comfort care outside of the acute care hospital, i.e. hospice.
      ii. Most end-of-life symptom medications come in a sublingual formulation (available in AHS IP Comfort Care Order Set).
   b. IV route is recommended for acute symptoms of distress.
      i. For patients who are requiring or expected to require frequent IV boluses of opioids and/or benzodiazepines, either due to severe pain or dyspnea or because mechanical ventilation, non-invasive positive airway pressure, or high flow nasal cannula oxygen are being withdrawn, boluses of opioids and/or benzodiazepines should be ordered.
      ii. Nurses should bolus patients off the infusion pump using comfort libraries available in all AHS infusion pumps (as opposed to having to leave the room to get bolus medications), so that patients can most rapidly receive relief from distressing symptoms. The initial infusion rate may be set to zero if the patient’s infusion need is not yet established.
OPIOIDS
1. Opioids are the mainstay of symptom management for moderate or severe pain and for dyspnea that is not controlled with non-pharmacological treatments and medical management.
2. All patients on comfort care should have a PRN opioid available; please select from the list on the AHS IP Comfort Care Order Set. It is appropriate to order an oral or sublingual medication as first line and an IV as second line.
3. Morphine is the first line except for patients who have impaired renal function; for patients with impaired renal function, avoid morphine (a metabolite accumulates causing delirium and myoclonus).
4. If pain or dyspnea is not controlled by enteral or sublingual opioids, IV PRN should be used as backup.
   a. If the initial bolus dose is ineffective after 10mins (IV) or 30mins (SL), double the dose and give immediately. If the first dose is somewhat effective, but inadequate, continue to give that dose q30min until comfort is achieved.
5. Patients who require frequent IV opioid boluses may benefit from scheduled IV opioid doses or an opioid infusion, accompanied by a PRN bolus for breakthrough pain coverage.
   a. When starting an opioid infusion, PRN boluses should be ordered to be administered via the pump.
   b. Continuous infusion rate increases are based on demonstrated PRN bolus need.
   c. When adjusting the basal infusion rate, initially provide PRN boluses to achieve comfort then increase the rate accordingly; note that the patient will not see response to basal rate changes for several hours.
   d. Nurses should bolus patients off the infusion pump using comfort libraries available in all AHS infusion pumps (as opposed to having to leave the room to get bolus medications), so that patients can most rapidly receive relief from distressing symptoms. The initial infusion rate may be set to zero if the patient’s infusion need is not yet established.

PAIN Assessment
- Assess pain using reliable assessment methods and validated assessment tool every hour and PRN until controlled (tolerable to patient), then every 2 hours and PRN. See Appendices for assessment tools.
  - Critical Care:
    - If patient is able to self-report, assess using a 0-10 scale.
    - If patient cannot self-report, assess using CPOT scale
  - Acute Care:
    - If patient is able to self-report, assess using a 0-10 scale.
    - If patient cannot self-report, assess using PAIN-AD scale

Documentation
- Pain assessment findings
- Medication or other non-pharmacologic interventions used
- Patient response to intervention(s)
- Address in nursing care plan as needed
- Communication with provider for new or uncontrolled symptoms
- Contact provider if pain is not well controlled.
Interventions
Pharmacologic therapies:
- Mild pain – acetaminophen or NSAIDS, opioids
- Moderate or severe pain – opioids are first line treatment
- See opioid section above. Effective PRN bolus dosing and documentation of patient response is critical to patient comfort

Non-pharmacologic therapies:
- Reposition as comfortably tolerated. Avoid repositioning per patient/family request.
  - Premedicate prior to repositioning
  - Manage disturbance pain (startling for patient) by explaining plan prior to repositioning
  - Reposition gently and slowly
- Provide calm environment, psychosocial support, relaxation techniques
  - Guided imagery, healing touch, music therapy, distraction
- Local application of cold/warm compress, gentle massage
- Spiritual support

DYSPNEA
Expect and respond to dyspnea as a part of the dying process, especially for patients for whom respiratory support (oxygen, non-invasive ventilation, mechanical ventilation) is being withdrawn or withheld.

Assessment
- Assess for dyspnea using reliable assessment methods and validated assessment tool every hour and PRN until controlled (tolerable to patient), then every 2 hours and PRN. See Appendices for assessment tool.
  - If the patient is able to self-report, assess using a 0-10 scale.
  - If the patient cannot self-report, use the Respiratory Distress Observation Scale (RDOS).

Documentation
- Dyspnea assessment findings
- Medication or other non-pharmacologic interventions used
- Patient response to intervention(s)
- Address in nursing care plan as needed
- Communication with provider for new or unrelieved dyspnea
- Notify provider for any new or unrelieved dyspnea

Interventions
- Goal of relieving the subjective sensation of breathlessness rather than alleviation of the underlying condition
- Medical management aimed at treating the cause of the dyspnea should be continued (e.g. heart failure management, diuresis, COPD management).
• The most common treatments for dyspnea include oxygen and opioids. Using a fan to blow air toward the patient’s face can also be used to control dyspnea and respiratory distress.

Pharmacologic therapies
• Opioids are the agent of choice for sensation of breathlessness, anxiety, and for cough.
  o Acute dyspnea is treated with boluses rather than initiating or increasing an infusion. Individualized infusion may follow once baseline needs have been established.
• Anxiolytic meds only if dyspnea accompanied by anxiety and opiates have been adequately titrated.
• For withdrawal of oxygen, non-invasive ventilation, mechanical ventilation: Ensure orders are in place for prophylactic intravenous bolus doses of BOTH an opioid and a benzodiazepine to be given just before beginning to wean support, followed by further doses as needed. Continue to give as needed doses throughout weaning process.
  o If respiratory support will be weaned, please order opioid infusion and PRN boluses via the pump so that boluses can be given promptly prior to and during weaning.

Non-pharmacologic therapies
• Routine administration of oxygen to patients who are near death is not supported by clinical evidence but may still contribute to patient comfort because of airflow into nose.
• On comfort care, oxygen should be titrated to patient comfort, NOT to a target saturation / pulse oximetry. SpO2 correlates poorly with perceived dyspnea at end of life, therefore continuous pulse oximetry (CPO) is not indicated, except for patients on High Flow Nasal Cannula (HFNC).
  o For patients on high-flow nasal cannula who are alert, continuous pulse oximetry (CPO) should be ordered to alert staff of sudden desaturation which would indicate dislodgement or a problem with the High Flow Nasal Cannula. When the patient becomes unresponsive, CPO can be discontinued
• Reposition patient to optimize ventilation (high-Fowlers or reverse Trendelenburg).
• Provide cool air toward patient’s face from a fan or window. Humidify if possible.
• Provide a calm environment, psychosocial support, relaxation techniques.
• Offer spiritual care.
AGITATION / ANXIETY

Assessment
- Assess for agitation using reliable assessment methods and validated assessment tool every hour and PRN until controlled (tolerable to patient), then every 2 hours and PRN. See Appendices for assessment tools.
  - Critical Care:
    - If the patient is able to self-report, assess using a 0-10 scale.
    - If the patient cannot self-report, assess using RASS scale
  - Acute Care:
    - If the patient is able to self-report, assess using a 0-10 scale.
    - If the patient cannot self-report, assess using RASS-PAL scale.

Documentation
- Assessment findings
- Medication or other non-pharmacologic interventions used
- Patient response to intervention(s)
- Address in nursing care plan as needed
- Communication with provider for new or unrelieved agitation/anxiety

Interventions

Pharmacologic therapies:
- Benzodiazepines
- Antipsychotics

Non-pharmacologic therapies
- Minimize uncomfortable stimuli and modify the room to create a less medical, more restful setting.
- Maximizing supportive presence at the bedside with familiar staff, friends, and/or family may be calming. For other patients, having fewer people present or providing time alone may be therapeutic.
- Consider whether spiritual care, social work, or psychiatry consultation might be beneficial.
DELIRIUM

Assessment
• Assess for delirium using reliable assessment methods and validated assessment tool every shift and PRN until controlled (tolerable to patient). Once controlled, continue to monitor for recurrence every shift and PRN. See Appendices for assessment tools.
  • Critical Care:
    • If the patient is able to self-report, assess using a 0-10 scale.
    • If the patient cannot self-report, assess using CAM-ICU scale
  • Acute Care:
    • If the patient is able to self-report, assess using a 0-10 scale.
    • If the patient cannot self-report, assess using CAM shortened version scale

Documentation
• Delirium assessment tool findings
• Medication or other non-pharmacologic interventions used
• Patient response to intervention(s)
• Address in nursing care plan as needed
• Communication with provider for new or unrelieved delirium

Interventions
• Identify and eliminate modifiable factors that may be contributing to delirium such as pain, anxiety, urinary retention, dehydration, constipation, infection, uncontrolled pain, physical restraints or certain medications such as analgesics, steroids, antihistamines, anticholinergics.
• Most patients with terminal delirium may not have a reversible cause.

Pharmacologic therapies
Intervene on modifiable factors first, then:
• Antipsychotics
• Benzodiazepines

Non-pharmacologic therapies
• Frequent reorientation to time of day, hospital setting, and care provided.
  o Facilitate family presence at the bedside when possible.
• Support normal sleep-wake cycles.
  o Match room environment to time of day.
  o Avoid sleep disruptions for labs/vitals during the night.
  o Brief naps can be helpful but avoid long sleep periods during the day.
• Minimize disruptive stimuli; lower lights and minimize noise.
• Ensure adequate pain management.
CONSTIPATION

Assessment
- Assess for presence of constipation and/or contributing factors
  - Assess last bowel movement (BM), usual bowel habits, consistency, ease of defecation
  - Use of opiates; all patients on opiates should have coinciding bowel regimen
  - Assess for fecal impaction

Documentation
- Constipation (actual or at-risk) assessment findings
- Medication or other non-pharmacologic interventions used
- Patient response to intervention(s)
- Address in nursing care plan as needed
- Communication with provider for new or unrelieved constipation

Interventions
- Goal is to promote bowel movement at least every 3 days.

Pharmacologic
- Preventative regimen, particularly in all patients receiving opioids.
  - Stimulant laxative (with or without a stool softener) daily
  - Osmotic laxative daily
  - Stimulant laxative (oral or suppository) as needed
- Invasive procedures such as enemas or manual disimpaction for bowel care are rarely indicated at end of life

Non-pharmacologic
- Patients at end of life typically have a decreased desire or ability for food/fluid intake, therefore interventions such as increasing fiber and hydration are not reasonable.
- Warm compress may be applied over abdomen for comfort
EXCESSIVE AIRWAY SECRETIONS
Weakness and decreased reflexive clearing of the oropharynx can lead to accumulation of upper airway secretions. Increased airway secretions may interfere with the patient’s ability to sleep, worsen dyspnea, and precipitate uncomfortable coughing spells. At the end of life these ‘noisy’ respiratory secretions can be distressing to loved ones.

Assessment
- Assess for presence of excessive secretions, level of distress for patient/family, presence of possible contributing factors
- If present, assess patient every hour and PRN until controlled (tolerable to patient), then every 2 hours and PRN

Documentation
- Assessment findings
- Medication or other non-pharmacologic interventions used
- Patient response to intervention(s)
- Address in nursing care plan as needed
- Communication with provider for new or uncontrolled excessive secretions

Interventions
- Despite limited evidence of pharmacologic treatment efficacy, it is reasonable to consider trial of pharmacologic treatment while carefully monitoring for potential side effects

Pharmacologic therapies
- Glycopyrrolate: IV or oral (tab or disintegrating tab)
- Atropine drops: sublingual

Non-pharmacologic therapies
- Primary intervention is prevention by minimizing fluid intake. Discontinue non-essential IV fluids or enteral feedings
- Reposition patient to facilitate movement of pooling secretions, ¼ turn to side for short periods and keep the HOB elevated.
- Avoid deep suctioning as it has minimal benefit and can be uncomfortable for the patient. Gentle oral suctioning can benefit patients with excessive drooling.
- Communication with provider for new or uncontrolled dyspnea
NAUSEA AND VOMITING
Patients with nausea at the end of life generally have a known condition causing the symptom. Generally, the new development of intractable nausea is uncommon in the dying phase.

Assessment
- Assess to determine presence of nausea and identify the underlying mechanism
  - Patient history, including review of prescription and over-the-counter meds
  - Physical exam to assess for frequency and character of nausea and/or emesis
    - Presence of abdominal pain, bloating, burning
    - Presence of dizziness, vertigo
    - Activity, medication, food/fluid intake, or treatment/therapy-induced
    - Presence of both nausea and emesis
- If nausea and vomiting are present, assess patient every hour and PRN until controlled (tolerable to patient), then every 2 hours and PRN

Documentation
- Nausea and vomiting assessment findings
- Medication or other non-pharmacologic interventions used
- Patient response to intervention(s)
- Address in nursing care plan as needed
- Communication with provider for new or unrelieved nausea and vomiting

Interventions
- Attempt to identify the cause of nausea to tailor treatment, e.g. Malignant bowel obstruction, medications, radiation or chemotherapy.

Pharmacologic therapies
- Antipsychotics
- Benzodiazepines

Non-pharmacologic therapies
- Assist the patient with nausea control techniques such as relaxation, guided imagery, music therapy, distraction, or deep breathing exercises.
- Aromatherapy (peppermint oil)
- Chewing gum (ginger, peppermint, or regular gum)
- Modifying the patient’s diet to include small, simple meals, carbohydrates, and cool, carbonated drinks
- Treat constipation if present
RESOURCES
The following resources are recommended for additional guidance for care of patients and families on comfort care:

**UpToDate**
Great referenced, evidenced-based palliative care topics. AHS has a subscription.
https://www.uptodate.com/login

**Fast Facts Palliative Care**
Quick evidence-based topic summaries on a range of palliative care topics.
Website: https://www.mypcnow.org/fast-facts/

**Center to Advance Palliative Care**
Free online resources and courses on pain and symptom management, communication, and more. AHS is a member; register with your AHS email (search and select "Highland Hospital"): https://www.capc.org/accounts/register/

REFERENCES
## APPENDICES

### Appendix 1. Huddle Checklist: Transition to Comfort Care for Patients Receiving Life Sustaining Therapies

<table>
<thead>
<tr>
<th>Patient Initials/MRN:</th>
<th>Bed:</th>
<th>Nurse:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>REQUIRED to be present (including ordering provider)</td>
<td>OTHER participants as able</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Team Attending/Fellow/Chief Resident</td>
<td>Chaplain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Team Resident/NP</td>
<td>Pharmacist (for complex sx management)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedside RN &amp; Charge RN</td>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>Palliative Care if consulting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topics for Discussion</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Plan</td>
<td></td>
</tr>
<tr>
<td>Does patient have an AICD? If yes, plan to turn off.</td>
<td></td>
</tr>
<tr>
<td>Sequence of life-sustaining treatment withdrawal?</td>
<td></td>
</tr>
<tr>
<td>Plan for vent and O2 weaning?</td>
<td></td>
</tr>
<tr>
<td>Anticipated trajectory and/or transfer out of ICU?</td>
<td></td>
</tr>
<tr>
<td>Any other anticipated challenges?</td>
<td></td>
</tr>
<tr>
<td>Plan for analgesia and sedation?</td>
<td></td>
</tr>
<tr>
<td>• Fentanyl bolus &amp; infusion for most patients. Initial infusion rate may be zero unless already on infusion or symptom distress expected.</td>
<td></td>
</tr>
<tr>
<td>• Lorazepam IV PRN for most patients; midazolam bolus &amp; infusion if patient expected to require anxiolysis or sedation beyond fentanyl.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient/Family Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the set expectations?</td>
</tr>
<tr>
<td>Any special requests?</td>
</tr>
<tr>
<td>Plan for family involvement?</td>
</tr>
<tr>
<td>Any cultural or religious preferences?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all staff comfortable with the plan?</td>
</tr>
<tr>
<td>Has Donor Network West been notified?</td>
</tr>
<tr>
<td>Medical Examiner case? Is family aware?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will put in note documenting comfort care huddle plan (use .ACP dotphrase)</td>
</tr>
<tr>
<td>Who will put in comfort care order set?</td>
</tr>
<tr>
<td>Who is contact for RN and RT if additional orders are needed?</td>
</tr>
</tbody>
</table>
Appendix 2. Critical-Care Pain Observation Tool (CPOT)

- To assess pain in patients who cannot self-rate on a 1-10 scale in the critical care setting.

### The Critical-Care Pain Observation Tool (CPOT)

(Gélinas et al., 2006)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial expression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed, neutral</td>
<td>0</td>
<td>No muscle tension observed</td>
</tr>
<tr>
<td>Tense</td>
<td>1</td>
<td>Presence of frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g., opening eyes or tearing during nociceptive procedures)</td>
</tr>
<tr>
<td>Grimacing</td>
<td>2</td>
<td>All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)</td>
</tr>
<tr>
<td><strong>Body movements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of movements or normal position</td>
<td>0</td>
<td>Does not move at all (doesn’t necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)</td>
</tr>
<tr>
<td>Protection</td>
<td>1</td>
<td>Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements</td>
</tr>
<tr>
<td>Restlessness/Agitation</td>
<td>2</td>
<td>Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed</td>
</tr>
<tr>
<td><strong>Compliance with the ventilator</strong></td>
<td></td>
<td>(intubated patients)</td>
</tr>
<tr>
<td>(OR) Vocalization (extubated patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerating ventilator or movement</td>
<td>0</td>
<td>Alarms not activated, easy ventilation</td>
</tr>
<tr>
<td>Coughing but tolerating</td>
<td>1</td>
<td>Coughing, alarms may be activated but stop spontaneously</td>
</tr>
<tr>
<td>Fighting ventilator</td>
<td>2</td>
<td>Asynchrony: blocking ventilation, alarms frequently activated</td>
</tr>
<tr>
<td>Talking in normal tone or no sound</td>
<td>0</td>
<td>Talking in normal tone or no sound</td>
</tr>
<tr>
<td>Sighing, moaning</td>
<td>1</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td>Crying out, sobbing</td>
<td>2</td>
<td>Crying out, sobbing</td>
</tr>
<tr>
<td><strong>Muscle tension</strong></td>
<td></td>
<td>Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned</td>
</tr>
<tr>
<td>Relaxed</td>
<td>0</td>
<td>No resistance to passive movements</td>
</tr>
<tr>
<td>Tense, rigid</td>
<td>1</td>
<td>Resistance to passive movements</td>
</tr>
<tr>
<td>Very tense or rigid</td>
<td>2</td>
<td>Strong resistance to passive movements or incapacity to complete them</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>____  / 8</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3. Pain Assessment in Advanced Dementia Scale (PAIN-AD)

- To assess pain in patients who cannot self-rate on a 1-10 scale in the medical/surgical care setting.

<table>
<thead>
<tr>
<th>A. Likert-type pain assessment scale</th>
<th>B. Wong-Baker FACES Pain Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;What is your current level of pain, between 0 and 10, with 0 being no pain and 10 being the worst pain you could imagine?&quot;</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>No hurt</td>
<td>Hurts</td>
</tr>
<tr>
<td>Little Bit</td>
<td>Little More</td>
</tr>
</tbody>
</table>

C. Visual analog scale

"Please place a mark on this line that best describes the intensity of your pain."

<table>
<thead>
<tr>
<th>No pain</th>
<th>Worst pain ever</th>
</tr>
</thead>
</table>

D. Pain Assessment in Advanced Dementia (PAINAD) scale

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Repeated troubled calling out</td>
<td></td>
</tr>
<tr>
<td>Low-level speech with a negative or disapproving quality</td>
<td>Loud moaning or groaning</td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Smiling or inexpressive</td>
<td>Sad, frightened, frown</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td>Relaxed</td>
<td>Tense</td>
<td>Rigid; fists clenched</td>
<td></td>
</tr>
<tr>
<td>Distressed pacing</td>
<td>Knees pulled up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fidgeting</td>
<td>Pulling or pushing away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Striking out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract, or reassure</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4. Respiratory Distress Observation Scale (RDOS)

- To assess dyspnea in patients who cannot self-rate on a 1-10 scale.

### Respiratory Distress Observation Scale (RDOS)

**Purpose**

This tool is to be used for assessing the intensity and distress of patients unable to report dyspnea during monitoring for Palliative Sedation Therapy.1,2,3

<table>
<thead>
<tr>
<th>Variable</th>
<th>0 Points</th>
<th>1 Point</th>
<th>2 Points</th>
<th>Sub-Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate per min (beats/min = bpm)</td>
<td>less than 90 bpm</td>
<td>90–109 bpm</td>
<td>greater than or equal to 110 bpm</td>
<td></td>
</tr>
<tr>
<td>Respiratory rate per minute (auscultated) (breaths/min)</td>
<td>less than 19 breathes</td>
<td>19–30 breaths</td>
<td>greater than 30 breaths</td>
<td></td>
</tr>
<tr>
<td>Restlessness: non-purposeful movements</td>
<td>No</td>
<td>Yes - Occasional, slight movements</td>
<td>Yes - Frequent movements</td>
<td></td>
</tr>
<tr>
<td>Paradoxical breathing pattern: abdomen moves in on inspiration</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessory muscle use: rise in clavicle during inspiration</td>
<td>No</td>
<td>Yes - Slight rise</td>
<td>Yes - Pronounced rise</td>
<td></td>
</tr>
<tr>
<td>Grunting at end-expiration: guttural sounds</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal flaring: involuntary movement of nares</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Look of fear:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Eyes wide open</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Facial muscles tense</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Brow furrowed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Mouth open</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Teeth together</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Instructions for Use**

- Count respiratory and heart rates for one full minute;
- Grunting may be audible with or without auscultation;
- An RDOS score of less than 3 indicates respiratory comfort;
- An RDOS score greater than or equal to 3 signifies respiratory distress and need for palliation;
- Higher RDOS scores signify a worsening condition.
Appendix 5. Richmond Agitation Sedation Scale (RASS)

- To assess sedation prior to and during withdrawal of life-sustaining therapies.

**Richmond Agitation Sedation Scale (RASS)***

<table>
<thead>
<tr>
<th>Score</th>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
<td>Overtly combative, violent, immediate danger to staff</td>
</tr>
<tr>
<td>+3</td>
<td>Very agitated</td>
<td>Pulls or removes tube(s) or catheter(s); aggressive</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent non-purposeful movement, fights ventilator</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
<td>Anxious but movements not aggressive vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and calm</td>
<td></td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
<td>Not fully alert, but has sustained awakening (eye-opening/eye contact) to <em>voice</em> (≥10 seconds)</td>
</tr>
<tr>
<td>-2</td>
<td>Light sedation</td>
<td>Briefly awakens with <em>voice</em> (&lt;10 seconds)</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate sedation</td>
<td>Movement or eye opening to <em>voice</em> (but no eye contact)</td>
</tr>
<tr>
<td>-4</td>
<td>Deep sedation</td>
<td>No response to <em>voice</em>, but movement or eye opening to physical stimulation</td>
</tr>
<tr>
<td>-5</td>
<td>Unarousable</td>
<td>No response to <em>voice</em> or physical stimulation</td>
</tr>
</tbody>
</table>

**Procedure for RASS Assessment**

1. Observe patient
   a. Patient is alert, restless, or agitated. (score 0 to +4)
2. If not alert, state patient’s name and say to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. (score −1)
   c. Patient awakens with eye opening and eye contact, but not sustained. (score −2)
   d. Patient has any movement in response to *voice* but no eye contact. (score −3)
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
   e. Patient has any movement to physical stimulation. (score −4)
   f. Patient has no response to any stimulation. (score −5)


Appendix 6. Richmond Agitation-Sedation Scale – Palliative Version (RASS-PAL)

- To monitor level of sedation in the palliative care setting.

### Richmond Agitation Sedation Scale – Palliative Version (RASS-PAL)

<table>
<thead>
<tr>
<th>Score</th>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+4</td>
<td>Combative</td>
<td>Overly combative, violent, immediate danger to staff, (e.g., throwing items); +/- attempting to get out of bed or chair</td>
</tr>
<tr>
<td>+3</td>
<td>Very Agitated</td>
<td>Pulls or removes lines (e.g. IV/SC/Oxygen tubing) or catheter(s); aggressive, +/- attempting to get out of bed or chair</td>
</tr>
<tr>
<td>+2</td>
<td>Agitated</td>
<td>Frequent non-purposeful movement, +/- attempting to get out of bed or chair</td>
</tr>
<tr>
<td>+1</td>
<td>Restless</td>
<td>Occasional non-purposeful movement, but movements are not aggressive or vigorous</td>
</tr>
<tr>
<td>0</td>
<td>Alert and Calm</td>
<td></td>
</tr>
<tr>
<td>-1</td>
<td>Drowsy</td>
<td>Not fully alert but has sustained awakening (eye-opening/eye contact) to voice for 10 seconds or longer.</td>
</tr>
<tr>
<td>-2</td>
<td>Light Sedation</td>
<td>Briefly awakens with eye contact to voice for less than 10 seconds</td>
</tr>
<tr>
<td>-3</td>
<td>Moderate Sedation (common goal)</td>
<td>Any movement (eye of body) or eye opening to voice, but no eye contact</td>
</tr>
<tr>
<td>-4</td>
<td>Deep Sedation</td>
<td>No response to voice but any movement (eye or body) or eye opening to stimulation by light touch</td>
</tr>
<tr>
<td>-5</td>
<td>Not rousable</td>
<td>No response to voice or stimulation by light touch</td>
</tr>
</tbody>
</table>

### Tool Notes

- The Richmond Agitation-Sedation Scale – Palliative Version (RASS-PAL) is a valid and reliable assessment tool to assess the person’s level of sedation during Palliative Sedation Therapy (PST).
- Unlike the original RASS, the RASS-PAL does not require eliciting a response using painful or startling stimuli.
- The aim of palliative sedation is to provide symptom relief with the lightest possible level of sedation necessary and/or as per the identified goals.
- Use of a standardized tool to assess level of sedation improves monitoring, communication and documentation in PST, see procedure on reverse.

### Procedure for RASS-PAL

**0 to +4**

1. Observe patient for **20 seconds**
   a. Patient is alert, restless or agitated **for more than 10 seconds**. Note if the patient is alert, restless or agitated for less than 10 seconds and is otherwise drowsy, then score patient according to your assessment for the majority of the observation period.

**-1**

2. If not alert, greet patient, call by name and say “open your eyes and look at me”.
   a. Patient awakens with sustained eye opening and eye contact (10 seconds or longer).
   b. Patient awakens with eye opening and eye contact, but not sustained (**less than 10 seconds**).
   c. Patient has any eye or body movement in response to voice but no eye contact

**-4 -5**

3. When no response to verbal stimulation, physically stimulate patient by light touch, e.g., gently shake shoulder
   a. Patient has any eye or body movement to gentle physical stimulation
   b. Patient has no response to any stimulation
Appendix 7. Confusion Assessment Method for the ICU (CAM-ICU)

- To monitor delirium in the critical care setting.

**CAM-ICU Worksheet**

<table>
<thead>
<tr>
<th>Feature 1: Acute Onset or Fluctuating Course</th>
<th>Score</th>
<th>Check here if Present</th>
</tr>
</thead>
</table>
| Is the pt different than his/her baseline mental status? OR 
Has the patient had any fluctuation in mental status in the past 24 hours as evidenced by fluctuation on a sedation scale (i.e., RASS), GCS, or previous delirium assessment? | Either question Yes → | ☐ |

<table>
<thead>
<tr>
<th>Feature 2: Inattention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Letters Attention Test</strong> (See training manual for alternate Pictures)</td>
</tr>
<tr>
<td>Directions: Say to the patient, &quot;I am going to read you a series of 10 letters. Whenever you hear the letter 'A,' indicate by squeezing my hand.&quot; Read letters from the following letter list in a normal tone 3 seconds apart.</td>
</tr>
<tr>
<td>S A V E A H A A R T</td>
</tr>
<tr>
<td>Errors are counted when patient fails to squeeze on the letter “A” and when the patient squeezes on any letter other than “A.”</td>
</tr>
<tr>
<td>Number of Errors &gt;2 →</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feature 3: Altered Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present if the Actual RASS score is anything other than alert and calm (zero)</td>
</tr>
<tr>
<td>RASS anything other than zero →</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feature 4: Disorganized Thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes/No Questions</strong> (See training manual for alternate set of questions)</td>
</tr>
<tr>
<td>1. Will a stone float on water?</td>
</tr>
<tr>
<td>2. Are there fish in the sea?</td>
</tr>
<tr>
<td>3. Does one pound weigh more than two pounds?</td>
</tr>
<tr>
<td>4. Can you use a hammer to pound a nail?</td>
</tr>
<tr>
<td>Errors are counted when the patient incorrectly answers a question.</td>
</tr>
<tr>
<td><strong>Command</strong> Say to patient: “Hold up this many fingers” (Hold 2 fingers in front of patient) &quot;Now do the same thing with the other hand&quot; (Do not repeat number of fingers) &quot;If pt is unable to move both arms, for 2nd part of command ask patient to &quot;Add one more finger”</td>
</tr>
<tr>
<td>Combined number of errors &gt;1 →</td>
</tr>
</tbody>
</table>

**Overall CAM-ICU**

Feature 1 plus 2 and either 3 or 4 present = CAM-ICU positive

**Criteria Met →**

CAM-ICU Positive (Delirium Present)

**Criteria Not Met →**

CAM-ICU Negative (No Delirium)
Appendix 8. Confusion Assessment Method (CAM) Shortened Version

- To screen for delirium in the medical / surgical care setting.
APPROVALS

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Departmental</td>
<td>9/2023</td>
</tr>
<tr>
<td>CPC</td>
<td>10/2023</td>
</tr>
<tr>
<td>Medical Executive Committee</td>
<td>10/2023</td>
</tr>
<tr>
<td>Board of Trustees</td>
<td>TBD</td>
</tr>
</tbody>
</table>

Note: This policy replaces the following policies, which should be retired:
- Care of the Imminently Dying Patient (AHS)
- CITY OF ALAMEDA HEALTH CARE DISTRICT ADMINISTRATIVE POLICY & PROCEDURE No. 25: WITHHOLDING/WITHDRAWING LIFE-SUSTAINING TREATMENT
1. Scope:
Alameda Health System ("AHS") is committed to the promotion and maintenance of high-quality health care. This Utilization Management Plan (the "UM Plan" or "Plan") provides for continuous measurable improvements in the appropriate and efficient use of services and resources at Highland Hospital, San Leandro Hospital and Alameda Hospital (together the “Hospitals”).

2. Approval and Operation of the Plan:
The operation of the UM Plan is a responsibility of the Utilization Management Committee ("UMC") and the Medical Staff. This UM Plan has the approval of the Medical Staff of the Hospitals. The UM Plan also has the approval of the Governing Body of AHS. The Medical Executive Committee(s) have delegated to the UMC the authority and responsibility to carry out the Utilization Management functions described in the Plan.

3. Objective:
The overall objective is the maintenance of high-quality patient care and an increase in effective and efficient utilization of resources and services in the most cost-effective manner. The UM Plan works towards assurance of effective, efficient and timely coordination of patient care across the continuum of services throughout the health system and with its community partners. This includes referrals for Outside Medical Services (OMS) when required. The UM Plan applies to hospitalized patients and provides for a timely review of the medical and professional services rendered.

The UM Plan describes the Hospitals’ establishment and implementation of utilization review to ensure the appropriateness and efficiency of care and resources furnished by the Hospitals and Medical Staff(s). Under this UM Plan, AHS for the Hospitals:

a. Delineates the responsibilities and authority of personnel for conducting internal utilization review, for conducting delegated review under managed care contracts and facilitating external review under payer arrangements and contracts.
b. Outlines processes to review the medical necessity of admissions, extended stays, professional services and appropriateness of setting.
c. Outlines processes to review outlier cases based on extended length of stay and/or extraordinarily high costs.
d. Defines processes to review potential overutilization, underutilization, and inefficient
utilization of resources.

e. Identifies framework for reporting corrective action recommendations of the UMC in coordination with AHS policies and procedures.

4. Reporting and Structure:
The UMC is a committee of the Hospitals’ Medical Staff(s). The UMC reports no less than quarterly to the Medical Executive Committee(s). In recognition of the regulatory environment surrounding the scope of this UM Plan, the UMC Chair or their designee shall report to the Executive Compliance Committee no less than semi-annually. The UMC shall approve the scope of the Medical Executive Committee(s) and Executive Compliance Committee reports.

5. UMC

a. Organization & Composition of Committee:
The Utilization Management function is overseen by the Medical Staffs of Highland and San Leandro Hospitals and Alameda Hospital consisting of at least five (5) physician members, with one (1) being the Chair appointed by the Chief of Staff or designee. Physician members shall be members of the Medical Staff(s). At least two (2) of the physician members must be doctors of medicine or osteopathy. The other physician members may be doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors or clinical psychologists who are licensed in the State of California.

b. Non-Physician Membership
Non-physician members of the committee include the following: Director of Care Management, Quality Director, System Manager Clinical Documentation Health Information Management, Director of Health Information Management, VP of Patient Financial Services and VP, Physician Services. Non-physician membership shall also include representation on an Ad Hoc basis from: Compliance, Regulatory Affairs, Nursing and Speech, Occupational and Physical Therapy. The UMC shall have the authority to invite such other AHS representatives as needed to fulfill its oversight responsibilities for the Utilization Management functions under this UM Plan.

c. Sub-Committees
The UMC may create sub-committees as needed to oversee the Utilization Management functions under this UM Plan. Should the UMC identify the need for a sub-committee to address a targeted area, it shall document in the minutes the scope of the sub-committee and any delegated functions. The minutes shall reflect the frequency of reports to the UMC which shall be no less frequent than quarterly.

6. Conflicts of Interest
The UMC members may not review or participate in a case review if the member has a direct financial interest in the case or was professionally involved in the care of the patient
whose case is being reviewed.

7. **Frequency and Purpose of Meetings:**
Meetings of the Committee shall be held, at a minimum, on a quarterly basis. Other professional personnel, physician, or non-physician, may meet with the committee as consultants at the request of the Chair. Additional meetings are scheduled when necessary:

   a. To provide timely transfer of information.
   b. To anticipate potential problems and facilitate efficient, timely, response to identified problems.
   c. To provide direct monitoring of CM/UR activities, validation of CM/UR Nurse and Physician Advisor decisions, and determinations of coverage in questionable cases.
   d. To provide a mechanism to initiate consultation.
   e. To provide direction for CM/UR personnel
   f. To maintain hospital and department goals and standards
   g. To assist in the determination of self-denials

8. **UMC Responsibilities**
   a. The UMC will oversee the Utilization Review functions of the Hospitals as those functions are described in the Utilization Review Policy. While not responsible for the day-to-day operations of the Utilization Review functions, the UMC will review patterns of Utilization Review functions and recommend corrective action to Care Management Department leadership. In addition to the oversight of Utilization Review functions, specific cases will be selected for UMC review based on the following:
      i. Duration of stay reasonably assumed to be outlier cases.
      ii. Over and underutilization practices.
      iii. Quality of Care Issues.
      iv. Ancillary services furnished (including drugs and biologicals) which may not be appropriate for the hospital setting.
      v. Professional services performed on the hospital premises, which may not be appropriate for the hospital setting.
      vi. Suspected utilization and physician related problems.

9. **Types of Records to be Kept:**
Records are kept of the activities of the UMC and reports are regularly made by the UMC to the Executive Committees of the Medical Staffs and relevant information and recommendations are reported through usual channels to the entire Medical Staffs, Quality Management, and the Governing Body of the hospital. Minutes of UMC meetings are maintained by the Care Management Department in accordance with the Medical Staff(s) Bylaws, Rules and Regulations and Policies.

10. **Overview and Scope Utilization Management**
   a. Review Process
      i. Patient Information Required for Utilization Review
The medical record for patients receiving treatment in the acute care hospital setting shall include the information needed for the Care Management staff to conduct the reviews pursuant to the Utilization Review Policy and for the UMC to perform its oversight role. At minimum, each record shall include:

i. Identification of the patient
ii. The name of the attending physician
iii. Date of admission and dates of application for and authorization of Medi-Cal benefits if application is made after admission.
iv. The plan of care.
v. Initial and subsequent continue stay review dates.
vi. Date of operating room reservation (if applicable).
vii. Justification of emergency admission (if applicable).
viii. Reasons and plan for continued stay when the attending physician believes continued stay is necessary.

b. Staff Conducting Reviews

The Review Process is carried out by clinical personnel who are appropriately trained and qualified. The staff performing reviews pursuant to the Utilization Review Policy have the UMC’s authorization to perform the assigned review functions using criteria set by the State Medi-Cal (Title 19), Medicare (Title 18) regulations, the UMC, Managed Care Organizations, payer contracts with Alameda Health System and Medical Review Criteria as that term is defined by 42 C.F.R. §456.51. Specific methods used by the Care Management Department to determine appropriateness of admission are described in the Utilization Review Policy which is incorporated to this UM Plan by reference.

c. Admission Review

1. Elective and emergency admissions of all acute care patients, regardless of payer source are reviewed pursuant to the Utilization Review Policy.
2. Preadmission screening review will be completed for Medi-Cal patients discharging to nursing facilities to determine the appropriate level of care and care needs of Mentally Ill and Mentally Retarded.

d. Continued Stay Reviews:

1. Continued stay reviews are completed throughout the patient’s acute care hospitalization pursuant to the Utilization Review Policy.

e. Administrative Days:

1. Administrative day (AD) process is determined and initiated when a patient whose payer is Medi-Cal no longer requires acute hospital care and needs placement in a Skilled Nursing Facility or Intermediate Care Facility (IFC) or other lower level of care for which Medi-Cal and Managed Medi-Cal payors provide coverage. Care Management staff shall follow the process described in the Utilization Review Policy to ensure compliance with Medi-Cal Administrative Day requirements. A report of Administrative Days shall be a standing item on the UMC Meeting agenda.

f. Review of Outlier Cases:
The UMC will review at each meeting any cases since the prior meeting that are reasonably assumed to be outlier cases due to the extended length of stay exceeding the threshold criteria for the patient’s diagnosis. The Utilization Management Committed has determined that an outlier case for length-of-stay purposes is a case that exceeds the Regulatory Length of Stay by seven (7) days or for outlier cost purposes the charges exceed the DRG payment for the case plus (a fixed dollar amount). At any time prior to a regularly scheduled UMC Meeting a member of the Case Management staff or Revenue Cycle staff may refer an outlier case to a physician on the UMC for review and determination.

11. Concurrent Review Process
   a. In conducting reviews pursuant to the Utilization Review Policy, the Care Manager reviews the medical record to determine if there is medical justification for the admission or for the continuation of acute hospital care.
   b. When the medical record yields insufficient justification for acute hospital care, staff will follow the escalation process described in the Utilization Review Policy.
   c. Determinations that the level of care ordered by the responsible physician should be changed will follow the process described in the Utilization Review Policy and include the responsible physician, physician advisor and a physician member of the UMC.
      1. Necessary notifications of such determinations will be made pursuant to the Utilization Review Policy and in compliance with the patient’s payer requirements and Federal and State laws rules and regulations.
   d. The Care Manager attends multidisciplinary rounds in which the physicians responsible for each patient’s care present clinical information regarding the patient including, but not limited to:
      2. Pertinent test results.
      3. Anticipated discharge date and level of care required.
      4. Prognosis and post hospital follow-up plans.
      5. Financial status determination by the Patient Financial Counseling Staff.
   e. The Care Management Director or designee may refer a case to the UMC, for appropriate intervention. The UMC shall:
      1. Verify the accuracy of the Care Manager, Physician, or other involved party information.
      2. Review the accuracy and completeness of the documentation in the medical record.
      3. Seek any necessary clarification of facts.
      4. Recommend action necessary for resolution.
      5. Report pertinent facts and recommended resolution to the UMC. The UMC will determine the relevant information to be included as part of the minutes in compliance with the Health Insurance Portability and Accountability Act privacy rule.
      6. Include within its report to the Medical Executive Committee(s) any trends pertaining to
medical staff members and clinical privilege holders’ compliance with processes under UMC’s oversights.

12. UMC Medical Care Evaluation Studies

In accordance with 42 C.F.R. §456.141, the UR Committee must have at least one Medical Care Evaluation study in progress at any time and complete one study each calendar year. The goal of Medical Care Evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of health care. Such medical care evaluation studies are designed to emphasize identification and analysis of patterns of patient care; and suggest appropriate changes needed to maintain consistent high-quality patient care, and efficient use of services.

a. The UMC:
   1. Determines the methods to be used in selecting and conducting medical care evaluation studies for the Hospitals;
   2. Documents the results of each study, and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of facilities and services;
   3. Analyzes its findings for each study;
   4. Acts as needed to perform a fact-finding review and recommend correction of deficiencies in the process for admissions or continued stay cases;
   5. Recommends more effective and efficient hospital care procedures when opportunities are identified; and
   6. Designates, when applicable, certain providers or categories of admissions for review prior to admission.

b. Each Medical Care Evaluation study shall:
   1. Identify and analyze medical or administrative factors related to the hospital's patient care;
   2. Include analysis of at least the following:
      - Admissions;
      - Durations of stay;
      - Ancillary services furnished, including drugs and biologicals;
      - Professional services performed in the hospital; and
      - If indicated, contain recommendations for changes beneficial to patients, staff, the hospital, and the community.

c. Data used to perform Medical Care Evaluation studies must be obtained from one or more of the following sources:
   1. Medical records or other appropriate hospital data;
   2. External organizations that compile statistics, design profiles, and produce other comparative data;
   3. Cooperative endeavors with Quality Improvement Organization(s); Fiscal Agent(s); other service providers; or other appropriate agencies.

13. Discharge Planning

Discharge planning is a process, not an outcome and it begins at the time of admission. Hospital patients will receive discharge planning services and be assessed for discharge needs through an interdisciplinary team that includes the physician, nurses, therapy providers and case management staff. This process identifies patients with complex discharge planning needs arising from diagnoses, therapies, and psychosocial or other
relevant circumstances. The discharge planning process shall be carried out pursuant to Alameda Health System policies and procedures. Pursuant to these policies, the Care Management Department will develop and implement an effective discharge plan that focuses on the patient’s goals and preferences and prepares patients, their family, and caregivers to be active partners in post-discharge care. The discharge planning process will plan for post-discharge care that takes into consideration the patient’s goals for care and treatment preferences but is ultimately consistent with the patient’s clinical needs. The discharge plan shall effectively transition the patient from the acute care hospital to the appropriate post-acute care setting and services with the goal of reducing factors leading to preventable hospital readmissions and assisting the patient with achieving ideal health outcomes. Discharge planning activities are documented in the patient’s Medical Record.

14. Patient Confidentiality:
   a. Patient confidentiality is the responsibility of all staff involved in all aspects of Care Management/Utilization Review activity. Cases shall be referred to by medical record number in meetings. All UMC records are maintained by the Care Management Department under the responsibility of the System Director for Care Management. The California Civil Code, Division 1, Part 2.6, State SB-40, and the confidentiality of Medical Information Act will be followed in submitting patient information for medical and billing purposes.

15. Annual Review Revision of Plan
   a. The UM Plan shall be reviewed annually and revised as necessary based upon the ongoing evaluation of the Utilization Management activities and their relationship to the quality of patient care or to meet changes in regulatory requirements.
   b. The UM Plan is approved pursuant to Alameda Health System policies, procedures and processes.

Reference
Medi-cal Inpatient Service Provider Manual www.dhcs.ca.gov Title 22, Section 51213

Approvals

<table>
<thead>
<tr>
<th>Utilization Management Committee</th>
<th>Date: 9/2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Practice Council</td>
<td>Date: 10/2023</td>
</tr>
<tr>
<td>Medical Executive Committee</td>
<td>Date: 10/2023</td>
</tr>
</tbody>
</table>
PURPOSE
To provide support for patients during their stay by accommodating visitors and encouraging visitation. To ensure that all visitors enjoy full and equal visitation privileges that are consistent with patient preference and our ability to provide patient and family centered care.

POLICY
It is the policy of Alameda Health System (AHS) to uphold patients’ rights to designate visitors of his/her/their choosing and to allow patient visitation, as authorized and in accordance with the provisions set forth below.

DEFINITIONS:
A. “Patient and family-centered care” is based on the assumption that “family” is the primary source of strength and support. Family-centered providers recognize that family members hold essential information that enhances the patient’s care.
B. Family – “Family” is defined by the patient as the group of significant people that normally provide physical, psychological, or emotional support.
C. “Visitors” are defined as any individual who presents to the health care facility for the purpose of visiting a patient.

RESTRICTED VISITATION
During flu season and other emerging public health situations/emergencies these visitation protocols may be amended to adhere to infection prevention and control safety guidelines.
Visitation approvals for patients on isolation precautions, will be allowed visitors once reviewed and approved by the charge nurse. Emergent situations will be handled by each site’s Infection Control manager in collaboration with the respective administrative leaders.

PROCEDURE
Visitor identification enforcement policy: All in-patient visitors that come into any of the AHS campuses are required to check-in and receive a visitor pass while at AHS. Badges are one day self-expiring badges that expire approximately 15 hours after activation. When red lines have
appeared the visitor badge is not valid and must be replaced immediately. Badges will be color coded for Highland Hospital ONLY.

- Emergency Department Red Visitor Badge
- ICU Yellow Visitor Badge
- 4th Floor Purple Visitor Badge
- 3rd Floor ISSU White Visitor Badge
- 5th Floor Yellow Visitor Badge
- 6th Floor Dark Blue Visitor Badge
- 7th Floor Green Visitor Badge
- 8th/9th Floor Blue Visitor Badge

Visiting hours are from 9 a.m. to 10 p.m. except for in FBC and ICU. From 10 p.m. to 9 a.m. is designated hospital quiet time. At the Wilma Chan Highland Campus a security officer is posted at the fourth-floor elevator area 24 hours a day to screen all persons entering the acute care hospital.

It is recommended that only two people should visit any patient at one time.

1. Children visiting must be supervised by responsible adults, other than the patient at all times. Children under 12 are not permitted in the ICU and NICU or Surgery waiting area on K5.

Special arrangements may be made through the Nurse Manager or designee for visits for pre-op patients.

Limiting the number of family members and/or visitors in a room may be necessary due to space and patient access issues.

There may be special circumstances when staff may request families/visitors to leave the patient’s bedside for a limited time. Staff will explain to visitors the clinical rationale for the request, when visitors may return, and where they may wait. Examples of circumstances which may necessitate restrictions or limitations on visitors might include (but are not limited to), when:

- When there might be an infection control issue
- Visitation might interfere with the care of other patients.
- The hospital is aware of an existing court order restricting contact.
- The patient is undergoing care interventions; however, if possible, the patient requests that at least one visitor be allowed to remain in the room to provide support and comfort will be accommodated.
- During the resuscitation process we will do everything possible to accommodate family requests to be present if desired.

Only 1 visitor may stay overnight in private rooms with a bathroom. Arrangements must be made with the charge nurse. Minors (under 12) are not permitted to stay overnight except for exclusive breastfeeding. Exclusive breastfeeding is for babies under the age of 6 months and only if
accompanied by a caregiver other than the patient.
Individuals who are disruptive to patient care or operations of the facility will be asked to leave. Acts or threats of violence, intimidation, vandalism, or verbal abuse will not be permitted or tolerated under any circumstances.

Visitors should refrain from sitting or lying on a patient’s bed.

1. **POST ANESTHESIA CARE UNIT**
   - Visiting patients in the PACU is not allowed unless permission is granted by the PACU nurse.

2. **ICUs**
   - No one under 12 years of age is allowed in the ICU’s unless special arrangements are made through the Charge Nurse.

3. **EMERGENCY DEPARTMENT**
   - The Emergency Department allows for the presence of a support individual (visitor) of the patient’s choice unless the individual’s presence infringes on safety or is medically or therapeutically contraindicated. If a visitor is already with a patient and the patient is agreeable the visitor may stay during rounds. Security will bring visitors back at the scheduled time after checking with the patient’s nurse. The Emergency Department Charge Nurse has the authority to suspend visiting anytime that there is a situation where visitors would be a safety issue, i.e., multiple GSW traumas. Visiting would resume as soon as the situation was resolved.

4. **FAMILY BIRTH CENTER**
   - Family and friends should refrain from visiting if they are febrile, have diarrhea, or have symptoms of an upper respiratory infection. Cold sores should be covered with a mask until the lesion is dry and scabbed. Anyone exposed to a known communicable disease (such as chickenpox or influenza) is not allowed in the birth center. All visitors must clean their hands and forearms when entering the mother’s room, and before handling the infant.
   - Each mother will be asked to designate her primary support person. This support person will have unlimited access to the mother and her infant(s). A mask will be provided to the support person if he/she/they have any signs of illness.
   - Labor & Delivery patients will be allowed 4 visitors as well as a doula and an apprentice doula.
   - All visitors will sign in and obtain a designated visitor badge to wear at all times while in the birth center. Visiting hours are as follows: L&D unrestricted; PP unrestricted for designated primary support person, 9 a.m. – 10 p.m. for all others; NICU 9 a.m. – 10 p.m. Visitors are allowed in the mother’s room or in the waiting room. They may not wait in the hallways or by the doors.
E. A member of the health-care team may request that the number and timing of visitors be limited at certain times to facilitate adequate patient access for care. Requests by staff members to limit the number of visitors and/or length of visit should include information that helps the family and friends understand the patient’s needs. If a visitor refuses to comply with the request to move to the waiting area, or is disruptive or violent, security will be notified.

F. Visitation during labor:
   i. No more than one visitor may accompany patients being evaluated in the OB Triage area for the initial 15 minutes. This is to protect the safety and privacy of other patients in the area.
   ii. After admission, the designated primary support person and a limited number of visitors may remain in the room throughout labor at the discretion of the birthing mother, the staff, and as dictated by patient safety.
   iii. Children of any age may be present during labor at the discretion of the birthing mother, the staff, and as dictated by patient safety. Another responsible adult must be present to care for the child.
   iv. During a non-emergent cesarean section, the designated primary support person may attend at the discretion of the patient. The support person is required to gown in appropriate attire, use head/hair cover, shoe cover, and mask. The support person is allowed to sit at the head of the OR table under the direction of Anesthesia Services. The surgeon, staff, or anesthesiologist may ask the support person to leave the room if complications arise, however, every effort will be made to permit the support person to remain at the bedside if desired.
   v. During an emergency cesarean birth, only surgical personnel are allowed in the operating room until the mother and infant are stable.
   vi. No more than two visitors may accompany patients in the post-anesthesia recovery area (PACU). No food or drink can be brought into the PACU. No children are permitted in the PACU.
   vii. The decision to allow visitors during the postpartum period is made by the patient and supported by the nursing staff based on maternal and infant needs.
   viii. The designated primary support person may remain with the patient overnight and will be provided with a couch or recliner and bed linens. The support person will provide her or his own food and personal items and will maintain a clean and orderly space, except for the first night on Postpartum when a special meal is prepared for the family.
   ix. Children of any age are encouraged to visit but may not stay overnight if they are under the age of 13. A responsible adult (not the patient) must be present to care for the child. Children who become disruptive or who will not remain in the patient’s room must be taken by a responsible adult outside the unit until the behavior is resolved.
   x. Postpartum will allow 4 visitors, with no ‘swapping’ of visitor.

G. NICU visitation:
   i. Only the mother and her designated, banded support person are allowed in the nursery. Either the mother or designated, banded support person may bring one other visitor to the bedside, not to exceed four at the bedside at any one time. There will be no ‘swapping’ of visitors”
ii. All visitors will be instructed on handwashing and must clean hands and
forearms with antiseptic soap or waterless cleanser when entering the NICU.
i. The mother and her designated support person may visit at any time.
ii. Each infant may have only 2 visitors at a time. Visitation may be limited
at the discretion of the infant’s nurse or other staff. Because infant care
is the first priority, any visitor may be asked to leave in the event of any
treatments, procedures, or emergencies.
iii. Children under the age of 12 are not allowed in the NICU unless they are
siblings of the infant. Siblings are allowed brief visits in the NICU, with
constant supervision by a responsible adult. During periods of
communicable disease outbreaks, sibling visitation in the NICU may
be suspended indefinitely at the discretion of the medical staff or
infection-control nurse, or on community recommendations.

5. CRIMINAL JUSTICE
- Visitors are not allowed unless authorized by the law enforcement agency responsible for
the patient.

6. VISITING PERSONNEL
- Alameda Health System personnel are required to observe regular visiting hours if they
have friends who are patients.

SHERIFF/SECURITY CONTACT NUMBERS:
Alameda County Sheriff Office: 44100
Highland Security 44815

APPROVALS

<table>
<thead>
<tr>
<th>Department</th>
<th>System</th>
<th>Alameda</th>
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<tbody>
<tr>
<td>Department Date:</td>
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<td>03/2020</td>
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<tr>
<td>Pharmacy and Therapeutics (P&amp;T)</td>
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<td>N/A</td>
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<tr>
<td>Clinical Practice Council (CPC)</td>
<td>03/2020,</td>
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<td>06/2021,</td>
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<td></td>
<td>10/2023</td>
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<td>Medical Executive Committee Date:</td>
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<td>10/2023</td>
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<td>Board of Trustees Date:</td>
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October 25, 2023

TO: Quality Professional Services Committee

FROM: Lan Na Lee, M.D., Alameda Health System Chief of Staff

SUBJECT: Agenda Item: B3

Meeting Date: October 25, 2023

Item Description: Medical Staff Policies and Procedures- AHS

COMMITTEE ACTION: Recommend Approval of Medical Staff Policies and Procedures

Background:
The Alameda Health System (AHS) Medical Staff align policies and procedures to provide the process for their leadership and governance of the medical Staff.

Analysis:
The Alameda Health System (AHS) Medical Staff policies support the operational functions and what action is desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care.

Prior Board Action: n/a

Board Action Requested:
Approval of the following AHS Medical Staff policies:
- Medical Staff Department Structure and Divisions

Fiscal Impact: n/a

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: n/a
Alameda Health System

MEDICAL STAFF DEPARTMENT STRUCTURE AND DIVISION LEADERSHIP

<table>
<thead>
<tr>
<th>Department</th>
<th>Medical Staff</th>
<th>Effective Date</th>
<th>9/2023</th>
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<tbody>
<tr>
<td>Campus</td>
<td>AHS</td>
<td>Date Revised</td>
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<tr>
<td>Unit</td>
<td>All</td>
<td>Next Scheduled Review</td>
<td>9/2026</td>
</tr>
<tr>
<td>Manual</td>
<td>Medical Staff</td>
<td>Author</td>
<td>Vice Chief of Staff</td>
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<tr>
<td>Replaces the following Policies:</td>
<td>Responsible Person</td>
<td>Chief of Staff</td>
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Printed copies are for reference only. Please refer to electronic copy for the latest version.

**Purpose**
To outline the organization of Clinical Departments and their Divisions within the Alameda Health System Medical Staff and define the process for their Leadership.

**Policy**
The Alameda Health System Medical Staff (AHS) divides the governance of the Medical Staff into Clinical Departments and their Divisions.

The Medical Executive Committee will periodically review the designation of the Departments and what action is desirable in creating, eliminating, or combining them for better organizational efficiency and improved patient care. Subsequent action shall be solely effective upon approval by the Medical Executive Committee.

**Procedure**
The Medical Staff shall be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a Chair selected and entrusted with the authority, duties, and responsibilities specified in the Medical Staff Bylaws.

A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which they function, and a Division Chief shall be selected and entrusted with the authority, duties and responsibilities specified. When appropriate, the affected Department Chair(s) may recommend to the Medical Executive Committee the creation, elimination, modification, or combination of divisions.

**Clinical Departments**
Clinical departments and Divisions shall be approved by the Medical Executive Committee and be under the supervision of the Chief of Staff. Their scope of services shall include leadership roles to assure their adequacy for quality of care, patient safety, and clinical efficiency of services.

The Medical Executive Committee will periodically review the designation of the Departments in creating, eliminating, or combining Departments for better
organizational efficiency and improved patient care. Action shall be solely effective upon approval by the Medical Executive Committee.

There shall be the following Departments and Divisions under the supervision of the Chief of Staff:

a. Ambulatory Care and Preventive Medicine
   i. Urgent Care
b. Anesthesiology, Perioperative and Pain Medicine
   i. Pain Medicine
c. Emergency Medicine
   i. Addiction Medicine
d. Imaging/Radiology
e. Obstetrics, Midwifery and Gynecology
   i. Family Planning
   ii. Gynecology
   iii. GYN Oncology
   iv. Maternal Fetal Medicine
   v. Obstetrics
   vi. Urogynecology
f. Medicine
   i. HIV Services
   ii. Cardiology
   iii. Pulmonary and Critical Care Medicine
   iv. Dermatology
   v. Endocrinology
   vi. Gastroenterology
   vii. Geriatrics
   viii. Hematology and Oncology
   ix. John George and Fairmont Internal Medicine
   x. Infectious Disease
   xi. Hospital Medicine
   xii. Nephrology
   xiii. Neurology
   xiv. Palliative Care
   xv. Primary Care Medicine
   xvi. Rheumatology
g. Orthopaedic Surgery
   i. Podiatry
   ii. Physical Medicine and Rehabilitation (PM&R)
h. Pathology & Laboratory Medicine
   i. Anatomical Pathology
   ii. Laboratory Medicine (Clinical Pathology)
i. Pediatrics
i. Ambulatory Pediatrics  
ii. Newborn Services  
j. Psychiatry  
   i. Inpatient Psychiatry  
   ii. Psychiatry Emergency Services  
k. Surgery  
   i. Dentistry  
   ii. General Surgery  
   iii. Neurological Surgery  
   iv. Ophthalmology  
   v. Optometry  
   vi. Oral Maxillofacial Surgery  
   vii. Otolaryngology  
   viii. Plastic Surgery  
   ix. Surgical Critical Care  
   x. Trauma Surgery  
   xi. Urology

**Creation of Divisions**
Departments may propose a new division to the Medical Executive Committee. The designation of a Division Chief is designed to effectively assist the Department Chair in leading credentialing and privileging, clinical care, operations and education within the specialty.

Consideration and the criteria for a new division shall be determined by the Department Chair in consultation with the Chief of Staff (COS) for quality and peer review considerations, and the Chief Medical Officer (CMO) for allocation of administrative time and support. This shall be summarized in a written request to the COS. The MEC shall review the request, may request a presentation and further details, and vote to approve the new division by majority vote (as defined in the Medical Staff Bylaws). The COS will report on the creation of a division to the BOT.

**Elimination of Divisions**
Consideration for eliminating a division shall be presented to MEC. MEC may request further details and/or a presentation and vote to approve the elimination by majority vote (as defined in the Medical Staff Bylaws).

**Assignment to Departments and Divisions**
Each member shall be assigned primary membership in at least one department, and to a division, if any, within such department. They may also be granted clinical privileges in other departments or divisions consistent with practice privileges granted.
Functions of Divisions
Subject to the approval of the Medical Executive Committee, each Division Chief shall perform the functions assigned to it by the Chair of Department. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review, privilege delineation, and continuing education programs. The Division Chief shall transmit regular reports to the Chair of the Department on the performance of their assigned functions.

Division Chief Qualifications
Each Division Chief must be an Active Staff member or a Provisional Staff member and a member of the division. The Division Chief must be qualified by training, experience, and demonstrated current ability in the clinical area covered by the Department/Division.

All Division Chiefs appointed after May 1, 2003, shall be:

a. board certified by an appropriate specialty board approved by the American Board of Medical Specialties or American Osteopathic Association, or have successfully completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved residency training program and achieve board certification within three (3) years of board eligibility; or

b. be board certified by the American Board of Podiatric Surgery or have completed a podiatric residency program approved by the Council on Podiatric Medical Education and achieve board certification within three (3) years of board eligibility; or

c. be board certified by the American Board of Oral and Maxillofacial Surgery as recognized by the American Dental Association or have successfully completed a residency program in an accredited oral and maxillofacial surgery program recognized by the American Dental Association and achieve board certification within three (3) years of board eligibility.

Division Chief Appointment and Removal
A Division Chief shall be appointed by the Chair of the Department after careful review of the candidate's qualifications. Such appointments shall be made in consultation with the CMO and the COS, and with approval of the Medical Executive Committee.

The Division Chief's performance shall be periodically reviewed by the Chair of the Department and the appointment shall continue if performance is satisfactory.

A Division Chief will immediately cease being the Division Chief upon any of the following:

a. They resign.

b. They are no longer an Active or Provisional Staff member.
c. They are removed by the Chair of the Department with the concurrence of the Chief of Staff and reported to the Medical Executive Committee.

- Such removal shall have no effect on the individual's clinical privileges or Medical Staff membership and is not subject to hearing procedures described in Article 9 of the Bylaws.

d. Their Division is eliminated.

**Division Chief Duties**

a. act as presiding officer at Division meetings;

b. assist in the development and implementation, in cooperation with the Chair of the Department, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the Division;

c. evaluate the clinical work performed in the Division;

d. conduct inquiries and investigations and submit reports and recommendations to the Chair of the Department;

e. recommend to the Chair of the Department, specific clinical privileges for providers requesting clinical privileges in the department/division; and

f. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chair of the Department, the Chief of Staff or the Medical Executive Committee.

**Approvals**

<table>
<thead>
<tr>
<th>Bylaws Committee</th>
<th>Date: 09/18/2023</th>
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<tbody>
<tr>
<td>Medical Executive Committee</td>
<td>Date: 10/18/2023</td>
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</table>
Revised Privilege Form
September 27, 2023

TO: Quality Professional Services Committee

FROM: Lan Na Lee, M.D., Alameda Health System Chief of Staff
Nikita Joshi, M.D., Alameda Hospital Chief of Staff

SUBJECT: Agenda Item: B4
Meeting Date: October 25, 2023
Item Description: Medical Staff Specialty Privilege Forms

COMMITTEE ACTION: Approval of revised Medical Staff Privilege Form

Background:
The specialty privilege form and Practice Agreement for Physician Assistants listed in the analysis section is a revised privileges forms and Advanced Practice Provider forms, designed to offer a systematic approach for care across our facilities as applicable.

Analysis:
Whether new or revised, the Medical Staff privilege forms are updated through a succinct process using best practice and clinical evidence.

Prior Board Action: n/a

Board Action Requested:
Approval of revised privilege forms and Advanced Practice Provider forms that offer a system-wide approach for privileges that support patient care at AHS.

Revised Privilege Form for AHS and AH:
- Addiction Medicine Multifacility

Fiscal Impact: n/a

Budgeted/Authorized: n/a

Estimated Cost Savings: n/a

Strategic Plan Pillar: Access, Quality, Experience
Applicant’s Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as **Core Privileges** or a **Special Privileges**.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

<table>
<thead>
<tr>
<th>Required Qualifications</th>
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<tr>
<td><strong>Membership</strong></td>
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<tr>
<td><strong>Education/Training</strong></td>
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<td><strong>Continuing Education</strong></td>
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<tr>
<td><strong>Certification</strong></td>
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<tr>
<td><strong>Clinical Experience (Initial)</strong></td>
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<tr>
<td><strong>Clinical Experience (Reappointment)</strong></td>
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# Outpatient (Ambulatory) Privileges in Addiction Medicine

**Description:** Prevention, clinical evaluation, treatment, and long-term monitoring of substance abuse disorders.

<table>
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<tr>
<th>Request</th>
<th>Request all privileges listed below.</th>
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<td></td>
<td>Click [shaded blue check box] to Request all privileges.</td>
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<td></td>
<td>Uncheck any privileges you do not want to request.</td>
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</tbody>
</table>

- **Currently granted privileges**
  - Perform history and physical examination
  - Evaluate, diagnose, provide treatment and consultation, and medically manage adult and adolescent patients with substance use disorders in outpatient settings. Privileges include specialized pharmacotherapy

## Procedures
- Management of the patient undergoing detoxification and substance withdrawal including management of related physical stress or instability
- Behavior modification techniques

## FPPE Requirements
- Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested

# Inpatient (Acute Care and Emergency Department) in Addiction Medicine

## Qualifications

**Education/Training**
- For initial applicants, effective January 1, 2022, completion of an ACGME accredited fellowship training program in Addiction Medicine
  - OR
  - Completion of approved Practice Pathway leading to board certification in Addiction Medicine

**Certification**
- Current certification or board eligibility in the examination process leading to certification in Addiction Medicine from the American Board of Addiction Medicine or the American Board of Preventive Medicine

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<th>Request all privileges listed below.</th>
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<td>Click [shaded blue check box] to Request all privileges.</td>
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<td>Uncheck any privileges you do not want to request.</td>
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<td>Currently granted privileges</td>
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<tr>
<td>Admit to inpatient or appropriate level of care</td>
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<tr>
<td>Perform history and physical examination</td>
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<tr>
<td>Evaluate, diagnose, provide treatment and consultation, and medically manage adult and adolescent patients with substance use disorders in emergency department and inpatient settings. Privileges include specialized pharmacotherapy</td>
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<th>Procedures</th>
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<td>Management of patients undergoing detoxification and substance withdrawal including management of related physical stress or instability</td>
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<td>Behavior modification techniques</td>
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### FPPE Requirements

<table>
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<tr>
<th>AHS Core</th>
<th>AH</th>
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<tr>
<td>Five (5) retrospective case reviews that are representative of the scope and complexity of privileges requested</td>
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### TELEMEDICINE PRIVILEGES INPATIENT OR OUTPATIENT CARE

#### Qualifications

These privileges are intended to support existing specialty privileges for physicians and Advanced Practice Providers who are not otherwise classified as Telemedicine ONLY providers

#### Request

Click **shaded blue check box** to Request all privileges. Uncheck any privileges you do not want to request.

<table>
<thead>
<tr>
<th>AHS Core</th>
<th>AH</th>
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<tr>
<td>- Currently granted privileges</td>
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<tr>
<td>TELEMEDICINE</td>
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<td>Telehealth initial and follow up consultations</td>
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<tr>
<td>Virtual Check-ins</td>
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<td>E-Visits</td>
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### Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Alameda Health System hospital(s) and I understand that:

A.  In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B.  Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.
**Department Chair Recommendation - Privileges**

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition/Modification/Deletion/Explanation</th>
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**Department Chair Recommendation - FPPE Requirements**

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Signature of Chief/Desigee

Date

Signature of Department Chair/Desigee

Date
Medical Staff Reports (estimated 20 min)
Alameda Hospital Medical Executive Committee (MEC) and
Alameda Health System Medical Executive Committee (MEC)
Report to the Quality Professional Services Committee of the Board
October 25, 2023

A. Community

Alameda Hospital
• Alameda Hospital Status Report and Planning for the Future
  o Joint Powers Affiliation Agreement (JPA) Option 3b presented

Alameda Health System
• St. Rose Hospital Steering Committee

B. Quality

Alameda Hospital and Alameda Health System
• Medical Staff Governance
  o Approval of the revised Epic Training Assessment Form which is included in the Medical Staff and Advanced Practice Provider applications and is used by our Epic Trainers to better assess the training needs of new providers as part of their onboarding requirements. (attached)

• 2023 BETA Incentive Programs
  o COS & JC Heart Domain
  o Rapid Event Investigation & Analysis Heart Domain

• FY 2024 QPSC True North Metric Dashboard
  o Includes 46 measures spread across 5 domains related to STEEEP- safety, timely effective, efficient, equity, patient centered

Alameda Hospital
• CMS Performance Improvement Programs
  o Leapfrog/STAR rating
  o Public Reporting
  o Merit Incentive Payment System (MIPS)
  o True North Metrics Dashboard

Alameda Health System
• Medical Staff Governance
  o Approval of the Medical Staff Medical Staff Department Structure and Division policy to support the operational functions for creating, eliminating, or combining departments for better organizational efficiency and improved patient care. (attached)

• 2023 BETA Incentive Programs: Highland and San Leandro Hospital
  o OB Quest Tier II
  o ED Quest Tier I
Alameda Hospital Medical Executive Committee (MEC) and
Alameda Health System Medical Executive Committee (MEC)
Report to the Quality Professional Services Committee of the Board
October 25, 2023

Report to QPSC is from the Alameda Health System Medical Staff and Alameda Hospital (pilot combined meeting)
Meeting Date: October 18, 2023

- True North Metrics Dashboards FYTD’24
  o Information to be shared with Department Chairs to provide front line staff
- Quality Assurance & Performance Improvement Plan (QAIP)
  o Quality and Patient Safety Innovation Award
    ▪ Dr. Valerie Ng and the Clinical Laboratory team: reducing Blood Culture Contaminations

C. Staff/Patient Experience

Alameda Hospital and Alameda Health System

- Presentation on Patient and Family Advisory Council
  o Emphasis on involvement with clinical leadership and front-line staff
  o Efforts on patient outreach during significant events

Alameda Health System

- Patient Centeredness (Pt. Experience Data)
  o Performance with the strategic goals include a focus is on metrics including Hospital Nursing/Doctor Communication, Likelihood of recommending.
  o Review of metrics for both Highland and San Leandro Hospitals
    ▪ Likely to recommend HCAHPS Rate the hospital 9-10
    Current performance for Highland 71% and San Leandro Hospital 68.9%

- Search Committees / Department Chair Recruitment
  o Imaging and Radiology
  o Obstetrics, Midwifery and Gynecology
  o Psychiatry

D. Sustainability

- Alameda Hospital Department Report(s)
  o Medicine

- Alameda Health System Department Report
  o Medicine (attached)
  o Orthopaedic Surgery (attached)
Overview: Alameda Health System requires every provider to complete Epic Training to be granted access to our Epic EHR. Or if eligible, pass a proficiency assessment. AHS Epic Instructor-Led Training can range from 3 to 6 hours.

Please note: The Epic Training team will reach out to you well in advance of your start date to confirm the following as well as to coordinate a date and time for your Epic Instructor Led Training session(s) or provide details for the Test Out Option. Please respond promptly to any queries from the Epic Training Team.

All Epic training requirements must be completed prior to your first clinical shift.

The information below will only be provided to the AHS Epic Training Team.

1. What is your scheduled or anticipated date to start patient care? _______________________

2. What is your specialty(s)? __________________________

3. Which department/settings will you be working in at Alameda Health System? (Check all that apply)

   ☐ Inpatient  ☐ Outpatient (any clinic)  ☐ Emergency

   ☐ Cath Lab  ☐ Pathology/Lab  ☐ Other_________

   ☐ John George Psychiatric Hospital:
     ☐ Psychiatric Emergency Services  ☐ Inpatient Psychiatry

4. Will you be performing Surgical Procedures in the Operating Room  ☐ YES  ☐ NO

5. Will you be performing Endoscopic Procedures  ☐ YES  ☐ NO

Epic Experience Attestation:

6. Have you previously used Epic?  ☐ YES  ☐ NO
   If YES, when, and where did you last use Epic?

   Date_______________________                     Where________________________

If you have used Epic within 6 months of your start date, you may qualify for the Test Out Option in lieu of attending an Instructor Led Training session. Not all clinical areas offer a test-out option.

7. Have you used Epic in the OUTPATIENT setting?  ☐ YES  ☐ NO  ☐ N/A
   If yes, would you like the option to Test Out in lieu of attending a training session?  ☐ YES  ☐ NO
## Internal Medicine Department Report

### Operational highlights:
- Primary care k6: 37,000 encounters/yr
- Specialty clinics: 5800 for GI; 2989 for Derm; 2500 for Endo
- Econsults: #1 in IM and 4 in AHS – GI and #2 in IM is Dermatology
- Procedures: >90th percentile for CV metrics; 99% cecal intubation rate GI

### Hospital Medicine:
- HGH: Doc of the Day; expansion to swing and Team 8; Obs planning
- SLH: 55% orders placed prior to 9am; LOS ratio <1.0 best at AHS
- AIM- wide scope and excellent patient care at all sites

### Education:
- Pipeline from middle school to faculty development
- largest residency program (70 residents/yr)
- 100% fellowship match rate
- trained 175 medical students/yr

### QI/PS:
Infrastructure development: Vice Chair QI/PS & 4 Patient Safety Officers for Peer Review, Education, Data Analytics and Health Equity, and Process Improvement.
Committees: IM Department represents at every AHS Med Staff committee and every TNM workgroup; Leadership at all levels from Division to BOT Quality.

### Regulatory:
Gold Plus for STEMI/NSTEMI/cardiac arrest receiving status from AHA
Procedural operations – Cath lab, Hemodialysis, Stroke Center, Endoscopy, Bronchoscopy, Infusion Center
**Expansion in Procedures to expedite diagnosis and treatment** – EBUS for lung cancer diagnosis & ERCP for interventional GI procedures

### Community Connection
- Palliative care- Stupski Grant for community and SNF expansion of pall. care
- Addiction Medicine – SUN Program and inpatient addiction medicine treatment to help transition to safe discharge and decrease readmission
- Human Rights Clinic – Forensic evaluations for victims of torture and oppression and assistance with asylum applications. Largest in NorCal
- Home Visit Program – Meet vulnerable patient needs at their homes.

### Advocacy:
- Reproductive rights rally
- Black Lives Matter advocacy and education
- Antiracism training
- Immigrant rights rally

### Community:
Publications and Op Eds, Book Club, Documentary of Betty Clark, Chaplain, URM med student electives in NFL sports medicine

### Staff & Physician Experience
- no faculty departures in one year
- 27 new faculty joined.
- 50% new faculty HGH trained

### DEI efforts:
- IM DEI Committee to recruit, retain, and support diverse workforce
- Celebration of diversity
- URM/Diversity scholarship for med students
- 45% URM recruited into faculty last year
- residency recruitment of URM > national averages

### Retention:
- Strength is psychological safety with clinical excellence -> growth mindset and decreased burnout.

---

117/189
## IMAGING DEPARTMENT REPORT

<table>
<thead>
<tr>
<th>Sustainability</th>
<th>Quality Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiatives:</strong></td>
<td><strong>QRC:</strong></td>
</tr>
<tr>
<td>• Rebuilding the provider pool for acute and elective coverage</td>
<td>• Monthly meeting led by Ortho Quality Director</td>
</tr>
<tr>
<td><strong>System Integration:</strong></td>
<td>• Reviewing patient Press Ganey and CAHPS scores</td>
</tr>
<tr>
<td>• Pilot program working with Dental and Anesthesia POET clinic to optimize patients for elective surgery</td>
<td><strong>Regulatory:</strong></td>
</tr>
<tr>
<td><strong>Finance:</strong></td>
<td>• No active issues</td>
</tr>
<tr>
<td>• Focus on operative utilization and process improvement</td>
<td><strong>Performance Metrics:</strong></td>
</tr>
<tr>
<td><strong>Performance Metrics:</strong></td>
<td><strong>Departmental ambulatory and operative volume</strong></td>
</tr>
<tr>
<td>• Departmental ambulatory and operative volume</td>
<td><strong>Infection and DVT rates</strong></td>
</tr>
<tr>
<td>• Infection and DVT rates</td>
<td><strong>Readmission rates</strong></td>
</tr>
<tr>
<td>• Readmission rates</td>
<td><strong>Staff &amp; Physician Experience</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Connection</th>
<th><strong>Staffing:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Projects:</strong></td>
<td>• Still 25% unfilled surgeon positions</td>
</tr>
<tr>
<td>• Redesigning the referral order and pathways to facilitate patient scheduling and identifying urgent acute patients.</td>
<td><strong>Workforce Development:</strong></td>
</tr>
<tr>
<td><strong>Opportunities:</strong></td>
<td>• Continuing to recruit Orthopaedic surgeons.</td>
</tr>
<tr>
<td>• Plan to meet with CHCN and other external providers to discuss expanded services offered at AHS</td>
<td>• 2 new Physician’s assistant positions that currently interviewing.</td>
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<tr>
<td><strong>Culture:</strong></td>
<td><strong>Culture:</strong></td>
</tr>
<tr>
<td>• Protected time for all providers to participate in regular department meetings, grand rounds and QRC meetings.</td>
<td></td>
</tr>
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</table>
Regulatory Affairs, Patient Safety, TNM Dashboard
In this report we will review the FYTD 2024 performance (September 1-30, 2023)

I. Patient & Staff Harm Events and Complaints/Grievances:

- In the month of September 2023, the Patient Harm Rate was slightly higher than target at a rate of 2.7% for the year (AHS target for Patient Harm rate of ≤ 2.5%).
- September 2023: All 13 of the 459 Safety Alerts resulted in an “E” risk significance resulting in temporary and minor patient harm.
- Patient Relation events continue to increase over the past 24 months, with an increase of 33% from FY2022 to FY2023. Drill down report attached in Annual Patient Safety Report for FY 2023.

Annual Patient Harm Rate – 2.7% (Target ≤2.5% Harm Rate)

Monthly Patient Harm Rate for September 2023 – 2.7%
II. 2023 Culture of Safety Survey:

- CONGRATULATIONS AHS – 74% Culture of Safety Survey Response Rate
- Improvement in ALL 15 Cultural and Engagement Domains
- Action Plans Developed and Implemented in 98% of Departments (156/160)
- 123/160 have completed all five steps of the Culture of Safety Survey work for 2023

<table>
<thead>
<tr>
<th>Steps in Debriefing Process</th>
<th>Total Work Settings</th>
<th>Step 1</th>
<th>Step 2 &amp; Step 3 Conducted by Neutral Facilitator</th>
<th>Step 4</th>
<th>Step 5 FINAL STEP</th>
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<tbody>
<tr>
<td>Culture of Safety Survey Steps 1-5:</td>
<td></td>
<td>Prepare to Debrief</td>
<td>Record Debriefing Notes</td>
<td>Review and Reflect</td>
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<td>Manager’s Actions Required:</td>
<td></td>
<td>Schedule Debriefing(s)</td>
<td>Neutral Facilitator to debrief and capture notes</td>
<td>Facilitator to review results with Unit Leader</td>
<td>1-2 Actions from COS Results or Debriefing Feedback</td>
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<td>Actions Due By:</td>
<td>May 15, 2023</td>
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<td>Due July 31, 2023</td>
<td>Aug 1 – Oct 31, 2023</td>
<td></td>
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<tr>
<td>Alameda Hospital</td>
<td>12</td>
<td>12/12</td>
<td>12/12</td>
<td>12/12</td>
<td>0/12</td>
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<td>Ambulatory Care</td>
<td>22</td>
<td>22/22</td>
<td>22/22</td>
<td>22/22</td>
<td>1/22</td>
</tr>
<tr>
<td>JGPH</td>
<td>9</td>
<td>9/9</td>
<td>9/9</td>
<td>9/9</td>
<td>0/9</td>
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<tr>
<td>Physicians &amp; APPs</td>
<td>23</td>
<td>23/23</td>
<td>23/23</td>
<td>19/23</td>
<td>2/23</td>
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<tr>
<td>Post-Acute</td>
<td>8</td>
<td>8/8</td>
<td>8/8</td>
<td>8/8</td>
<td>7/8</td>
</tr>
<tr>
<td>San Leandro Hospital</td>
<td>10</td>
<td>10/10</td>
<td>10/10</td>
<td>10/10</td>
<td>0/10</td>
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<tr>
<td>Systemwide Services</td>
<td>51</td>
<td>51/51</td>
<td>51/51</td>
<td>51/51</td>
<td>8/51</td>
</tr>
<tr>
<td>Total – 8 Facilities</td>
<td>160 Work Settings</td>
<td>160/160 Debriefings Assigned</td>
<td>160/160 Debriefings Completed</td>
<td>156/160 or 98% Have developed their Action Plans</td>
<td>23/160 Completed Action plans</td>
</tr>
</tbody>
</table>

*All five steps to be completed and transition to sustainability due by October 31, 2023*
A. Key Point #1 – Site Visits
   1. One complaint was investigated by the California Department of Public Health at SLH.
   2. One licensing visit was conducted at San Leandro Hospital on behalf of Imaging Services.

B. Key Point #2 – CDPH Reportable Events
   1. One adverse event from Highland Hospital was self-reported

C. Key Point #3 – Joint Commission Complaints
   1. None

D. Key Point #4 – Joint Commission Sentinel Events
   1. None.

E. Key Point #5 – Joint Commission 2023 Triennial Survey
   1. AHS corrective action plans (ESCs) and monitoring are in progress.

F. Key Point #6 – CMS EMTALA SURVEY
   1. CMS EMTALA Survey conducted in July at Highland and San Leandro hospitals resulted in two citations for the Highland Emergency Department.
Annette Johnson, MBA – Director of Quality Analytics

October 25, 2023

There is a total of 11 True North Metrics under the Care Quality Pillar, which are balanced across IOM STEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient Centered. The menu of metrics is inclusive of all service lines and are intended to improve efficiencies, workflows and to support patient flow across the system.

Key Point 1: Hospital Acquired Harms

AHS is targeting a minimum reduction of 50% in Fiscal Year 2024 as compared to Fiscal Year 2023. The harm index includes following 8 harm types: Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), MRSA Blood Stream Infections (MRSA BSI), C. Difficile infections, surgical site infections (SSI), patient falls with injury, hospital acquired pressure injuries (HAPI) and behavior events that result in injury.

In the initial month of the fiscal year there were 36 harms reported which exceeded AHS’ monthly target of 16 or less harms per month. AHS was experiencing a downward trend in harms during the final quarter of FY23 that continued into FY24. The most common harm type for this month was behavior events that resulted in injury (18) the majority of which occurred at John George Psychiatric Hospital (14). This campus actively reviews all events for learning and improvement opportunities. Including updating care plans to help patients with impulsive behaviors avoid triggering situations and identify patient specific stressors so staff can recognize escalating behavior early and intervene before behavior becomes aggressive.

Key Point 2: Hospital and Post-Acute Handwashing Compliance

In fiscal year 2024 AHS is targeting a hand hygiene compliance equal to greater than 95%. AHS started out FY24 with strong results (July 93%) falling short of goal by just 2% in the first month of the year. In FY25 AHS will extend hand hygiene auditing to our Ambulatory clinics. To help further promote hand hygiene AHS will be launching an informational campaign empowering patients and their families to encourage staff to wash their hands before and after interacting with a patient.

Key Point 3: Third Next Available Primary and Specialty Care (Return Patients)

This fiscal year AHS has set our target equivalent to the timely access to care standards established by California Department of Health Care Services: Primary (10 days) and Specialty care (15 days). The Ambulatory Care Division has been actively working to decrease wait times for appointments and started out the fiscal year with performance better than target in both Primary (Adult and Pediatrics) and Specialty Care in July.

Key Point 4: Acute All-Cause 30-day Readmission Rate

This Fiscal Year 2024 readmission rate will focus specifically on African American/Black patients with the goal of bring their readmission rate consistent with overall readmission rate 10.7%. Care Management Team continues drive early identification and referral for patients who need Health Advocates, Substance Use support, and/or Community Health Workers to address post-acute care needs and decrease likelihood or readmission. As result of this ongoing work AHS has already seen improvement in African American/Black readmission rate in July (13%) over the previous fiscal year (14.4%).

Key Point 5: Adult Health Maintenance Up to Date
AHS targeted a 10% gap closure to 90th percentile for preventative screenings which are up to date for AHS assigned patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization). The target is based on QIP and results needed to achieve performance targets under this program. Performance began to decline in December which continues into the new Fiscal Year. Improvement work will continue to focus on patient outreach, maximization of every patient touchpoint to encourage health care screenings and preventive care, and special events to promote cancer screenings.

**Key Point 6: Median Time form Decision to Admit to Inpatient Bed**

In Fiscal Year 2024 AHS will target 4 hours for median time from decision to admit to inpatient bed. Per Joint Commission any patient that waits longer than 4 hours for inpatient bed after the decision to admit is made is considered an “Emergency Department Boarder.”

There was a pilot in August where Emergency Physicians were designated to identify patients that were eligible for transfer from Highland to our community hospitals. The results were promising and increased the number by transfers. A workgroup has been assigned to review and analyze these results and determine if this intervention is scalable. In addition, Nursing is actively engaged in decreasing the delay between bed identification and patient arrival to unit.

**Key Point 7: Rate of Inpatients Screened for Health-Related Social Needs and Rate of Inpatients Positive for Health-Related Social Needs:**

To better address unmet needs that can negatively affect a patient’s health and well-being, AHS is targeting screening 90% of inpatient acute admissions for food, housing, transportation, safety, and utilities security. Measurement will begin in late December and results from the first year of measurement will be used to establish a baseline rate of need amongst AHS’ patient population.

**Key Point 8: Patient Experience Metrics**

Nursing Communication is the number one driver of patient satisfaction in the acute inpatient care setting. AHS is targeting the national 50th percentile (76.53%) as per Centers for Medicare and Medicaid Services (CMS). While AHS did not meet goal last fiscal year results were trending upward and this upward trend is continuing in July. Performance was less than 1% away from achieving goal.

In Fiscal Year 2024 AHS will monitor the Likelihood of Recommending Composite metric. This metric measures the percentage of patients willing to recommend AHS to others and includes survey results from Inpatient Acute Rehabilitation, Acute Inpatient, Ambulatory, Emergency Department, Outpatient Services, Dental and Radiology. The composite target of 80.3% represents a 10% improvement at the composite level and National 50th percentile for each service line. AHS has yet to achieve the target, though performance continues to improve with a July rate (74.13%) better than FY23 (73.0%).

Improvement efforts continue to focused on purposeful hourly and nurse leader rounding allowing staff to connect with patients, conduct real time service recovery, keep patients informed on their course of care and address patients concerns and fears. The expectation was set that 100% of patients would be rounded on, and is reinforced with daily compliance tracking reports.
Patient Safety Report

QPSC – Open Session

Darshan Grewal, MPH, MBA, BSN, CPHQ, CPHRM, CPPS, LSSBB, Master Certified in Just Culture
System Director of Patient Safety

ALAMEDA HEALTH SYSTEM
AHS PATIENT SAFETY REPORT – SYSTEM WIDE

I. RISK EVENTS

<table>
<thead>
<tr>
<th>AHS Pillar</th>
<th>Safety Alert Focus Areas</th>
<th>Metrics</th>
<th>FY 21</th>
<th>FY 22</th>
<th>FY 23</th>
<th>FYTD 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality: Patient Safety, Risk Mgmt</td>
<td>Safety Alert Reporting - Risk Events</td>
<td>Total Reported Events</td>
<td>5,722</td>
<td>5,694</td>
<td>5,779</td>
<td>1,409</td>
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<tr>
<td></td>
<td></td>
<td>Total SA Events</td>
<td>2.5%</td>
<td>3.2%</td>
<td>2.7%</td>
<td>2.7%</td>
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<tr>
<td></td>
<td></td>
<td>Significance E - I</td>
<td>149 Pt. Harm Events</td>
<td>186 Harm Events</td>
<td>154 Harm Events</td>
<td>39 Total Events</td>
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<tr>
<td></td>
<td></td>
<td>(Target 2.5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Alert Risk Event Follow Up</td>
<td>Median Time Event to Close</td>
<td></td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

(Target 7 days)
II. PATIENT RELATION EVENTS

<table>
<thead>
<tr>
<th>AHS Pillar</th>
<th>Safety Alert Focus Areas</th>
<th>Metrics</th>
<th>FY 21</th>
<th>FY 22</th>
<th>FY 23</th>
<th>FYTD 2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>MIDAS Safety Alert Reporting - Patient Relations Events</td>
<td>Total Patient Relation Events</td>
<td>621</td>
<td>773</td>
<td>998</td>
<td>246</td>
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<tr>
<td></td>
<td></td>
<td>Complaints</td>
<td>278</td>
<td>259</td>
<td>324</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grievances</td>
<td>338</td>
<td>509</td>
<td>674</td>
<td>176</td>
</tr>
<tr>
<td></td>
<td>Grievance Follow Up</td>
<td>Median Time Event to Close</td>
<td>38</td>
<td>34</td>
<td>29</td>
<td>22</td>
</tr>
</tbody>
</table>

(Target 30 days)
### AHS CULTURE OF SAFETY SURVEY

#### 2023 Culture of Safety Survey Update

**Step 5 (Final Step) Action Plans Implemented, Monitored, and Sustained**

<table>
<thead>
<tr>
<th>Steps in Debriefing Process</th>
<th>Total Work Settings</th>
<th>Step 1</th>
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<td></td>
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<td>Record Debriefing Notes</td>
<td>Review and Reflect</td>
<td>Develop Action &amp; Monitoring Plans</td>
</tr>
<tr>
<td>Manager’s Actions Required:</td>
<td>Schedule Debriefing(s)</td>
<td>Neutral facilitator to debrief and capture notes</td>
<td>Facilitator to review notes with Unit Leader</td>
<td>1-2 Actions from CDS Results or Debriefing Feedback</td>
<td>Implement actions and monitor effectiveness for 3 months</td>
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<td>Actions Due By:</td>
<td>May 15, 2023</td>
<td>Debriefing Extended to July 7, 2023</td>
<td>Due July 31, 2023</td>
<td>Aug 1 – Oct 31, 2023</td>
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</tbody>
</table>

- **Alameda Hospital**: 12
  - 12/12
  - 12/12
  - 12/12

- **Ambulatory Care**: 22
  - 22/22
  - 22/22
  - 22/22

- **Highland Hospital**: 25
  - 25/25
  - 25/25
  - 25/25

- **JGPH**: 9
  - 9/9
  - 9/9
  - 9/9

- **Physicians & APPs**: 23
  - 23/23
  - 23/23
  - 19/23

- **Post-Acute**: 8
  - 8/8
  - 8/8
  - 8/8

- **San Leandro Hospital**: 10
  - 10/10
  - 10/10
  - 10/10

- **Systemwide Services**: 51
  - 51/51
  - 51/51
  - 51/51

- **Total – 8 Facilities**: 160 Work Settings
  - 160/160 Debriefings Assigned
  - 160/160 Debriefings Completed

- **156/160 or 98%**: Have developed their Action Plans

- **23/160 Completed Action plans**

*Updated on 10/5/23*
Regulatory Affairs QPSC Report
- OPEN Session

Nilda Perez – System Director of Regulatory Affairs
ALAMEDA HEALTH SYSTEM
I. Regulatory Events Summary – Open Session

A. CDPH Site Visits and Complaints
   
   1. 09/08/23 – San Leandro Hospital, Emergency Department (ED) – unannounced complaint visit. 9/18/23 – complaint closed unsubstantiated.
   
   2. 09/30/23 – San Leandro Hospital, Mobile CT – licensing survey

B. CDPH Self-Reported Events
   
   1. 09/23/23 – Highland Hospital, 8ACT – Patient Fall adverse event

C. Joint Commission Complaints
   
   1. None

D. Joint Commission Sentinel Events
   
   1. None

E. Follow-up: The Joint Commission 2023 Triennial Survey, 04/18/23 -04/21/23
   
   1. AHS corrective action plans are being implemented and monitored by operational leaders and are ongoing. Results shared on an ongoing basis with AHS Quality Services Committee (QSC).

F. CMS EMTALA SURVEY – UPDATE
   
   1. CMS EMTALA Survey conducted in July at Highland and San Leandro hospitals resulted in two citations for the Highland Emergency Department.
      
      • Plan of correction submitted on 09/08/23. Corrective actions implemented.
<table>
<thead>
<tr>
<th>STEEP</th>
<th>Metric</th>
<th>FY23 Base line</th>
<th>FY24 Goal</th>
<th>Current Month All</th>
<th>FYTD 24</th>
<th>Accountable Team</th>
<th>Performance Trend</th>
<th>Action Plans</th>
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<tbody>
<tr>
<td>Safety</td>
<td>Patient Harm ↓</td>
<td>32 Month 386 Year 16 month 193 Year</td>
<td>20</td>
<td>96</td>
<td>Asian</td>
<td>11</td>
<td>Annette Johnson Felicia Tomabene</td>
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<tr>
<td></td>
<td>Acute</td>
<td>245 10 month 122 Year</td>
<td>14</td>
<td>59</td>
<td>African American/ Black</td>
<td>14</td>
<td>Annette Johnson Dusty Gilliland Andrea Wu</td>
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<tr>
<td></td>
<td>Post Acute</td>
<td>23 &lt;1 Month 11 Year</td>
<td>2</td>
<td>3</td>
<td>White</td>
<td>2</td>
<td>Richard Espinoza</td>
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</tr>
<tr>
<td></td>
<td>Ambulatory</td>
<td>1 5 Month 59 Year</td>
<td>4</td>
<td>34</td>
<td>African American/ Black</td>
<td>15</td>
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<tr>
<td>Safety</td>
<td>Handwashing Compliance ↑</td>
<td>82.5% 95%</td>
<td>92% 93%</td>
<td>N/A  N/A</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Acute</td>
<td>88.3% 95%</td>
<td>92% 93%</td>
<td>N/A  N/A</td>
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<tr>
<td></td>
<td>Post Acute</td>
<td>89.0% 95%</td>
<td>87% 91%</td>
<td>N/A  N/A</td>
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<tr>
<td></td>
<td>Ambulatory</td>
<td>N/A 95%</td>
<td>Pending  Pending</td>
<td>N/A  N/A</td>
<td>N/A</td>
<td>Parsha Mack Fitzgerald Shaw</td>
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</tr>
<tr>
<td>Timely</td>
<td>Days between appointment request and appointment :Primary Return ↓ (TNAA)</td>
<td>27 10</td>
<td>11</td>
<td>4</td>
<td>N/A  N/A</td>
<td>Parsha Mack Fitzgerald Shaw</td>
<td><img src="Image9" alt="Graph" /></td>
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<tr>
<td></td>
<td>Adult</td>
<td>28 10</td>
<td>14</td>
<td>4</td>
<td>N/A  N/A</td>
<td></td>
<td><img src="Image10" alt="Graph" /></td>
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<tr>
<td></td>
<td>Pediatrics</td>
<td>13 10</td>
<td>7 5</td>
<td>N/A  N/A</td>
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<td></td>
<td><img src="Image11" alt="Graph" /></td>
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## FY 2024 QPSC True North Metric Dashboard

Oct 2023 Report Data Through: Aug 2023

<table>
<thead>
<tr>
<th>STEEP</th>
<th>Metric</th>
<th>FY23 Base Line</th>
<th>FY24 Goal</th>
<th>Current Month All</th>
<th>FYTD 24</th>
<th>Accountable Team</th>
<th>Performance Trend</th>
<th>Action Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timely</td>
<td>Days between appointment request and appointment Specialty Return ↓(TMAA)</td>
<td>18.5</td>
<td>15</td>
<td>9</td>
<td>10</td>
<td>N/A</td>
<td></td>
<td>Dana Littlepage, Hena Boreno</td>
</tr>
<tr>
<td>Effective</td>
<td>All-cause 30 day Readmissions for Black/African American Pts ↓</td>
<td>14.40%</td>
<td>10.70%</td>
<td>19%</td>
<td>15%</td>
<td>N/A</td>
<td></td>
<td>Dusty Gilliland, Andrea Wu, Charlotte Willis</td>
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<tr>
<td>Effective</td>
<td>Patient with up-to-date preventive health screenings ↑</td>
<td>70.20%</td>
<td>71.36%</td>
<td>65.91%</td>
<td>65.76%</td>
<td>White</td>
<td></td>
<td>Jamie Martin, Natalie Curtis</td>
</tr>
<tr>
<td>Efficient</td>
<td>ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed ↓</td>
<td>6:35</td>
<td>4:00</td>
<td>6:16</td>
<td>6:36</td>
<td></td>
<td></td>
<td>Dana Littlepage, Tangerine Bingham</td>
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<tr>
<td>Equity</td>
<td>Rate of inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑</td>
<td>N/A</td>
<td>90%</td>
<td>Pending</td>
<td>Pending</td>
<td>Pending</td>
<td></td>
<td>Dana Littlepage, Tangerine Bingham</td>
</tr>
<tr>
<td>Equity</td>
<td>Rate of inpatients who screened positive for health-related social needs (food, housing, transportation, safety, utilities) ↓</td>
<td>N/A</td>
<td>N/A</td>
<td>Pending</td>
<td>Pending</td>
<td>Pending</td>
<td></td>
<td>Dana Littlepage, Tangerine Bingham</td>
</tr>
<tr>
<td>Patient Centered</td>
<td>Rate of patients who reported that their nurses “always” communicated well ↑</td>
<td>71.40%</td>
<td>76.53%</td>
<td>76.27%</td>
<td>74.55%</td>
<td>White</td>
<td></td>
<td>Angela Ng, No Lofton, Brandon Boesch</td>
</tr>
<tr>
<td>Patient Centered</td>
<td>Rate of patients who would “definitely” recommend AHS(Composite) ↑</td>
<td>73.00%</td>
<td>80.3%</td>
<td>75.57%</td>
<td>74.63%</td>
<td>Native American</td>
<td></td>
<td>Angela Ng, Brandon Boesch</td>
</tr>
<tr>
<td>Acute</td>
<td></td>
<td>61.61%</td>
<td>69%</td>
<td>65.07%</td>
<td>64.19%</td>
<td>White</td>
<td></td>
<td>Angela Ng, Brandon Boesch</td>
</tr>
<tr>
<td>Post Acute (Acute Rehab Only)</td>
<td></td>
<td>68%</td>
<td>75%</td>
<td>66.67%</td>
<td>73.08%</td>
<td>Asian</td>
<td></td>
<td>Richard Espinosa</td>
</tr>
<tr>
<td>Ambulatory</td>
<td></td>
<td>85.50%</td>
<td>86.80%</td>
<td>84.97%</td>
<td>85.83%</td>
<td>Native American</td>
<td></td>
<td>Porsha Mack, Terrance Fitzgerald-Shaw</td>
</tr>
<tr>
<td>Metric</td>
<td>Definition</td>
<td>GOAL</td>
<td></td>
<td></td>
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<td>-----------------------------------------------------------------------</td>
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<tr>
<td>Patient Harm</td>
<td>The number of potential health-care acquired patient harms Includes: CLABSI, CAUTI, MRSA BSI, C-Diff, SSI for Acute Med-Surg/Critical Care, and Patient Falls with injuries, Hospital Acquired Pressure Injuries and Behavior Events that result in injury for all areas (practically, not inclusive of ambulatory)</td>
<td>CMS 50th Percentile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handwashing Compliance</td>
<td>Percentage of observed encounters where handwashing was completed</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Days to Primary Care (Third Next Available Appointment Primary Return)</td>
<td>The average length of time in days between the day a patient makes a request a Primary Care appointment and the third next available appointment.</td>
<td>Based on DMHC Timely Access of Care</td>
<td></td>
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<tr>
<td>Days to Specialty Care (Third Next Available Appointment Specialty Return)</td>
<td>The average length of time in days between the day a patient makes a request a Specialty Care appointment and the third next available appointment.</td>
<td>Based on DMHC Timely Access of Care</td>
<td></td>
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</tr>
<tr>
<td>All-cause 30 day Readmissions for Black/African American Pts ↓</td>
<td>Percentage of Black/African American patient encounters, regardless of payer type, with an unplanned readmission to any AHS facility within 30 days for any cause among encounters for acute care inpatients with a principal discharge diagnosis/procedure for a clinical classification category in the Cardiorespiratory, Cardiovascular, Medicine, Neurology, or Surgery/Gynecology cohort. Note: This measure approximates, but likely does not match, the value of the corresponding CMS readmission measure.</td>
<td>Close the performance gap between overall rate and African American/Black rate.</td>
<td></td>
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</tr>
<tr>
<td>Patient with up-to-date preventive health screenings ↑</td>
<td>Percentage of preventative screenings which are up to date for AHS patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization) Note: Patients can get &quot;partial&quot; credit if some, but not all, screenings complete</td>
<td>Composite Rate equal to all screening metrics reaching QIP Targets</td>
<td></td>
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<tr>
<td>ED Boarding Time Time in ED from Decision to Admit to Inpatient Bed</td>
<td>Median time from Decision to Admit to departure from the emergency department for admitted patients. Decision to Admit = First Admit Disposition Admit = Time patient admitted to Inpatient Unit</td>
<td>Per the Joint Commission ED patients who wait more than 4 hours for an inpatient bed are considered boarders</td>
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</tr>
<tr>
<td>Rate of inpatients screened for health-related social needs (food, housing, transportation, safety, utilities) ↑</td>
<td>The percentage of inpatient acute medical/surgical admissions where the patient is screened for social determinants of health: food insecurity, housing, transportation, safety and utilities</td>
<td>Establish consistent screening practice</td>
<td></td>
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</tr>
<tr>
<td>Rate of inpatients who screened positive for health-related social needs (food, housing, transportation, safety, utilities) ↓</td>
<td>The percentage of inpatient acute medical/surgical admissions that screen positive for at least one social determinant of health: food insecurity, housing, transportation, safety and utilities</td>
<td>No goal establishing a baseline in first year of measurement</td>
<td></td>
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<tr>
<td>Rate of patients who reported that their nurses “always” communicated well</td>
<td>Percentage of patients who rated nursing communication top box. Nurse Communication is a composite composed of three questions related to nursing care, attitude, attention paid to personal needs, and how well the nurses explained the care they were providing</td>
<td>CMS 50th Percentile</td>
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<tr>
<td>Rate of patients who reported they would “definitely” recommend AHS</td>
<td>Percentage of patients who would recommend AHS (includes rehab, acute, ambulatory, ED, outpatient surgery, dental, radiology)</td>
<td>Composite rate where service lines are at or above the national 50th Percentile</td>
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</table>
Care Quality Pillar
There are 11 True North Metrics in fiscal year 2024 under the Care Quality Pillar, which are balanced across IOM STEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient Centered. The menu of metrics is inclusive of all service lines and is intended to improve efficiency, workflows, and to support patient flow across the system.

Hospital Acquired Harms:
Alameda Health System is continuously driving towards the goal of zero preventable harm. As an incremental step towards this goal AHS targeted a minimum reduction of 50% in Fiscal Year 2024 as compared to Fiscal Year 2023. The harm index includes following 8 harm types: Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), MRSA Blood Stream Infections (MRSA BSI), C. Difficile infections, surgical site infections (SSI), patient falls with injury, hospital acquired pressure injuries (HAPI) and behavior events that result in injury.

In the initial month of the fiscal year there were 36 harms reported which exceeded AHS’ monthly target of 16 or less harms per month. AHS was experiencing a downward trend in harms during the final quarter of FY23 that continued into FY24. The most common harm type for this month was behavior events that resulted in injury (18) the majority of which occurred at John George Psychiatric Hospital (14). This campus actively reviews all events for learning and improvement opportunities. Including updating care plans to help patients with impulsive behaviors avoid triggering situations and identify patient specific stressors so staff can recognize escalating behavior early and intervene before behavior becomes aggressive. Of the five Hospital Acquired Infections, CLABSI, and CAUTI present the greatest opportunities for improvement. The CAUTI/CLABSI performance improvement team is focused on device necessity and maintenance. Efforts around CLABSI and CAUTI events continue to focus on device necessity and maintenance. CLABSI and CAUTI events are reviewed with staff directly involved in the care. Lessons learn are then summarized and shared at all Facility and Unit Safety Huddles. In addition, Infection Prevention and Control has developed Micro Minutes which are one-page job aides highlighting relevant best practices and care bundles related to recent HAI events. These job aides are shared simultaneously with event summaries during huddles.

Hospital and Post-Acute Handwashing Compliance
Practicing hand hygiene is a simple yet effective way to prevent infections and can prevent the spread of germs, including those that are resistant to antibiotics and are becoming difficult, if not impossible, to treat. In fiscal year 2024 AHS is targeting a hand hygiene compliance equal to greater than 95%. Throughout Fiscal Year 2023 AHS saw system wide improvement in both volume of audits collected and compliance rates. AHS started out FY24 with strong results (July 93%) falling short of goal by just 2% in the first month of the year. In FY25 AHS will extend hand hygiene auditing to our Ambulatory clinics. To help further promote hand hygiene AHS will be launching an informational campaign empowering patients, and their families to encourage staff to wash their hands before and after interacting with a patient.

Third Next Available Appointment Primary and Specialty Care (Return Patients):
Third Next Available Appointment (TNAA) is the industry standard measure of the patient’s ability to seek and receive care with the provider of their choice, at the time they choose, and indicates how long a patient waits to be seen. This measure is used to assess the average number of days to the third next available appointment for an office visit. In contrast to first and second available appointments (often the result of last-minute cancellations, working patients into the schedule, or other events), the TNAA best represents the performance of the appointment access system. This fiscal year AHS has set our target
equivalent to the timely access to care standards established by California Department of Health Care Services: Primary (10 days) and Specialty care (15 days). The Ambulatory Care Division has been actively working to decrease wait times for appointments and started out the fiscal year with performance better than target in both Primary (Adult and Pediatrics) and Specialty Care in July.

**Acute All-Cause 30-Day Re-admit:**
Over the last three fiscal years AHS has made significant progress in decreasing acute all cause 30 day readmissions. However a disaggregation by race shows that all populations have been improving but our African American/Black population remains consistently higher than our overall rate and other groups. To address this Fiscal Year 2024 readmission rate will focus specifically on African American/Black patients with the goal of bring their readmission rate consistent with overall readmission rate 10.7%.

The Readmission Team led by Dr. Borneo in coordination with the Utilization Management Team are actively engaged in decreasing this gap and understanding the root cause. Care Management Team continues drive early identification and referral for patients who need Health Advocates, Substance Use support, and/ or Community Health Workers to address post-acute care needs and decrease likelihood or readmission. As result of this ongoing work AHS has already seen improvement in African American/Black readmission rate in July (13%) over the previous fiscal year (14.4%).

**Adult Health Maintenance Up to Date**
AHS targeted a 10% gap closure to 90th percentile for preventative screenings which are up to date for AHS assigned patients (includes screening/counseling for: breast/cervical/colon cancer, depression, tobacco, chlamydia, HIV, influenza immunization). The target is based on QIP and results needed to achieve performance targets under this program. Patients can get “partial” credit if some, but not all, screenings are complete. After a promising start to the fiscal year performance began to decline in December which continues into the new Fiscal Year. Improvement work will continue to focus on patient outreach, maximization of every patient touchpoint to encourage health care screenings and preventive care, and special events to promote cancer screenings.

**Median Time from Decision to Admit to Inpatient Bed:**
In Fiscal Year 2024 AHS will target 4 hours for median time from decision to admit to inpatient bed . AHS recognizes this is an ambitious goal but feels strongly that it is necessary for the safety of our patients and staff. Per Joint Commission any patient that waits longer than 4 hours for inpatient bed after the decision to admit is made is considered a an “Emergency Department Boarder.” Fiscal Year 2023 proved to be a challenging year for emergency room throughput but work is already underway to decrease admission wait times.

<table>
<thead>
<tr>
<th></th>
<th>System</th>
<th>Highland</th>
<th>San Leandro</th>
<th>Alameda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul YTD</td>
<td>Jul YTD</td>
<td>Jul YTD</td>
<td>Jul YTD</td>
<td>Jul YTD</td>
</tr>
<tr>
<td>25% of Admits w/in</td>
<td>2:58</td>
<td>3:06</td>
<td>7:23</td>
<td>6:16</td>
</tr>
<tr>
<td></td>
<td>2:15</td>
<td>2:09</td>
<td>2:19</td>
<td>2:27</td>
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</tbody>
</table>
There was a pilot in August where Emergency Physicians were designated to identify patients that were eligible for transfer from Highland to our community hospitals. The results were promising and increased the number by transfers. A workgroup has been assigned to review and analyze these results and determine if this intervention is scalable. In addition, Nursing is actively engaged in decreasing the delay between bed identification and patient arrival to unit.

Rate of Inpatients Screened for Health-Related Social Needs and Rate of Inpatients Positive for Health-Related Social Needs:
Social determinants of health (SDOHs) are the conditions in the environments where people are born and live that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Many health conditions and diseases can be improved by simple behavioral changes, such as eating nutritious food, safe and secure housing, managing stress and getting enough sleep. To better address unmet needs that can negatively affect a patient’s health and well-being, AHS is targeting screening 90% of inpatient acute admissions for food, housing, transportation, safety, and utilities security. Measurement will begin in late December and results from the first year of measurement will be used to establish a baseline rate of need amongst AHS’ patient population.

Hospital Nursing Communication (HCAHPS) Experience
Industry wide Nursing Communication is the number one driver of patient satisfaction in the acute inpatient care setting. AHS is targeting the national 50th percentile (76.53%) as per Centers for Medicare and Medicaid Services (CMS). While AHS did not meet goal last fiscal year results were trending upward and this upward trend is continuing in July. Performance was less than 1% away from achieving goal. Improvement efforts continue to focused on purposeful hourly and nurse leader rounding allowing staff to connect with patients, conduct real time service recovery, keep patients informed on their course of care and address patients concerns and fears. The expectation was set that 100% of patients would be rounded on, and is reinforced with daily compliance tracking reports.

Likelihood of Recommending (Composite)
In Fiscal Year 2023 AHS expanded monitoring of patient experience beyond inpatient HCAHPS and Ambulatory CG-CAHPS to include all service lines with the creation of the Likelihood of Recommending Composite metric. This metric measures the percentage of patients willing to recommend AHS to others and includes survey results from Inpatient Acute Rehabilitation, Acute Inpatient, Ambulatory, Emergency Department, Outpatient Services, Dental and Radiology. The first year of monitoring saw promising improvement and monitoring will continue in FY24. The composite target of 80.3% represents a 10% improvement at the composite level and National 50th percentile for each service line. AHS has yet to achieve the target, though performance continues to improve with a July rate (74.13%) better than FY23 (73.0%).

<table>
<thead>
<tr>
<th>50% of Admits w/in (Median)</th>
<th>6:36</th>
<th>6:36</th>
<th>16:50</th>
<th>15:43</th>
<th>2:59</th>
<th>3:18</th>
<th>3:39</th>
<th>3:48</th>
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<tbody>
<tr>
<td>75% of Admits w/in</td>
<td>19:19</td>
<td>18:30</td>
<td>29:12</td>
<td>26:24</td>
<td>4:48</td>
<td>5:33</td>
<td>5:20</td>
<td>5:52</td>
</tr>
</tbody>
</table>
Post Acute
Alameda SNF’s/SA Quality Measures

Alameda Hospital D/P Snf

Quality measures

Learn more about quality measures

Find out why these short-stay measures are important

Find out why these long-stay measures are important

Get current data collection period

Quality measures rating

★★★★★
Much above average
Fairmont Quality Measures

Alameda County Medical Center D/P Snf

Quality measures

Learn more about quality measures

Find out why these short-stay measures are important

Find out why these long-stay measures are important

Get current data collection period

Quality measures rating

★ ★ ★ ★ ★
Much above average
CDPH Visits

- Three self reports – no visits on self reports
- HCAI: visit for Southshore repair completion – passed 9/29/23
- CDPH visit for SNF compliance to move – passed 10/18/23
Southshore moving home

- HCAI and CDPH: surveys passed
- Bed suspension reversed for South shore

- Move day on 10/22/23:
  - High level of items involved
    - 23 residents moved
    - Billing and authorizations processes
    - Admission packets
    - Dr. James Yeh and AIM discharge and re-admit residents
    - Level of transport – working with Royal Ambulance
    - Resident and family involvement
    - Order review, PASRR validation of process with DHCS, two teams – one at Fairmont one at South shore
    - Nursing and psycho-social aspects addressed
CARF Survey Acute Rehab

About CARF

We are an independent, nonprofit organization focused on advancing the quality of services you use to meet your needs for the best possible outcomes.

CARF provides accreditation services worldwide at the request of health and human service providers. Whether you are seeking rehabilitation for a disability, treatment for addiction and substance abuse, home and community services, retirement living, or other health and human services, you can have confidence in your choice. Providers that meet our standards have demonstrated their commitment to being among the best available.

- Commission on Accreditation of Rehabilitation Facilities
- Survey occurred 9/28 and 9/29
- Preliminary findings suggest another 3-year accreditation will be achieved
- 3-year highest accreditation granted
- Would be third time the unit achieved the 3-year accreditation
Rehabilitation Volumes

- Highland – OT out on LOA
- ARU – census below budget and admin patients
- SL PT of by 26 treatments
- Other areas surpassing budgeted volumes – more patients and treatments being performed – growing programs

<table>
<thead>
<tr>
<th>THERAPIES SUMMARY</th>
<th>OCCUPATIONAL - BTU</th>
<th>PHYSICAL THERAPY - BTU</th>
<th>SPEECH &amp; AUDIO - BTU</th>
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<tr>
<td>HGH</td>
<td>37,268</td>
<td>31,568</td>
<td>5,700</td>
</tr>
<tr>
<td></td>
<td>(5,026)</td>
<td>-10%</td>
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<tr>
<td>HGH</td>
<td>45,293</td>
<td>50,319</td>
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<td>HGH</td>
<td>11,526</td>
<td>10,838</td>
<td>688</td>
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<td>ARU</td>
<td>34,500</td>
<td>35,134</td>
<td>(634)</td>
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<tr>
<td></td>
<td>(5,317)</td>
<td>-14%</td>
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<tr>
<td>ARU</td>
<td>32,719</td>
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<tr>
<td>ARU</td>
<td>16,290</td>
<td>20,063</td>
<td>(3,773)</td>
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<tr>
<td>FMT</td>
<td>20,443</td>
<td>14,265</td>
<td>6,178</td>
</tr>
<tr>
<td></td>
<td>(634)</td>
<td>-2%</td>
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<tr>
<td>FMT</td>
<td>31,130</td>
<td>22,972</td>
<td>8,158</td>
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<td>FMT</td>
<td>6,714</td>
<td>4,814</td>
<td>1,900</td>
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<td>AH</td>
<td>13,965</td>
<td>13,291</td>
<td>674</td>
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<td></td>
<td>(634)</td>
<td>-2%</td>
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<tr>
<td>AH</td>
<td>30,115</td>
<td>29,300</td>
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<td>(634)</td>
<td>-2%</td>
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<tr>
<td>SLH</td>
<td>8,115</td>
<td>8,141</td>
<td>(26)</td>
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<tr>
<td>SLH</td>
<td>2,416</td>
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<td>181</td>
</tr>
<tr>
<td></td>
<td>8%</td>
<td></td>
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</tbody>
</table>
Thank you

Questions?
AHS Quality Retreat Update (estimated 20 min)
Summary and Key Take-Aways: Quality and Performance Improvement Retreat

August 31st, 2023
Why We Held a Retreat

**Background**

• Create Energy and Urgency Around TNM Dashboard

• Metrics on the TNM dashboard were intentionally chosen to bring focus to key quality issues:
  • Access – Inpatient and Outpatient
  • Harms
  • Patient experience
  • Health equity

• Kick off new structure for supporting quality work on the TNM

• Quality of care as both a mindset and process

**Goals**

• Obtain commitment and accountability of Operational/Provider leads of TNM metrics

• Outline TNM Responsibilities and Expectations

• Outline structure to and identify ways to integrate performance improvement into existing governance structures (Pt Care

• Increase front line staff involvement in Performance Improvement and solution design
<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Description</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00</td>
<td>Lunch</td>
<td>Fellowship, Nourishment</td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>Rose, Bud, Thorn</td>
<td>Ice Breaker</td>
<td>Annette</td>
</tr>
<tr>
<td>1:00</td>
<td>Only the Best for Our Patients</td>
<td>Welcome and FY24 Vision</td>
<td>Dr. Tornabene</td>
</tr>
<tr>
<td>1:10</td>
<td>Better Together: Accountability and Transparency</td>
<td>Introduce True North Metrics, FY2024 Improvements</td>
<td>Annette</td>
</tr>
<tr>
<td>1:20</td>
<td>In Pursuit of the Best:</td>
<td>Committing to Our Patients and Each Other</td>
<td>Ana Torres</td>
</tr>
<tr>
<td>1:45</td>
<td>Performance Improvement Current State and Future Proposal</td>
<td>Understanding current state and proposed PI Structure, Inventory of TNM PI</td>
<td>Dr. Wills, Ro Lofton, Dr. Swift</td>
</tr>
<tr>
<td>2:30</td>
<td>Bettering Ourselves</td>
<td>Addressing the Root Causes that Limit Participation and Slow Progress</td>
<td>Fanny Domijan</td>
</tr>
<tr>
<td>3:30</td>
<td>Bring the Best together</td>
<td>Recap FY2024 and Current State</td>
<td>Dr. Tornabene</td>
</tr>
<tr>
<td>3:50</td>
<td>Measuring for the Best</td>
<td>Meet with Quality Liaisons, Review Data</td>
<td>Annette</td>
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<tr>
<td>4:10</td>
<td>Driving for the Best: Analyzing Root Cause(s)</td>
<td>Determining Performance Drivers, Intro to Driver Diagram</td>
<td>Annette</td>
</tr>
<tr>
<td>4:25</td>
<td>Envisioning the Best: Idea Generation and Prioritization</td>
<td>Innovation and Idea Generation, Intro to Priority Matrix, Identify Low Hanging Fruit for Improvement</td>
<td>Annette</td>
</tr>
<tr>
<td>4:45</td>
<td>Only the Best for Our Patients and Ourselves</td>
<td>Closing and Next Steps</td>
<td>Ana Torres</td>
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</tbody>
</table>
### The Event

- **65 Leaders from the Physicians, Patient Care Services, Medical Staff, and Quality In attendance**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Tornabene, Felicia</td>
<td>Geddis, Joshua</td>
<td>Harding, Mario</td>
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<tr>
<td>Gilleland, Dusty</td>
<td>Grieff, Trudy</td>
<td>Subramanian, Indhu</td>
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<tr>
<td>Stark, John</td>
<td>Holder, Adam</td>
<td>Akileswaran, Chitra</td>
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<tr>
<td>Cooper, Theresa</td>
<td>Tequame, Menbere (Fe Fe)</td>
<td>Wu, Andrea</td>
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<tr>
<td>Adams, Peter (Christopher)</td>
<td>Grumbach, Sheila</td>
<td>Ellis, Deborah</td>
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<td>Lofton, Romoanetia</td>
<td>Colbert, Hannah</td>
<td>Littlepage, Dana</td>
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<td>Lang, Laura</td>
<td>Boesch, Brandon</td>
<td>Chen, Tze-Ming</td>
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<td>Mistry, Sunita</td>
<td>Okorie, Jovita</td>
<td>Torres, Ana</td>
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<tr>
<td>Foo, Patricia</td>
<td>Dillard, Cherisse</td>
<td>Domijan, Fanny</td>
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<tr>
<td>Wills, Charlotte MD</td>
<td>Espinoza, Richard A</td>
<td>Lee, Nathan</td>
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<tr>
<td>Mack, Porshia</td>
<td>Delaney, Rodney</td>
<td>Leer, Charlie</td>
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<tr>
<td>Fitzgerald Shaw, Terrance</td>
<td>Beaty, Craig</td>
<td>Wagey, Frena</td>
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<td>Swift, Mini</td>
<td>Espeseth, Patricia</td>
<td>Nelson, Jessa</td>
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<td>Johnson, Annette</td>
<td>Garcia, Holly</td>
<td>Sours, Ranee</td>
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<td>Ng, Angela</td>
<td>Kilgore, Steve</td>
<td>Perez, Berenice MD</td>
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<tr>
<td>Lotsko, Joseph</td>
<td>Curtis, Natalie</td>
<td>Senekjian, Lara</td>
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<tr>
<td>Vinkavich, Jessica</td>
<td>Jackson, James</td>
<td>Thornblade, Lucas</td>
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</tbody>
</table>
| Arteaga, Patricia            | Fratzke, Mark               | Borneo, Hena                 | 152/189
## Positives and Strengths

<table>
<thead>
<tr>
<th>Positives and Strengths</th>
<th>Pre-Op Checklist</th>
<th>Standardization of CHG baths</th>
<th>Telesitters</th>
<th>Ambulatory dashboard</th>
<th>Breakout of assault data.</th>
<th>Ambulatory Pt Experience Steering Committee</th>
<th>Text messaging</th>
<th>EVS patient surveys</th>
<th>Promising results from Doc of the Day pilot</th>
<th>Equity measures to be added to TNM dashboard</th>
<th>PI Triad</th>
<th>MOR Meeting Review of TNM results</th>
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<tbody>
<tr>
<td>Some standardization centered on best practices to reduce harm:</td>
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<td>TNM and HAI data more visible and widely available</td>
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<tr>
<td>Efforts related to Patient Experience</td>
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<td>Work to improve pt access; inclusion of Equity as part of the foundation of all QI work.</td>
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<td>Leadership engagement and promotion of a structured approach is effective and motivating.</td>
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Barriers and Opportunities

- Need for collaboration and coordination around Quality issues both horizontally and vertically.
- Call for more data availability/visibility all the way down to the frontline.
- Lack of standardization of processes and protocols.
- Organizational culture: change resistance, "wait it out," need for accountability.
Key Takeaways

• There is a strong, shared desire to be accountable to our patients first and foremost

• AHS leadership and staff are excited, engaged, and ready to take QI/PI to the next level.

• Many resources, tools and best practices exist, but they’re not getting to the people who do the work (e.g., antibiotic guidelines, operational checklist binder, etc.)
  • How does Standard Work/practice guidelines get to the point of use? Where can they be found when needed?
  • How do we train on standard work?
  • Who is accountable for enforcement of standard work?

• Many benefits could be realized by embracing the Plan, Do, Study, Act structure for improvement

• Medical Residents comprise a large piece of PI work and should be involved in planning and training.
Impact of Retreat

• Engaged and strong sense of Urgency Around TNM and improving safety and quality

• Embraced and accepted accountability structure

• Improved attendance and involvement in PI Teams

• Both Nursing and Providers engaged integrating PI into existing governance to inform front line staff of priorities and progress
  • Unit Based Councils
  • PI Updates at Provider Department Meetings
Conclusion

Next Steps

• Forming triad QI/PI teams around key HAIs
  • Established CLABSI/CAUTI
  • Developing SSI, HAPI and Falls

• Coordinating to provide support to established teams:
  • Readmissions, ED Throughput, Social Determinants of Health, Hand Hygiene

• Use QI/PI team as a jumping-off point to:
  • Standardize processes and protocols
  • Break down siloes and prioritize improvement efforts
  • Include Equity as a foundational building block of all QI/PI efforts
  • Improve data availability/visibility
  • Standardize stakeholder analysis process

• Additional Retreats:
  • Falls & HAPI – 11/29/2023
  • HAIs – 1/29/2024
Conclusion

Needs for Success

• Protected Time for Leaders and Front-line staff to engage in performance improvement
• Leaders to communicate TNM Priority, Progress and results to front line staff and clinicians
• Incorporate Patient Voice into Performance Improvement
• Resources to support educational needs associated with PI Implementations
Patient Safety Annual Report (estimated 20 min)
AHS Board of Trustees
QPSC – October 25, 2023

Patient Safety Performance Report
Fiscal Year 2023

Presenter’s Name
Darshan Grewal, MPH, MBA, BSN, CPHQ, CPHRM, CPPS, LSSBB
System’s Director of Patient Safety
Master Certified in Just Culture
Measuring Organizational Risk and Patient Harm

Section 1
Measuring Harm for Past Five Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Count</th>
<th>Total Acuity</th>
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<tbody>
<tr>
<td>FY18</td>
<td>426</td>
<td></td>
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<tr>
<td>FY19</td>
<td>289</td>
<td></td>
</tr>
<tr>
<td>FY20</td>
<td>174</td>
<td></td>
</tr>
<tr>
<td>FY21</td>
<td>142</td>
<td></td>
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<tr>
<td>FY22</td>
<td>186</td>
<td></td>
</tr>
<tr>
<td>FY23</td>
<td>154</td>
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</table>

Harm Acuity Scale
1=E; 2=F; 3=G; 4=H; 5=I

Sum of Acuity Scale
AHS Performance with BETA Healthcare Group

AHS Closed Claim Counts for 2018 - 2023

- Less Claims

AHS Indemnity Costs for 2018-2023

- Less Claims Cost

AHS Indemnity & Defense Costs for 2018 - 2023

- Less Patient Harm
AHS CELEBRATION

JUST CULTURE & CULTURE OF SAFETY DOMAIN
RAPID EVENT RESPONSE & ANALYSIS
OB QUEST FOR ZERO TIER II
ED QUEST FOR ZERO TIER I

Enjoying the Rewards of our Hard Work
AHS Journey to Excellence

AHS Won the 2023 Inaugural BETA Jeopardy Game
Culture & Measurement
- Culture of Safety Survey, Debriefing, & Action Plans
- Just Culture Implemented

Rapid Event Response & Analysis
- Comprehensive Event Investigation and Analysis program utilizing the RCA process in a multi-disciplinary learning environment.
- Future Go-Team for Immediate Event Management

Communication & Transparency
- Timely & Empathetic Communication with Patient, Families, and Clinicians
- Begin Early Communication and Continuous Throughout the process

Care for the Caregiver
- Trained Peer Support Team accessible to involved clinicians
- Proactive and prevents burnout and resilience.

Early Resolutions
- Timely Intervention with patients and families
- Includes Financial and Non-Financial resolutions

FY 2022 Achieved. Ongoing Re-Validation Surveys Required
 FY 2023 Achieved. Ongoing Re-Validation Surveys Required
 Projected for FY 2024. Start C4C, Plus Two Re-Validation Surveys Required
 Projected for FY 2025. Plus, Three Re-Validation Surveys Required
 Projected for FY 2026. Plus, Four Re-Validation Surveys Required
The 2023 AHS Culture of Safety Innovation Award is being presented to the following departments for their innovative, creative and engaging efforts to improve Teamwork, Safety Climate & Burnout in their work settings.
Highest % Improvement from 2022 to 2023

- Alameda Hospital – Inpatient Pharmacy – 10%
- Ambulatory – Marina Specialty Staff – 17%
- Behavioral Health – JGPH Unit D – 17%
- Highland Hospital – Same Day Surgery – 16%
- Physicians & APPs – SLH Internal Medicine & AHS Gastroenterology
- Post-Acute – Leadership Team – 36%
- San Leandro Hospital – Respiratory Therapy – 22%
- Systemwide Services – Quality Outcomes – 20%
2023 Action Plans Focused on Improving Teamwork, Safety Culture, & Burnout

Alameda Hospital – OR/PACU/SDS
Ambulatory – Bridge Clinic
Behavioral Health – PES
Highland Hospital – Staffing and OR
Physician & APPs – HGH Dental, OMFS, & HGH Internal Medicine
San Leandro Hospital – Clinical Lab
Systemwide Services – IS – Desktop Support, HR OLE & PACE
Patient Relations
Complaints & Grievances

Section 2
Patient Relations Event Volume

FY2021: 1238
FY2022: 1554
FY2023: 2071

Increase: 33%
Acute Care
(Alameda, Highland, San Leandro)

Wellness Centers - Clinics
(Eastmont, Hayward, Highland, & Newark)
Top Three Patient Relations Events - Location

**Acute Care**

(Alameda, Highland, San Leandro)

- Quality of Care: 289 (FY2021), 482 (FY2022), 638 (FY2023)
- Access: 223 (FY2021), 252 (FY2022), 380 (FY2023)
- Staff Professionalism: 250 (FY2021), 291 (FY2022), 277 (FY2023)

- Increase: 32% (FY2023 vs. FY2021)
- Increase: 51% (FY2023 vs. FY2021)

**Clinics**

(Eastmont, Hayward, Highland, & Newark)

- Access: 100 (FY2021), 129 (FY2022), 229 (FY2023)
- Quality of Care: 54 (FY2021), 117 (FY2022), 220 (FY2023)
- Staff Professionalism: 41 (FY2021), 38 (FY2022), 50 (FY2023)

- Increase: 78% (FY2023 vs. FY2021)
- Increase: 88% (FY2023 vs. FY2021)
Patient Relations – Quality of Care

- Quality of Care: Physician
  - FY2022: 107
  - FY2023: 175
  - Increase: 64%

- Quality of Care: Other
  - FY2022: 83
  - FY2023: 166
  - Increase: 100%

- Communication: Not listening to patients, dismissive
  - FY2022: 96
  - FY2023: 126
  - Increase: 31%

- Communication: Inadequate explanation, delayed or absent with patient/family
  - FY2022: 108
  - FY2023: 108
  - Increase: 0%

- Quality of Care: Disagreement with plan of care
  - FY2022: 67
  - FY2023: 91
  - Increase: 36%
Risk Events
Risk Events by Fiscal Year and Significance

<table>
<thead>
<tr>
<th>Year</th>
<th>Count of Risk Events</th>
<th>No Harm (A-D Significance)</th>
<th>Harm (E-I Significance)</th>
<th>% of Harm Events</th>
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<tbody>
<tr>
<td>FY2021</td>
<td>5721</td>
<td>162</td>
<td>2.75%</td>
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<tr>
<td>FY2022</td>
<td>5675</td>
<td>191</td>
<td>3.26%</td>
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<tr>
<td>FY2023</td>
<td>5439</td>
<td>155</td>
<td>2.77%</td>
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</table>
Top 5 Safety Alert Classes FY2023

- Patient Behavior: FY2021 = 1195, FY2022 = 1245, FY2023 = 1376 (10% increase)
- Medication / Other Substance: FY2021 = 1270, FY2022 = 1255, FY2023 = 1153 (8% decrease)
- Treatment / Test / Non-Surgical Procedures: FY2021 = 706, FY2022 = 868, FY2023 = 744 (14% decrease)
- Staff/Provider Clinical Practice /Behavior: FY2021 = 830, FY2022 = 720, FY2023 = 764 (6% increase)
- Patient Fall: FY2021 = 553, FY2022 = 643, FY2023 = 663
Patient Behavior Events

Threats/WPV events between Patients and Staff rose by 24% in FY23

- PT BEH: Assault, Patient/Visitor to Staff: FY22 258, FY23 312 (21% increase)
- PT BEH: Against Medical Advice: FY22 133, FY23 228 (71% increase)
- PT BEH: Assault, Patient/Visitor to Patient/Visitor: FY22 110, FY23 141 (28% increase)
- PT BEH: Behavior, Verbal, Abusive, Threatening: FY22 108, FY23 142 (31% increase)
- PT BEH: Elopement: FY22 142, FY23 67
Facilities With Increasing Staff Behavior Events

Alameda Hospital

- ST BEH: Hospital Employee Issue, Nursing, Clinical Practice: 36, 59, 64%
- ST BEH: Hospital Employee Issue, Nursing, Behavior: 45, 175%
- ST BEH: Physician Issue, Clinical Practice: 20, 55%

San Leandro

- ST BEH: Hospital Employee Issue, Nursing, Behavior: 30, 175%, 30%
- ST BEH: Hospital Employee Issue, Nursing, Clinical Practice: 39, 37%
- ST BEH: Hospital Employee Issue, Non-Nursing, Behavior: 24, 33%
- ST BEH: Hospital Employee Issue, Non-Nursing, Clinical Practice: 30, 17%
- ST BEH: Physician Issue, Behavior: 17, 5%
- ST BEH: Hospital Employee Issue, Non-Nursing, Clinical Practice: 6, 7%
Facilities With Increasing Patient Behavior Events

Highland Hospital

John George Hospital

WPV/Threats between Patients and Staff increased 19% in FY2023

<table>
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<tr>
<th>Category</th>
<th>FY2022</th>
<th>FY2023</th>
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<tbody>
<tr>
<td>PT BEH: Against Medical Advice</td>
<td>78</td>
<td>132</td>
</tr>
<tr>
<td>PT BEH: Elopement</td>
<td>90</td>
<td>42</td>
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<tr>
<td>PT BEH: Assault, Patient/Visitor to Staff</td>
<td>56</td>
<td>58</td>
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<tr>
<td>PT BEH: Behavior, Verbal, Abusive, Threatening</td>
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<td>63</td>
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<tr>
<td>PT BEH: Behavior, Disruptive</td>
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<tr>
<th>Category</th>
<th>FY2022</th>
<th>FY2023</th>
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<tbody>
<tr>
<td>PT BEH: Assault, Patient/Visitor to Staff</td>
<td>146</td>
<td>215</td>
</tr>
<tr>
<td>PT BEH: Assault, Patient/Visitor to Patient/Visitor</td>
<td>94</td>
<td>129</td>
</tr>
<tr>
<td>PT BEH: Other Patient Initiated Behavior</td>
<td>44</td>
<td>77</td>
</tr>
<tr>
<td>PT BEH: Seclusion</td>
<td>57</td>
<td>31</td>
</tr>
<tr>
<td>PT BEH: Sexually Inappropriate Behavior</td>
<td>20</td>
<td>33</td>
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In Summary

Patient Relations – Access

- True North Metrics – Believe in the Best Initiative
- Ambulatory Care Focus

Risk Events – Patient Behavior Events

- Workplace Violence Workgroup
- WPV BETA Incentive Program available to AHS

Patient Relations – QOC

- True North Metrics – Believe in the Best Initiative
- Robust QRC and N-QRC Programs to address QOC
- Communication & Transparency Initiative

Patient Relations – Access
- True North Metrics – Believe in the Best Initiative
- Ambulatory Care Focus

Patient Relations – QOC
- True North Metrics – Believe in the Best Initiative
- Robust QRC and N-QRC Programs to address QOC
- Communication & Transparency Initiative
ADDENDUM ONE: ABCs of Communication
Agreements for Better Communications and Processes

**Prevailing Premise:** Effective organizational communication creates trust and supports business objectives.

1. Trustee responsibility includes overseeing effective operations in order to ensure accountability and effective delivery of care. The Board is the entity that is responsible for compliance with laws and policies. The Board must always act in a manner that supports the organizational mission and meets the needs of patients while ensuring the organization’s sustainability.

2. Individual Trustees have limited power. The source of trustee power comes from the Board as a whole (the majority); the same principle applies to trustee authority within committees. To ensure accountability and eliminate duplication, requests to staff for specific future action, reports etc., must come through formal consensus of the majority or formal motion. Staff responding to “individual” requests for data or documents can be accommodated only if the work required is limited and the information is readily available.

3. Trustees are expected to come to meetings prepared to participate and act if necessary. A Trustee who has a question about an agenda item should seek clarification with the appropriate staff prior to the Board meeting. When concerns remain after staff input, the trustee should advise the chair and staff that he/she may raise the issue in the public meeting.

4. If one Board member requests information about an issue that may be of concern to other board members, the CEO or staff will provide a timely response, sharing the query and the analysis with all members of the board. The Clerk of the Board is the “gatekeeper” for all communications; thus, she should be informed of communications going to and from the Board from staff or other agencies.

5. It is the responsibility of individual trustees to notify Clerk of the Board in the event of an anticipated absence at a meeting or scheduled event.

6. Within the first year of appointment, every Board member should have visited/toured at least 90%, if not all, the sites which formally fall with the AHS system.

7. Meetings dates for standing committees and Board Meetings, once set, should not be moved unless extreme emergency. Should such emergency occur, changes go to the Clerk of the Board who distributes to all Trustees.

8. It will be the responsibility of the Board Chair to conduct a time efficient and effective public meeting where respectful discourse can occur without personal attack and disrespect.
9. All items from staff to be included on/in Board agenda or packet must be in the hands of the clerk and submitted by the specified time or they cannot be included. Addendums should not be posted after formal agenda is posted.

10. Service and program changes that may be expected to have a patient and/or staff impact should always be brought to the board for review and approval. Service expansions, additions and reductions, and new or revised provider contracts should also be vetted with the board of trustees.

11. Staff should always provide the most timely information in the initial agenda packet and avoid supplemental materials distributed at the meeting whenever possible. When updated materials are necessary due to changing environmental conditions staff should include narrative explaining any changes from original documents.

12. A Board tracking system and action calendar will be developed and will become a formal part of each Board agenda.

13. A common template for all information supporting agenda items will be consistently used. A template for “committee reports” should also follow a common format so all reports have same or similar elements. Reports for action by trustees should always include certain details as determined by the board depending on environmental conditions. Such considerations should include financial impact, safety, staffing and alternative options.

14. Committee reports should be drafted by the committee chair or other trustee committee member with input from staff. Written committee reports will appear in the agenda packet under committee reports.

15. The AHS CEO should identify which staff have permission to contact trustees directly regarding AHS business. Staff should go through CEO before contacting individual BOT members; and notify CEO after communication.

16. Timeline / tracking system for significant Board reports should be developed so public and Board knows when to expect such report. Committee work plans and timelines should be driven by Board Meeting timelines and dates, not the reverse.

17. The CEO must commit to and produce weekly updates highlighting issues and progress throughout the system.

18. Staff working with AC Supervisors should immediately report contacts to CEO and Trustees (Friday updates good place for inclusion). Communications between AHS and Alameda County staff is welcomed, and staff should ensure that significant requests for information from the Board of Supervisors is always approved by the Board or, in some cases the Board Chair, before submission to supervisors. The information sharing is critical whenever staff is responding to requests from the BOS Health Committee.
ADDENDUM TWO: Committee Charter
Appendix J

QUALITY AND PROFESSIONAL SERVICES COMMITTEE CHARTER

1. Membership.

1.1. Trustees. The Quality and Professional Services Committee (“QPSC”) will be comprised of not fewer than three (3) Trustees and the Chiefs of Staff from each of the Medical Staffs (nonvoting members).

1.2. Staff Liaison. Chief Executive Officer (or his/her designee)

2. Meetings.

The Committee shall meet once each month. Meetings of QPSC are subject to the agenda/notice requirements of the Brown Act.

3. Purpose/Goals/Responsibilities

3.1. Purpose. QPSC is established to provide oversight and leadership for medical staff credentialing, review of organizational policies, and monitoring of organizational, quality assurance, performance improvement, and safety programs. QPSC is charged with continuing the practice of direct communication with medical staff leaders on issues of clinical operations and patient care.

3.2. Delegated Authority – Credentialing. The Board of Trustees has delegated authority to QPSC to act on behalf of the full Board of Trustees on matters related to approving credentials recommended by each of the medical staffs.

3.2.1. The Board of Trustees delegation of authority to QPSC related to credentialing is unrestricted except as it relates to certain credentialing decisions discussed below (section 3.2.3 below).

3.2.2. Following a positive recommendation from the applicable Medical Staff Executive Committee (MEC) on an application, QPSC may grant the privileges identified by the MEC. QPSC shall review and evaluate the qualifications and competencies of the practitioner applying for appointment, reappointment or renewal, or modification of clinical privileges and render its decision. A positive decision by QPSC shall result in the status or privileges requested.

3.2.3. An applicant is ineligible for the credentialing process above and requires consideration of the full Board of Trustees if at the time of appointment or since the time of reappointment, any of the following has occurred:

3.2.3.1. There is a current challenge or previously successful challenge to licensure or registration.

3.2.3.2. The applicant has received an involuntary termination of Medical Staff membership at another organization.

3.2.3.3. The applicant has received involuntary limitation, reduction, denial, or loss
of clinical privileges.

3.2.3.4. There has been a final judgment adverse to the applicant in a professional liability action which in the opinion of the MEC represents a significant clinical departure from accepted standards of practice.

3.2.3.5. QPSC is not recommending that privileges be granted to the applicant.

3.3. Delegated Authority – Policies and Procedures. The Board of Trustees has delegated authority to QPSC to act on behalf of the full Board of Trustees on matters related to approving policies and procedures that have been approved and recommended by the appropriate medical staff.

3.3.1. All actions of QPSC taken pursuant to this delegation by the Board of Trustees shall be forwarded to the Board of Trustees for ratification on a regular basis.

3.4. Other Responsibilities. QPSC shall receive reports and make recommendations to the Board on matters related to any of the following in conjunction with the Board’s safety and quality of patient care responsibilities:

3.4.1. Organizational quality assurance report and quality related reports related to Medical Staff and AHS organizational performance including departmental quality assurance reports, mortality and morbidity rates, significant adverse drug reactions, medication errors, transfusion reactions, and infection rates;

3.4.2. Patient satisfaction;

3.4.3. Medical Staff monitoring and special committee reports, and results of performance improvement team activities;

3.4.4. Other reports related to patient care and safety including safety committee reports, assessments of the buildings and grounds (at least annually);

3.4.5. Reports related to the adequacy of access to all services;

3.4.6. Risk management reports of all unusual occurrences and significant potential and actual liabilities;

3.4.7. Staff competency reports of all unusual occurrences and significant potential and actual liabilities;

3.4.8. AHS performance improvement plan (at least annually);

3.4.9. Survey and regulatory reports, including Department of Health Services;

3.4.10. Licensure and certification reports;

3.4.11. Sentinel events or near-miss sentinel events and analysis thereof;

3.4.12. Corrective action plans in response to survey or regulatory reports, complaints and sentinel events, including review of all plans of correction to regulatory reports;

3.4.13. Medical Staff peer review and performance improvement activities;

3.4.14. Reports related to adequacy of house staff supervision;

3.4.15. Additions or modifications to Medical Staff Bylaws and Rules and Regulations; and

3.4.16. Additions or modifications to the Medical Staff and organizational clinical policies and procedures.

4. Reporting to Full Board

QPSC will report (written report) to the full Board at the next Board meeting following the meeting of the Committee.