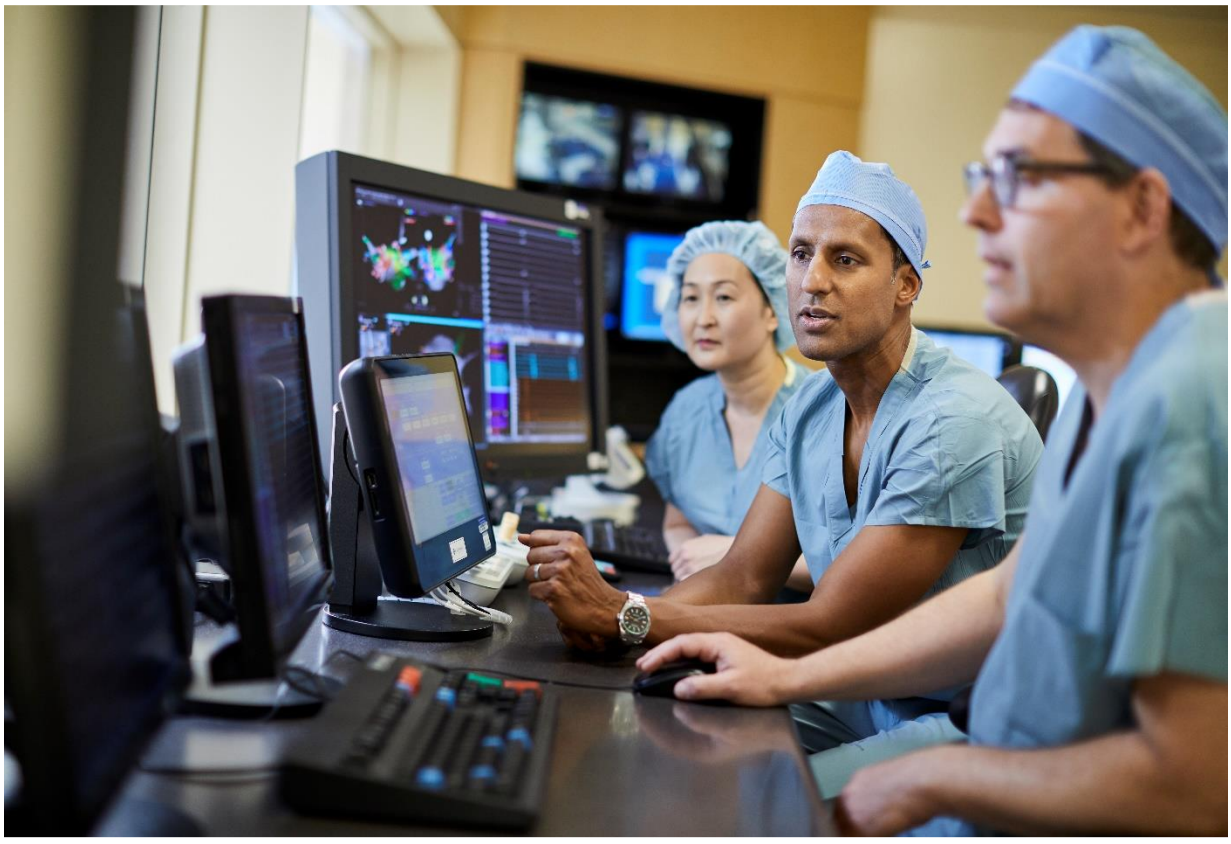
High Census Playbook



Northern California High Census Action Plan

2023 – 2024

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**Highlighted sections have been updated in 2023*

Preface

Northern California High Census Action Plan

2023 - 2024

High Census Planning Workstreams

	Workstream	Summary
Pre-Hospital	**Appointment & Advice Call Center (AACC)**	▪ Flu Taskforce to monitor efficiency/effectiveness of AACC resources in place
	Outpatient Primary Care: Adult Family Medicine (AFM)	▪ Release additional appointments if influenza demand exceeds predictions by 10% (RASE program)
	Outpatient Primary Care: Pediatrics	▪ Release additional appointments if influenza demand exceeds predictions by 10% (RASE program)
	Outpatient Pharmacy	▪ Flex staff and leverage Consolidated Prescription Processing (CPP) Pharmacy and Pharmacy Call Center (PCC)
	Outpatient Vaccination	▪ Monitor and share weekly/monthly vaccination performance report by medical center
	Infusion Centers	▪ Ensure sufficient access to infusion center to avoid unnecessary ED visits
Peri-Hospital	**Emergency Department (ED)**	▪ Augment with traveler RNs, flex staff to meet demand with OT and extra shifts
	Administrator on Call (AOC)	▪ Develop schedule and confirm competencies for all KFH AOC leaders (CNO / COO / AM)
	National Emergency Department Overcrowding Score (NEDOCS)	▪ Update and implement NEDOCS plan by Nov 15th of the year ▪ Ongoing updates by medical centers
	Command Center Activation	▪ Activate regional and local command center structures when standard triggers are met
	Communication Channels	▪ Ensure communication channels within (intra) facilities, between (inter) facilities, between facilities and region, and within region

Alternative Care Areas	▪ Developing triggers for opening alternative care areas with detail on regulatory considerations, quality oversight, and care experience
Tele-Critical Care	▪ Currently live at 12 medical centers, with plans to roll out to remaining medical centers. ▪ Recommend close collaboration and partnership among ICU Chief, Medical Director, Nurse Manager and HBS Chief to anticipate overnight needs which can be addressed during the day (i.e., routine labs)
Hospital Model of Care (HMOC) ▪ **Patient Care Coordination** ▪ **Social Services**	▪ Allocate Resource Management teams to maximize Patient Care Coordinators and Social Workers to highly impacted areas
Care Experience	▪ Implement training to support high census preparation, service recovery, and traveler/campus support ▪ Consider care for patient caregivers and ED boarders rounding plan
Hospital Quality & Patient Safety	▪ Consider ways to maintain patient safety and high-quality care as priorities during high census periods
Risk Management	▪ Utilize Electronic Responsible Reporting Form (eRRF) process to capture risk events that are related to surges
Patient Care Services	▪ Order contingent traveler RNs and PCTs (leverage regional forecasting tools) ▪ Order contingent staff
Surgery Optimization	▪ Reduce backlogs as much as possible when capacity allows ▪ Plan for continuation of access to OR for emergent, cancer, two-week "semi-urgent" cases and previously postponed patients in that order
Inpatient Pharmacy	▪ Flex staff to meet high census demand, increase centralized inpatient order verification process, and prioritize assistance with efficient hospital throughput for discharging patients

	Inpatient Rehabilitation	▪ Revise scheduling for additional coverage, extend hours if possible, and streamline discharge workflows
	Mental Health	▪ First step escalation in cases of increased volume of Behavioral Health patients is to the Regional Psychiatric Call Center
	Labs	▪ Implement rapid influenza ▪ Flex staff to meet demand w/ OT and extra shifts
	Medical Imaging	▪ Ensure appropriate staffing by current staffing models to provide mobile equipment to meet demand and utilize staffing partners to close staffing gaps
	Equipment & Supply Plans	▪ Assess anticipated equipment/supply needs and determine trigger for additional ordering, track available supplies to detect rapid consumption, and establish contingency plan for limited primary sources of supply
	EVS & Support Services	▪ Ensure EVS per diem pools are sufficient ▪ Ensure plan for reallocating staff from outpatient to inpatient setting when capacity constrained.
	Launch of Medical Center Influenza Testing	▪ Medical center labs can perform patient influenza testing locally
	Inpatient Pediatrics	▪ Utilization of 5% Flex Beds ▪ Consider admission of 14–17-year-olds to adult inpatient beds ▪ Utilize expanded Pediatric Area in ED with increased staffing
	Labor/Delivery & Obstetrics	▪ *New* LD High Census and Capacity Management Plan
	Respiratory Syncytial Virus (RSV)	▪ Work with Outpatient Teams to decompress ED/Hospital census ▪ Ensure equipment and supplies can meet the needs of RSV patients ▪ Assess nursing staff capacity to meet demand

Post-Hospital	Continuum	**Acute Rehab**	▪ 5 additional beds now live at KFRC (VAL) as of July 2023. ▪ Two 50-bed facilities in Sacramento area, and one 50-bed facility in Stockton to provide additional overflow access in September 2023
		Continuing Care Advice Program (CCAP)	▪ Assess incoming call volume daily. Flex staffing levels based on call volume according to union rules ▪ Collaborate with SNF, Hospice, and DME leaders
		Durable Medical Equipment (DME)	▪ Flex staffing based on volume and continue with use of temporary staff
		Extended Length of Stay (ELOS) Management	▪ Ensure ELOS standard work, as outlined in the HMOC, is being completed and monitor processes Encourage timely escalations for barriers.
		Medical Transportation	▪ Evaluate utilization with demand analysis and baseline planning for transportation demand surge ▪ Monitor timeliness standards
		Outside Services: EPRP / OURS	▪ Ensure all House Sups and AOCs are trained on escalation process
		Skilled Nursing Facility	▪ Ensure close collaboration with Continuum Administrator and Regional Complex Patient Hub for network adequacy. ▪ Ensure standard escalation process to ensure timely patient placements.
		Home Health & Hospice	▪ Evaluate and maximize internal and divert capacity

Tools & Technology	**Average Daily & COVID-19 (ADC) Census Report**	▪ Daily information on Average Daily Census performance for all KP regions with hospitals
	Census Planning Tool	▪ Predicts average daily census 6 months into future using past activity and membership grown projections, at facility level data
	Hospital Throughput Tool	▪ Provides line of sight of patient flow performance and includes tool that defines areas for patient flow opportunity
	OWL Mobile Application	▪ Shows current state of total hospital and drill down to view patient detail (no PHI)
	Hospital Throughput Monitor (HTM)	▪ Shows near real-time capacity across all facilities to enable patient placement and planning at the region or facility level
	Hospital Throughput Simulation (HTS)	▪ Tool to plan out scenarios based on levers update to identify bottle necks, latency, and deadlocks

What is the NCAL High Census Action Plan?

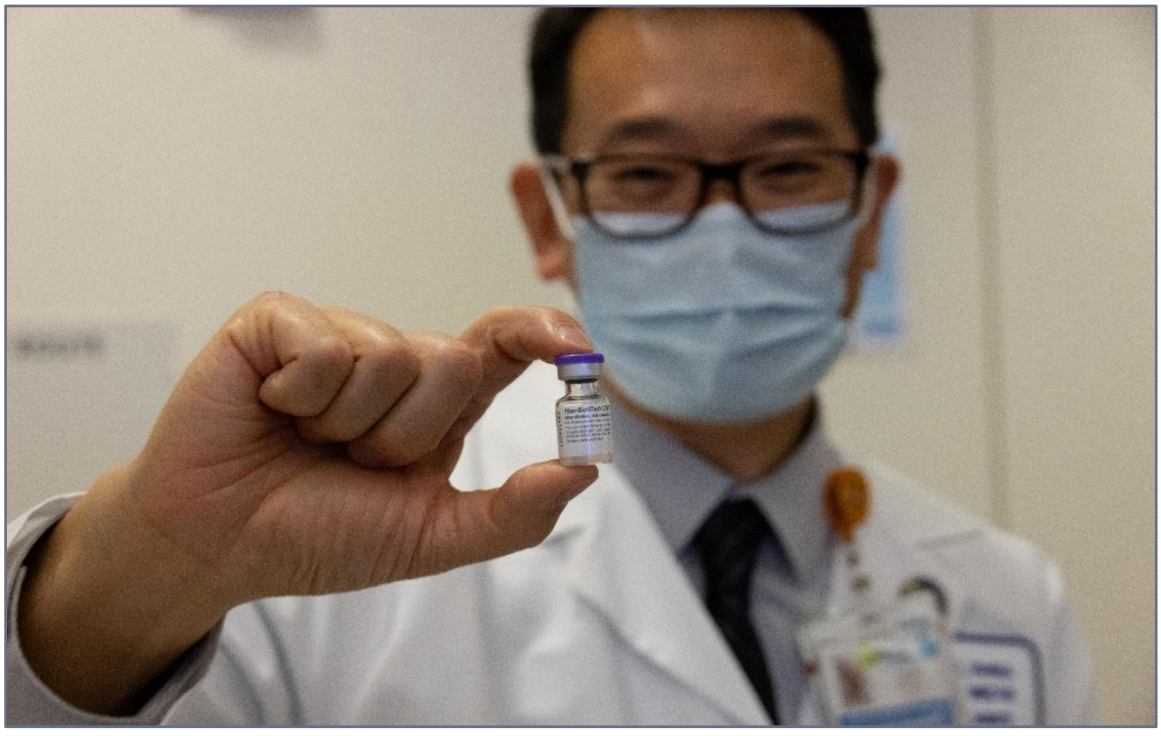
Overview

Continual readiness for high census volume ensures that our members have access to the right care, at the right time, in the right venue. To support this aim, the high census planning work group will continue to engage with our local ED and Hospital leaders, and regional leaders to ensure successful implementation of the plan. Our aim is to continue to update the NCAL High Census Action Plan (our regional playbook), through our collaborative effort, and share best practices.

Background

The NCAL High Census Action Plan was created because KP Hospitals, including Emergency Departments, have been experiencing historically unprecedented high census along with the recent COVID-19 pandemic beginning in 2021. Historical influenza seasons and the COVID-19 pandemic are a reminder of how important ongoing preparedness is to ensure that systems can rapidly adjust to spikes in ED visit volume and increased average daily census that puts unexpected stress on our system.

As a result of ongoing high census challenges and predictive analytics, an interdisciplinary regional team worked to collaboratively develop the NCAL High Census Action Plan for ongoing high census readiness. This regional playbook is the compilation of their work and findings and will be continually reviewed and updated as needed.



Acknowledgements

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High Census Planning Best Practices

High Census Best Practices	
Teamwork & Communication	▪ **Data sharing and transparency** among leaders / facilities for alignment ▪ **Robust team communication** (i.e., Throughput Chat via Teams, NEDOCS, text threads, etc.) for prompt escalation and barrier removal for care delays/discharges/ED boarding
Collaboration	▪ **Strong intra-facility collaboration** of local medical center leaders ▪ **Strong TPMG/KFH collaboration** (i.e., "Care Without Walls") ▪ **Sub-regional partnership** is crucial for success; paired hospitals act as one
Leadership	▪ KFH/TPMG Leaders rounding together in the ED and Hospital ▪ **Frequent, standard daily touch points (increasing as needed)** with a focus on census / ED patient flow
Proactive Early Assessment & Planning	▪ **Shift from reactive to proactive culture** ▪ Local flu planning / clinic ▪ Proactive staffing (i.e., IP/ED travelers, vacation/holiday coverage) ▪ **Anticipation planning of supply and demand** (i.e., staff, staffed bed / physical bed capacity, time, space, supplies, etc.)
Patient Flow & Throughput	▪ Low acuity triage / treatment tents ▪ Pediatricians stationed in ED for pediatric patients ▪ **Reviewing avoidable minutes** vs. avoidable hours / days ▪ **Admission assessment on boarders** to determine alternative to admission ▪ **Telemetry optimization** ▪ **Effective utilization of CDA** ▪ Implementation of transfer center in 2023. ▪ **Adherence to HMOC principles** ▪ **Ensure timely availability of ancillary services** (i.e., lab, imaging, interventional services, physical therapy, echocardiogram, PICC placement providers, wound nurses, etc.) ▪ Ensure planning meetings and updates occur at quarterly minimum for operational leaders and department managers / directors to review flex plans for provision of ancillary services in high census.

Capacity	▪ **Planning for overflow capacity** (i.e., effective utilization of expanded care areas, z-beds, etc.) ▪ CDPH authorized *Discharge Lounge*

Tools	▪ **Effective utilization of technology** tools (i.e., Predictive Analytic Tool, NEDOCS, OWL, Census Planning Tool, etc.)
	  ▪ Plan staffing based on predictive analytics
	  ▪ Use Hospital Throughput Monitor and Dashboard

High Census Planning Checklist: Recommended Actions

High Census Management Checklist ** We recommend all hospital leaders review this checklist at a regular cadence to ensure a state of consistent readiness. This checklist may be used virtually or may be printed.*	
Secure PCS traveler staffing order verification ☐	▪ Review Regional PCS projected traveler demand tool and confirm traveler shifts and specialties. ▪ Regional Offices will bulk-upload requisitions on behalf of the Medical Centers.
Ensure proactive, optimal vacation and surge planning ☐	▪ Ensure adequate staffing for physicians, ancillary departments (i.e., lab, echo tech, imaging tech, physical therapy, wound nurses, PICC nurses, etc.)
Confirm EVS per diem pools are sufficient ☐	▪ The EVS Director and Support Service Administrator ensure EVS per diem pools are sufficient to cover demand during high surge months.
Ensure EVS able to reallocate staff from Outpatient to Inpatient, if needed ☐	▪ EVS Director to ensure and confirm medical center plan in place to reallocate staff from the Outpatient to Inpatient setting when capacity is constrained. ▪ This plan should be stress-tested and staff cross-trained to ensure the viability of the plan and staff competency.

Check bed supply and perform any necessary bed maintenance.

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- Director of Engineering and Support Services Administrator to ensure and confirm bed maintenance up to date and the availability of a full complement of beds.
- All available bed supply should be deployed or ready for deployment.
    - Engineering and Clin Tech to ensure broken beds and other equipment are repaired expeditiously.
- Leaders to ensure adequate supply of operational beds as part of overflow capacity plan.

High Census Response Plan

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- Adopt the Activation Triggers and Communications Protocol documents into Emergency Operations Plan.
- Ensure Emergency Operations Plan is reviewed annually and as needed.
- Perform tabletop exercises to prepare for high census.
- Ensure medical center's High-Census Response Plan is up-to-date and well socialized.
- Confirm ED High-Census Response Plan is aligned with the five standard overcrowding levels below:

Standard NEDOCS Ranges	Normal Operations	Busy	Overcrowded	Severely Overcrowded	Critically Overcrowded
	0 – 50	51 - 100	101 - 140	141 - 180	>180

In situations where NEDOCS is minimally effective (i.e., long periods of red or black), deploy alternative plans (including but not limited to Teams communication in real time and alternative technology*) for escalating and resolving barriers to improve patient flow.

**High Census Planning Committee to explore options for increased leverage of technology*

Confirm scheduling to ensure the following roles are ALWAYS in place, especially during weekends and holidays* ☐	▪ Leverage technology to ensure call schedules are transparent and accessible
	  ▪ Administrator on Call (AOC) for KFH and TPMG
	  ▪ PCS Director on Call (DOC)
	  ▪ House Supervisors
	
	**Should be accompanied by adequate operational leadership presence*

Check equipment / supplies and ensure processes are in place to meet demand during high census surge ☐	▪ Assess anticipated equipment and supply needs. Determine a trigger point for ordering extra resources. ▪ Check the availability of consumable and durable supplies. ▪ Supply Chain Manager and SSA evaluate the existing supply tracking system to ensure it detects rapid consumption and responds to surge in requests. ▪ Establish a contingency plan for situations in which primary sources of supplies become limited.

Minimize the impact of surgeries on inpatient bed demand during high census ☐	**We recommend the following actions:** ▪ Continue working to reduce backlogs when capacity allows. ▪ Maintain path to OR for emergencies, Cancer patients, and/or two-week "semi-urgent" surgical needs, with dedicated rooms if necessary. ▪ Shift to fill elective schedules with outpatients if inpatient census is full*. ▪ Refocus on inpatient cases when hospital census allows. ▪ Continue to promote Surgical Home Recovery for eligible patients. ▪ Review operating room (OR) schedules to help smooth flow during peak times. ▪ Minimize the number of postponements as possible*, considering disease progression may occur with unusually long delays. ▪ Repurpose peri-op spaces, staff, and supplies as a last resort for surge to avoid backlogs that may result from elective postponements. **Any consideration of surgery postponement should be discussed first with local leaders (OR/Surgery APIC, PIC, Area Manager, MGA) and regional leaders (Surgery AED, Regional Physician Lead OR Operations).*

Ensure all leaders are trained on and familiar with key workflows
 	
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	▪ There are key workflows and protocols of which local leaders must be aware and fully understand- leadership includes but is not limited to:
	  ▪ Area Manager
	  ▪ COO
	  ▪ CNE
	  ▪ Continuum Administrator
	  ▪ PIC
	  ▪ APIC for Hospital Operations
	  ▪ AMGA for Hospital Operations
	  ▪ ED Chief and Director
	  ▪ HBS Chief
	  ▪ RM Chief
	  ▪ All individuals who will serve as AOC, PCS Director on Call, and House Supervisor
	▪ Ensure all senior KFH and TPMG leaders are familiar and comfortable with the bulleted workflows below:
	  ▪ EPRP
	  ▪ Hospital Incident Command System (HICS)
	  ▪ Repatriations
	  ▪ KP Health Connect Hospital Dashboard
	  ▪ SNF Placement
	  ▪ KP Insight Hospital Throughput Monitor
	  ▪ Acute Rehab Referrals
	  ▪ Command Center Activation Triggers and Communications Protocol

Implement medical center-based influenza and COVID vaccination ☐	▪ Ensure influenza and COVID vaccination campaign for patients, physicians, and staff ▪ Monitor medical center influenza and COVID vaccination rate on a regular basis and adjust vaccination plan as needed

Ensure key communication channels are in place ☐	**Within (Intra) Facilities** ▪ Follow local guidelines around communication, as outlined in facility's Escalation / High Census Plan. ▪ Ensure broad awareness of facility NEDOCS and action plan in place (e.g., post NEDOCS score on intranet site front page, designate individual/role to send score notifications to key leaders). ▪ Include medical office leadership in local escalation plans (e.g., AMGA, site leaders, etc.). ▪ Conduct joint leadership rounding in ED and Hospital. ▪ Leverage KP Health Connect Hospital Dashboard. **Between (Inter) Facilities** ▪ Leverage Hospital Throughput Monitor and/or KP Health Connect Hospital Dashboard to understand current state at neighboring medical centers. ▪ Ensure strong and proactive intra-facility communication and collaboration among hospital leaders within neighboring facilities and geo-clusters. **Between Facilities and Region** ▪ Provide regional team with AOC schedule for high census months. ▪ Proactively reach out to regional team to escalate issues and/or request needed assistance. **Within Region** ▪ High Census Planning Committee and HOLT Sponsors to hold weekly high census planning committee check-in call to monitor and respond in real time to high census needs of medical centers during surge.

Pre-Hospital

Northern California High Census Action Plan

2023 - 2024

Appointment & Advice Call Center (AACC)

The Appointment and Advice Call Center (AACC) is responsible for TPMG Outpatient Primary Care/Adult Family Medicine (AFM) standard methodology for forecasting demand for Adult and Pediatric Primary Care. The AACC has historically anticipated a significant increase in upper respiratory symptom volume from November through the end of March, and then a secondary – but not as significant – increase in volume during allergy season through April and May. The AACC typically uses the last ten years of normalized data as an early predictor, while tracking current volume related to upper respiratory symptoms. In addition, as of the pandemic years, the forecasting model now includes potential COVID-19 surge activity. Influenza data surveillance is monitored first in the Southern Hemisphere to determine the strains of influenza, and if there is an adequate match for the vaccine. The focus areas for any increase in respiratory volume are as follows: forecasting, staffing, booking guidelines, script and protocol content, reporting, and training.

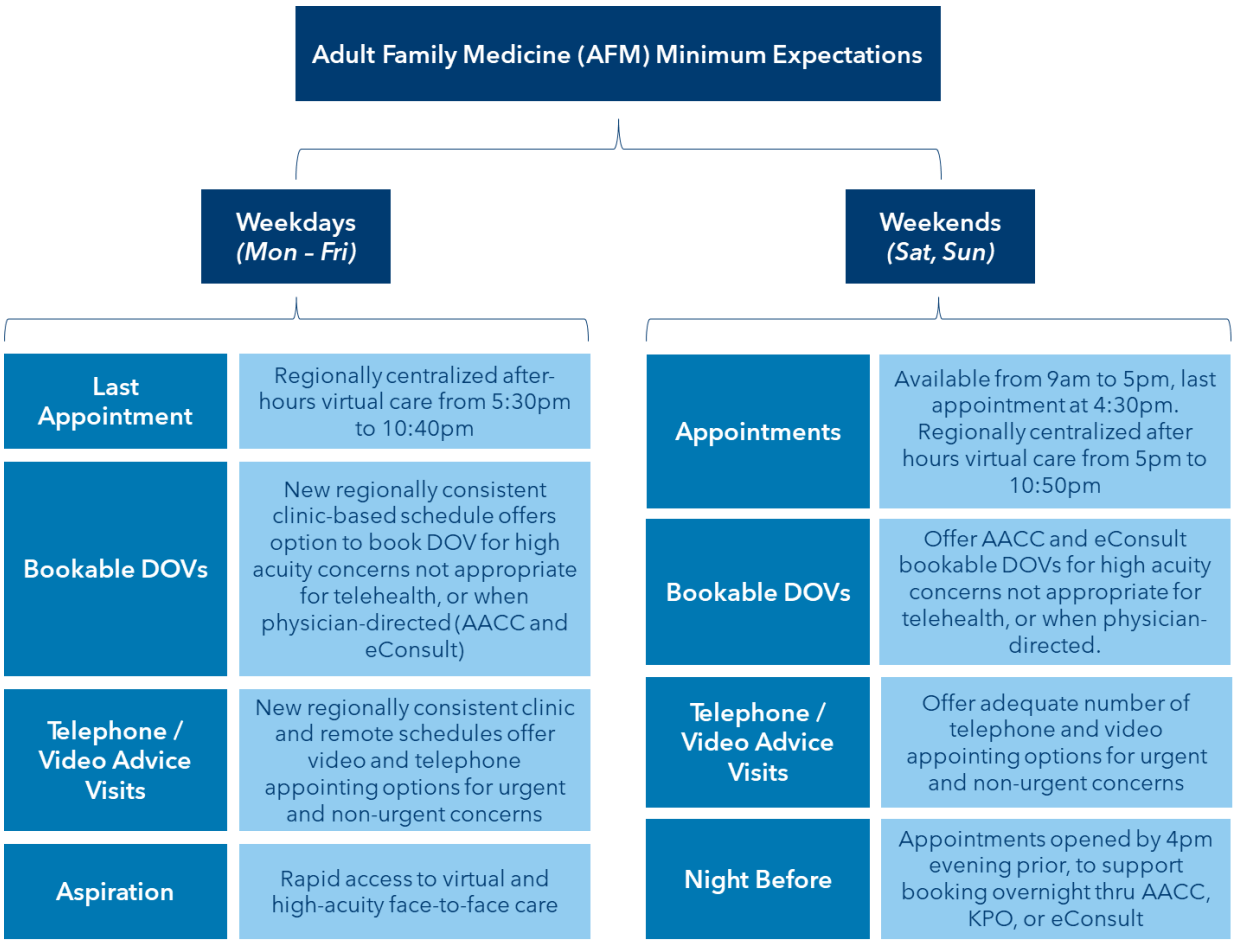
To allow for rapid response to higher-than-normal demand, NCAL has implemented a program with two key components:

- Tracking influenza, RSV, and COVID-19 demand closely for variation from average
- Creation of reserved appointment supply which can be made available if demand is above expectation.

Outpatient Primary Care – Adult Family Medicine (AFM)

Adult Family Medicine (AFM) focuses on the following during high census:

- **Promoting influenza vaccinations** using the My Panel Manager tool with a personalized message to supplement regional messaging.
- **Increasing appointment supply** using a regionally controlled process during high volume cold & flu surges: Cold & Flu Appointment Supply Escalation (CASE). **CASE** is a streamlined, regionally standard program implemented to improve the efficient implementation, monitoring, and execution of the high census plan.
    - In AFM, every physician has at least one additional appointment per half day session reserved.
- **Regionalizing after-hours care (weekday) to gain efficiencies** and bring more physician FTEs to core hours; expand and contract after hours care on weekends in response to fluctuations in demand.
- **Setting up local walk-in influenza clinics** where and when appropriate.
- **Develop E-visits** for algorithmic care to minimize appointment utilization.
- **Refine AACC booking sequences** to map concerns to the medically appropriate care options.

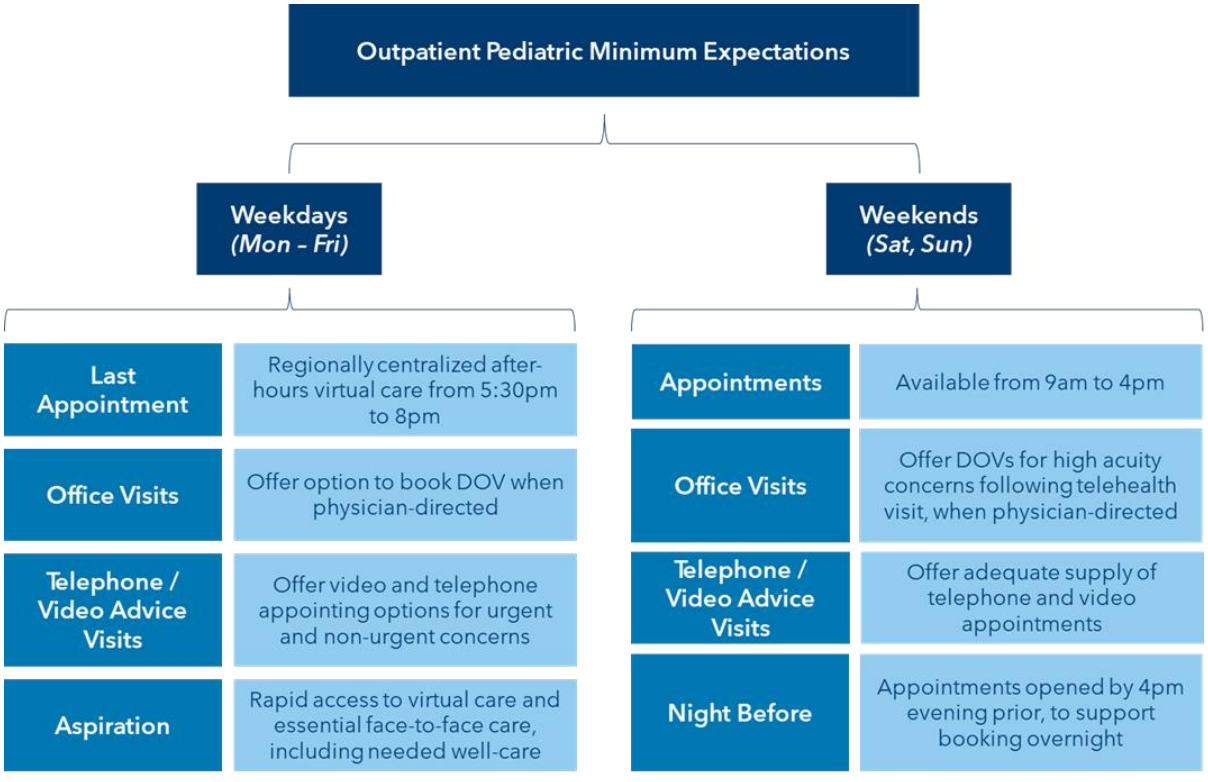


Outpatient Primary Care – Pediatric

Outpatient Pediatrics focuses on the following during high census:

- **Promoting influenza vaccinations** using the My Panel Manager tool with a personalized message to supplement regional messaging
- **Increasing appointment supply** using a regionally controlled process during high volume cold & flu surges: Cold & Flu Appointment Supply Escalation (CASE). **CASE** is a streamlined, regionally standard program implemented to improve the efficient implementation, monitoring, and execution of the high census plan.
    - In Pediatrics, every physician has two additional telephone appointments per unit reserved
        - If session is equal to unit, then there are 2 TAVs per session
        - If session is equal to day, then there are 4 TAVs per day
- **Regionalizing after-hours care (weekday) to gain efficiencies** and bring more physician FTEs to core hours; expanding and contracting after hours care on weekends in response to fluctuations in **demand.**
- **Setting up local walk-in influenza clinics where and when appropriate**

Additionally, Pediatrics has begun to implement Desktop Medicine, which allows doctors to address messages more quickly and efficiently. An initial pilot site was launched in late 2022, with continued roll out to full implementation by Fall 2023.



Outpatient Pharmacy

The Outpatient Pharmacy helps ensure that patients are provided discharge medications and that wait times are managed in the retail pharmacies.

Some key activities for Outpatient Pharmacy during high census include:

Flexing staff to meet increased demand

- Ask staff to flex-up and utilize short hours and on calls, as needed
- Cross train pharmacy teams for additional support

Manage utilization through proactive communications

- High Census specific communications – jointly shared by Pharmacy, KFH/HP, and TPMG leadership – encourage **employees** as Kaiser Permanente members, to utilize mail order pharmacy services. If employees must visit a pharmacy during high census, they are encouraged to visit outside peak hours and/or to use less frequented pharmacies on the same campus.
- Promotion of mail order services with **members** is emphasized starting in the late fall and with new members in onboarding communications.

Utilize Service Action Plans to address increased demand

- In anticipation of the higher volumes experienced during high census, both from influenza and new members, Outpatient Pharmacies develop Service Action Plans to address this increased demand on service. Actions include regular meetings with Service Area Leadership, leveraging pharmacy and non-pharmacy staff as lobby greeters, waiting line triage and management, refreshing staff on Customer Service and Recovery Training, Management Rounding, monitoring of and quick resolution to IT problems (ePIMS slowdowns, broken terminals/printers), revised scheduling to provide additional coverage during peak hours, streamlining discharge workflows and using Workstation-on-Wheels (WOW) carts to reduce wait times

Increase centralized Consolidated Prescription Processing (CPP) Pharmacy staffing capacity to meet demand

- The **Consolidated Prescription Processing (CPP) Pharmacy** is NCAL's centralized refill pharmacy and leverages large amounts of automation. Recent and upcoming technology improvements will provide increased efficiency and increased capacity to handle the surge in prescriptions. Additional shifts may be added to handle additional increases in prescription volume. On-call, part-time, and overtime may be utilized to handle the additional volume. With the added capacity of the CPP Pharmacy, more prescriptions may be shifted from the local

pharmacies to the CPP Pharmacy, which will allow the local pharmacies to focus on the prescriptions for patients in the waiting rooms

Leverage Pharmacy Call Center (PCC) staffing capacity to meet demand

- **The Pharmacy Call Center (PCC)** helps process medication orders for patients and transitions medications into the Kaiser pharmacy system for our new members. In collaboration with the Pharmacy Continuum, *the PCC* helps ensure patients are provided medication counseling after discharge from a Skilled Nursing Facility. Some key activities for Pharmacy Call Center include: new member onboarding, medication consultation, process Mail Order and local pharmacy pickup requests, responding to member questions regarding medication refill status, recalls, interactions, drug information, and transfer requests.
    - **Flex staff to meet increased demand.** Ask staff to flex-up and utilize short hours and on-calls, as needed.

Outpatient Vaccination

Regional Influenza physician lead and team proactively provides communication regarding the influenza vaccine, influenza clinics, and influenza arrival to key stakeholders. This team distributes the Influenza Activity Report on a weekly basis. The report includes information on the influenza vaccine, information from the lab on how and whom to test, AACC call volume for the cold/influenza script, and the most recent rates of lab confirmed cases of Influenza A, Influenza B and RSV by percent positives. Historically, 10% positive has been used to mark the beginning of the influenza season. Daily reporting is also maintained to show average ED visits and inpatient admissions related to influenza.

Key outpatient vaccination high census activities include:

- **Weekly/monthly performance report by medical center is sent out to wide distribution list**
- Robust regional outreach with ongoing PI changes based upon response rates by member subgroup
- In-reach display on PROMPT
- In-reach BPA banner in HC
- Mass influenza clinic vaccinations
- Regular virtual meetings to drive PI and share best practices
- Working with teams to ensure operations support co-vaccination with COVID-19 to the maximal extent possible

Infusion Centers

Infusion Center space is available after hours, weekends or holidays. Check with local Infusion Center leadership prior to implementation of high census workflow to confirm space availability. Space should be cleaned in accordance with infection prevention guidelines for immunocompromised patients at the conclusion of high census operation and prior to returning to daily infusion center operations. All supplies should be replaced at the conclusion of high census operations.

Local leadership should ensure sufficient access to infusion center to avoid unnecessary ED visits during high census.

Regional infusion center availability & capacity:

- 22 Infusion centers open Monday – Friday: typical hours of operations 8 am -6pm
  - One at each of 21 medical centers + Dublin location
- 12 Infusion centers open Saturdays, 8 am – 5pm
  - MOD, WCR, OAK, SLN, VAL, ROS, SRY, SCL, FRS, RWC, SJO, SRO
- 8 Infusion centers open on Sundays, 8 am – 5 pm
  - MOD, WCR, OAK, SLN, VAL, ROS, SRY, SCL

Peri-Hospital

Northern California High Census Action Plan

2023 - 2024

Emergency Department (ED)

Background

The ED is an important component of a Medical Center's Peak Census Policy, with smooth ED operations being critical during high census; the volume of patients boarding in the ED can significantly impact operational flexibility, resources, and, eventually, timeliness of care throughout the medical center. The objective of the high census management plan is to maintain continuity of patient care operations and meet the medical needs of our members and the community through effective management of patient surge. To do so requires that the safety and security of staff, physicians, and volunteers be the top priority in responding to a patient surge. The ED high census plan is an evolving document based on best practices and lessons learned.

The below summarizes key tactics in the ED to prepare for the high census.

Key Operational Tactics

Physicians and nurses collaborate to perform rapid decompression. Consider the following:

1. **Consider admissions that can have their consult assessment finished on the floor** (if inpatient beds available).
2. **Expedite resources or final pending tests for patients that can be safely discharged to home** with a follow up appointment.
3. **Discharge patients who can safely be moved to the waiting room, pending transport or final resources** (e.g., MSW consult/care coordination) until disposition is finalized. If any pending needs, clearly instruct patient to stay in waiting room until final arrangements made for transport/discharge.
4. **Review hallway bed protocol and ensure appropriate patients are moved** to/roomed in hallway beds when possible.
5. **Create additional virtual and physical capacity to meet demand**
    - To further support additional volumes during high census, the EDs have created additional capacity where able, leveraging virtual and nearby physical space within licensing requirements.
    - The ED leadership recognizes that the most limited ED resource is the physical ED bed in the department. Because of this, there is a goal to see as many patients vertically as possible. This means seeing stable patients (low and mid acuity) in a streamlined fashion on arrival to the ED. This provides safe and reliable care while preserving the ED bed for high acuity patients; this is especially critical in times when patients are boarded in the ED. During high census, these systems are optimized, and additional physician,

nurse, and tech staff are incorporated into the area. However, the ability to upstaff urgently is challenging in the current environment due to national and local staffing shortages

6. **Implement ED surge plan for times of high volume**
    - An ED surge plan for high census has been optimized in many ED's. This is done with either a standardized overcrowding score or with triggers such as ED census. This allows for a standardized approach for times of high volume and reduces ambiguity. In times of high utilization of resources, small reductions in service time can be high impact. These plans create service agreements prior to the time of surge so there are clear expectations and accountability for assistance.
7. **In counties where this is allowed, consider ambulance diversion as appropriate**
    Assess number of patients arriving by ambulance
    - Assess available resources in the ED, including critical care/code resource availability
    - During Ambulance Diversion ensure expedited patient flow, ED standard work processes, and coordinate with ancillary services to free additional resources in the ED by the time ambulance diversion expires.

Staffing Plan

NCAL Emergency Departments use the Emergency Severity Index (ESI) to triage patients and understand their resource and staffing needs in the ED. Historical and predictive data allow for ESI modeling by the hour and day of the week, which in turn is leveraged to develop a staffing model in accordance with Title 22 requirements.

Assess ED staffing and anticipate contingency needs

To prepare for high census volumes ED Directors assesses whether they will need to augment their employed nursing staff with traveler nurses to meet anticipated census surges. Contingent traveler nurses are ordered to support increased volumes during high census. This order may increase as census demands. In addition to supplementing with traveler nurses, the ED can flex staff to care for increased patient volumes through on-call employees and by offering extra shifts. Additionally, ED Directors anticipate vacancies, proactively hiring-up in advance to not be caught short staffed during busy times of the year. Physician staffing in the ED also flexes with demand, with plans in place to staff physicians for full demand (i.e., virtual/flex beds in addition to permanent bays).

Communication

Ensure communication and transitions between ED and hospital:

- During high census, communication between the ED and the hospital is critical with close communication as hospital plans are developed. This collaboration assures smooth patient flow and care.
- When hospital capacity is full and there are admitted boarded patients in the ED, they should be cared for by inpatient nursing when possible. If not possible, the ED directors will use predictive models to anticipate this and have adequate nursing coverage for all patients in the ED.

Administrator on Call (AOC)

The local medical center KFH and TPMG Administrators on Call (AOC) play a pivotal role in helping ensure continuity of hospital operations. Given the importance of these roles, it is paramount that all medical centers plan for AOC coverage during high census. To support the AOC in his/her role, medical centers should likewise plan for Patient Care Services (PCS) Director on Call and House Supervisor, with a particular focus on days with traditionally high vacancy rates, e.g., Thanksgiving weekend, Christmas Day, and New Year's Day. **We recommend from Thanksgiving Day through New Year's Day, the KFH AOC be a senior leader such as the Area Manager, Chief Operating Officer, or Chief Nursing Executive.**

Planning the AOC schedule now will illuminate potential gaps in coverage and/or training. To ensure that all individuals who will be serving as AOC are prepared for the role, confirm they have completed the AOC Competency Checklist. A best practice is to not have all junior staff covering the above-mentioned roles at the same time. At least two individuals should be experienced in their respective roles at any given time. Developing the calendar for AOC, PCS Director on Call, and House Supervisor now enables medical centers to train and develop anyone new to these roles in advance of high census.

National Emergency Department Overcrowding Score (NEDOCS)

As we continue to experience high census in our emergency departments and hospitals, it is important for us to closely examine our current NEDOCS (National Emergency Department Overcrowding Score) plans for continual readiness. NEDOCS is a warning system built to identify in real-time issues related to overcrowding in the ED and capacity in the hospital. This allows hospital leaders an opportunity to respond before the overcrowding reaches a crisis level. NEDOCS measurements for your specific medical center can be found on your hospital dashboard, Operations Watch List, and ED Dashboard in Health Connect.

The NEDOCS plan is an interdependent tool that assists us in identifying strategies to deploy during times of high census. This interdependent surge plan requires an interdisciplinary review, updating, and tabletop exercises between both the ED and hospital leaders to be ready for unexpected high census in our medical centers. Please ensure that each medical center has a clear actionable plan with levers and accountability to respond to the plan.

NEDOCS SCORING GRID:

Standard NEDOCS Ranges	Normal Operations	Busy	Overcrowded	Severely Overcrowded	Critically Overcrowded
	0 – 50	51 - 100	101 - 140	141 - 180	>180

For your reference, below are the links to a NEDOCS planner on One Drive, which contains a blank plan template, some examples of completed NEDOCS plan, a NEDOCS calculator, and a high-level scoring grid.

NEDOCS PLAN TEMPLATE: Link

NEDOCS CALCULATOR: Link

The NEDOCS score is available on your facility's "Hospital Dashboard," "ED Dashboard," and "Operations Watch List Dashboard" within KP Health Connect and the OWL mobile app. Individual alerts can be set for when the NEDOCs score exceeds a predefined threshold that the user can set. The team is working on enhanced functionality that will allow for multiple thresholds to be set for an individual metric to help create accountability and action plan. Refer to the Job Aid in the Appendix for further information.

Command Center Activation

Regional Command Center

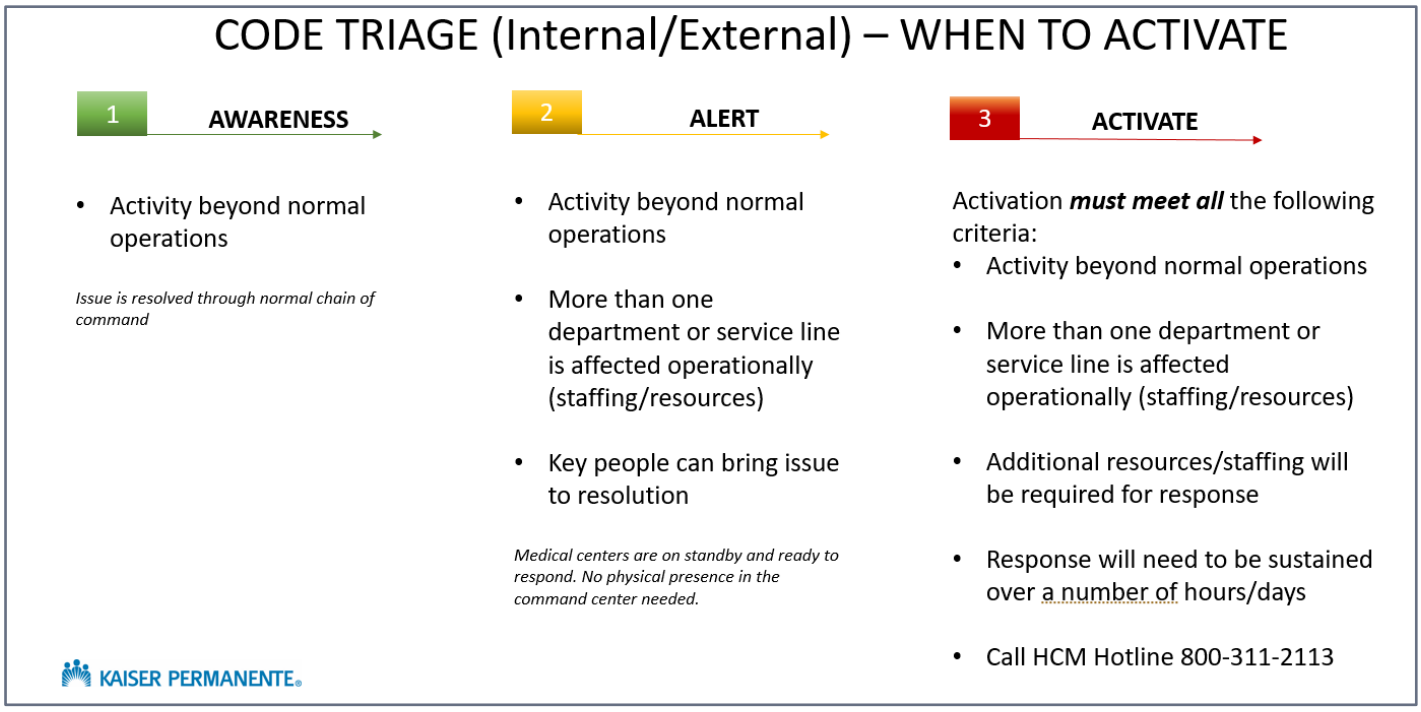
The NCAL Regional Command Center (RCC) will be activated when standard triggers are met. Please see the image below for specific triggers. The Incident Commander(s) will direct operations regionally and communicate guidance to facilities throughout the incident. KPIRS (WebEOC) can be used for facilities to transmit status information and requests directly to the RCC.

RCC communication processes will supersede the above recommendations regarding communication channels between facilities and Region for the duration of RCC activation.

Local Command Centers

Local Command Centers will be activated when standard triggers are met. The Incident Commander(s) will direct operations and communicate guidance to local leadership throughout the incident. KPIRS (eICS) can be used for medical centers to create incidents and communicate with staff.

Command Center communication processes will supersede the above recommendations regarding communication channels within and between facilities for the duration of Command Center activation.



Communication Channels

Within Facilities

- Follow local guidelines around communication, as outlined within your facility's Escalation / High Census Plan.
- Ensure broad awareness of facility NEDOCS overcrowding status (e.g., post NEDOCS score on intranet site front page, designate individual/role to send score notifications to key leaders)
- Include medical office leadership in local escalation plans (e.g., AMGA)
- Conduct joint leadership rounding with Chief Nursing Executive (CNE) and Chief Operating Officer (COO).
- Leverage KP Health Connect Hospital Dashboard

Between Facilities

- Leverage Hospital Throughput Monitor and/or KP Health Connect Hospital Dashboard to understand current state at neighboring medical centers to help reduce call volumes.

Between Facilities and Region

- Provide regional team with AOC schedule for high census months
- Proactively reach out to regional team to escalate issues and/or needed assistance when needed

Within Region

- High Census Planning Committee and HOLT Sponsors to hold weekly high census planning committee check-in call to monitor for high census needs of medical centers

Alternative Care Areas (Expanded Care Areas)

For additional information and resources related to *Alternative Care Areas*, please visit the KP NCAL Emergency Management SharePoint or download the KP NCAL ED & Inpatient Surge Playbook.

Space refers to where you will treat patients requiring hospitalization (including ED and critical care). This includes areas both within and outside of the ED/medical/telemetry/critical care units that can be modified to allow care for hospitalized patients. You should also be aware of adjacent areas (physically or functionally adjacent) that may have an impact on the flow into and out of the hospital such as triage areas that will be a frequent source of patient intake or congregate living facilities/rehab centers that may reach capacity and be unable to accept patients ready for hospital discharge.

Keep in mind that regulatory requirements may change over time. Engage with local Accreditation, Regulatory and Licensing (AR&L) to ensure medical center compliance.

Some general space concepts apply:

- Should be opened under the purview of the hospital command center
- Used when there is a significant risk to patient safety
  - Potential triggers: ED/outpatient visit volume, PCS staffing, Inpatient census, NEDOCS levels
  - Potential sites: hospital space (preferred), outpatient space, surge tents
  - Potential scope: ESI level 3/4/5: breathing treatments, IV fluids, anti-nausea and fever medications, inhalers, IM, or PO pain medication
  - Staffing: ED Tech, Nurse, ED physician. RN staffing ratios apply
- Maximize non-hospital space for low/medium acuity patients
  - Urgent Care for low acuity patients
  - Tent and Intermediate Care Areas for low to medium acuity patients
- Maximize existing hospital space for ED, MST, and ICU patients
  - Operating Room space (PACU, Operating Room, Pre-Op)
  - Intermediate Care Areas
  - Interventional Radiology, Cath Labs, CDA, Outpatient Procedure Space/Ambulatory Surgery Units that are contiguous with the hospital
  - Medical/Surgical hospital beds
  - MCH Mother Baby (MBU) Rooms, Pediatric Inpatient Units (for non-COVID-19, non-PUI care)
  - Other inpatient care areas

- Maximize existing hospital space for pediatric patients
    - Adult Medical/Surgical hospital beds for pediatric patients aged 14-17 years
- Expansion of Inpatient Clinical Care Areas for additional ED, MS/MST, and ICU Space
    - Double occupancy in single ED, Pediatric, MS/MST, ICU rooms
    - Hallway beds
- Conversion of Non-Clinical Care Areas to MS or MST Space
    - Visitors' Waiting Rooms
    - Conference Room Space, Dining Rooms/Cafeterias
    - Shelled space

TeleCritical Care (TCC)

TeleCritical Care is a population management approach to critical care leveraging remote monitoring and audio-visual communication; allowing a team of Critical Care Nurses and Intensivists from a remote center to support hospital ICUs during the hours of 8p-8a. TCC is currently live at 12 medical centers, with plans to roll out to remaining 9 medical centers by Q1 2024:

- VAC – Sep 12, 2023
- VAL – Late October, 2023
- WCR – Mid-November, 2023
- ANT – Early December, 2023
- RWC – January 2024
- SSF – February 2024
- SRO – February 2024
- SRF – March 2024
- SFO – March 2024

To best leverage the benefit of TeleCritical Care, the following are recommended:

- **Close collaboration and partnership** among ICU Chief, Medical Director, Nurse Manager, HBS Chief and RT to anticipate overnight needs which can be addressed during the day (i.e., routine labs and ventilator setting changes
- **Continued education for new hires and travelers / locums** (i.e., annual skills day, clinician orientation)
- **Frequent feedback to TCC program** regarding Care Experience, service and escalations of concerns and successes

Labor/Delivery & Obstetrics

Regional Maternal Child Health has developed a robust L&D / OB High Census Capacity and Management Plan, found here. The following actions are recommended to plan for L&D / OB high census:

- Utilize published reports and delivery projections to plan for increases and decreases in Labor & Delivery (L&D) census (See appendix for images of reports)
- Access the "Planned Delivery" report using the following link: kp.org/ncaldata
    - This report will provide data to support planning for census based on pregnancy encounters that have indicated an intent to deliver in a specific medical center. The data is a rolling 120 days (about 4 months)
- Access the OB Snapboard and Master Daily Schedule (PHYSICIANS) in KPHC to review scheduled procedures including inductions and C-sections daily. OB Telephone Advice calls advised to "come to L&D" should be scheduled on the OB Snapboard
    - Consider strategies to balance the procedural and surgical schedule to smooth the L&D census when appropriate
    - Move to a 6 or 7-day OR schedule to assist with smoothing the L&D OR schedule and postpartum OB unit census
- Access Hospital MCH Dashboard in KPHC to review a rolling 5-weeks of planned deliveries based on gestational age and intent to deliver at the hospital location

Inpatient Pediatrics

There are several mechanisms by which our KPNC facilities could be overwhelmed with pediatric patients. Planning assumptions should account for:

- Existing pediatric beds are limited and have a restricted ability to surge at any given point.
- Transfers of pediatric patients from non-pediatric centers to pediatric centers will have to be coordinated at the jurisdictional and regional level.

Following are some general strategies to increase inpatient pediatric capacity to accommodate for a surge in pediatric patients.

Utilization of 5% Flex Beds

Per CDPH guidelines, 5% of a medical center's licensed beds may be utilized in a "flex" manner to admit types of patients not normally admitted to that type of bed license, provided there are demonstrated staff competencies to provide care to the patient population flexed into that bed type. (i.e., admitting a pediatric patient into an adult med-surg licensed bed.)

Consider admission of 14–17-year-olds to adult inpatient beds

If pediatric bed capacity is reached and there is sufficient adult bed capacity and staffing to accommodate, consider moving adolescent patients (14-17 years old) from pediatric floors to adult inpatient floors (e.g., Medical/Surgical or Intensive Care Unit/Critical Care) to preserve pediatric beds.

- Maintain continued communication structure to Pediatrics Intensive Care Unit (PICU)
- Where possible, ensure a staffing model of Pediatric Hospital Based Specialist and Adult RN staffing to support pediatric patients
- Consider utilizing teleconsultation to round on pediatric patients when no Pediatric Hospital Based Specialist is on shift

Utilize expanded Pediatric Area in ED with increased staffing

Staffing strategies could include the following providers if not utilized elsewhere:

- Pediatric Clinic and Family Practice MDs
- ED/Fast Track/Urgent Care MDs
- Anesthesia MDs
- Surgery MDs

Consider Respiratory Therapy (RT) staffing strategies as respiratory pathogens are common in the pediatric population work with RT leaders to ensure each facility has a

plan to staff current and expansion units appropriately. ***If RT Staffing levels do not meet workload demands review the Regional RT Staffing Levers.***

Open Alternate Care Areas if criteria met. Work with Outpatient Teams to decompress ED/Hospital census.

- Consider how to extend outpatient access to meet demand of RSV patients
- Survey outpatient clinical space and appropriate equipment availability for outpatient treatment rooms
- Evaluate ability to schedule virtual appointments to allow for in-person visits for critically ill
- Build on existing workflows for asthmatic patients to apply towards RSV care delivery

KP NCAL Pediatric Inpatient, Labor and Delivery, and Neonatal/NICU Capability

- Tier 1: Hospitals with a PICU, Inpatient Pediatrics, L&D, NICU, Well-Baby Nursery
- Tier 2: Hospitals with Inpatient Pediatrics, L&D, NICU, Well-Baby Nursery
- Tier 3: Hospitals with L&D, NICU, Well-Baby Nursery
- Tier 4: Hospitals with no Pediatric or MCH care

Tier	Inpatient Pediatrics	Labor & Delivery?	Neonatal / Nursery
Pedi Tier 1 Oakland Roseville Santa Clara	Pediatric ICU; Pediatric M/S	Yes	*Level 3 NICU* Well-Baby Nursery
Pedi Tier 2 Modesto San Francisco Walnut Creek	Pediatric M/S	Yes	*Level 3 NICU* Well-Baby Nursery
Santa Rosa Vacaville	Pediatric M/S	Yes	*Level 2 NICU* Well-Baby Nursery
Pedi Tier 3 San Leandro	None	Yes	*Level 3 NICU* Well-Baby Nursery
Antioch Fresno South Sacramento Vallejo Redwood City San Jose	None	Yes	*Level 2 NICU* Well-Baby Nursery
Pedi Tier 4 Richmond Manteca Sacramento Fremont San Rafael South San Francisco	None	No	None

Patient Care Services (PCS)

Regional PCS meets weekly throughout the year with local medical center teams to review nursing, PCT and RT position controls to support ongoing backfill of vacancies and staff leave of absences (LOAs) with traveler requests. These baseline needs are an important part of meeting high census demand.

Regional PCS utilizes projected census data from the Regional High Census team and develops a corresponding staffing recommendation that is sensitive to the facility, cost center, and shift level. This data is compiled into the KP NCAL Staffing Tool (Adult + Pedi/PICU) and is used to determine how many additional staff and travelers will be needed to meet care for patients during high census. Traveler orders are placed regionally using a bulk upload process through HR Connect.

Surgery Optimization

To minimizing the impact of surgeries on inpatient bed demand during high census, the following tactics are recommended:

Reduce backlogs when capacity allows

- **Continue to reduce operating room backlogs** ahead of high census.

Review the mix of planned inpatient versus outpatient surgeries

- **Continue Surgical Home Recovery** for patients who can safely recovery at home rather than an inpatient admission post operatively.
- **Schedule same-day discharge patients early in the day** so they can go home, preferably from PACU, while allowing time for inpatients who are ready for discharge to be identified, leave the hospital, and those rooms be cleaned.
- **Consider planning for longer recovery times in PACU** if that would safely accommodate the patient care needs and avert admission.
- With high inpatient census, we **recommend focusing on outpatient surgeries** and modulating inpatient surgeries. As soon as inpatient bed demand decreases shift to the inpatient backlog.

Review operating room (OR) schedules to smooth flow during peak times

Any consideration of surgery postponement should be discussed first with local leaders (OR/Surgery APIC, PIC, Area Manager, MGA) and Regional Leaders (Surgery AED, Regional Physician Lead OR Operations).

Hospital Model of Care (HMOC)

The NCAL Hospital Model of Care (HMOC) Playbook is a set of interconnected processes and practices that support consistently safe, high-quality care for our patients to achieve a culture of care without delay.

The HMOC Playbook contains information on:

- Foundational elements for each hospital
- Standard roles and responsibilities
- Standard work, tools, and references

Medical Centers should maintain the HMOC standard work during high census to optimize patient flow. During times of high census, standard work should focus on managing avoidable days, Complex Case/Extended Length of Stay Rounds, Team Communication Rounds, and collaboration with Continuum using escalation pathways. Patients should be mobilized early and often, and tethers removed as soon as possible as outlined in Enhanced Recovery Medicine workflows. Consider adding resources to facilitate Enhanced ED disposition as a key focus area.

The HMOC Playbook and SharePoint can be accessed here.

Patient Care Coordination

Hospital throughput is a key strategy in managing high census surges. The Resource Management Teams should be prepared to maximize Patient Care Coordinator Case Manager (PCCCM) and Social Work (MSW) assigned in the Emergency Department and Medical/Surgical areas where we anticipate we will have the most patients requiring immediate discharge planning and care coordination services. We recommend that medical centers implement a combination of the following strategies to ensure assignments are aligned to meet the needs during a high census surge.

Daily Assignments During Census Surge

- Designate 1 RM leader to take responsibility for evaluating and making assignment recommendations to accommodate clinical areas impacted by surge.
- Designated RM leaders assesses current hospital and ED census **and allocate resources to highly impacted areas**
- ED PCCCMs should closely follow all CDA patients and help facilitate non-member transfers
- Maintain pairing model and standard work described in the HMOC
- ED and Hospital PCCCMs should address barriers and delays with early escalation

Social Services

Maintain Hospital Model of Care (HMOC) MSW cadence with priority of staffing in ED and adult census. Social services should be staffed in ED 16 hours per day 7:00am-11:30pm to ensure enhanced disposition from ED. For any urgent issues after 11:30pm the on-call Social Services Manager should be contacted utilizing the operator.

Ensure staffing is appropriate for adult units and prioritize assigning patients with social barriers to discharge. Maximize the use of community resources to supplement the discharge plan. Maintain presence in standard throughput meetings to provide necessary social support for identified barriers to progress discharge plan and remove barriers to discharge. During high census, social workers should work proactively with the rounding teams to identify and address barriers.

Care Experience

The goal of creating exceptional experiences for our patients and families is to provide quality and compassionate care. Often the combination of our set roles and tasks amidst the rush of high census periods, heightens our primary focus on just the technical aspects only of providing care.

It is imperative that healthcare professionals not separate the clinical and quality aspects of care from the compassion and personal connection that our patients require for truly healthy outcomes. Patients ***expect*** the clinical expertise, they assume the ***quality*** of care provided, but they ***remember*** the relationship between themselves and the care team members. As such, maintaining our commitment to monthly meeting structures designed to discuss aspects of care and experience, i.e., the Inpatient ECX Committee, are even more critical during periods of high census. These committees, comprised of both KFH/TPMG leadership, are better able to assess current needs and respond quickly and effectively.

Equally critical, is fostering an environment that promotes self-care and gratitude on the units. Resiliency requires that we be emotionally flexible, able to adapt to changing dynamics, and positive in our attitudes. Our teams require leaders who promote self-care, feelings of gratitude, and reminders of our work's meaning and purpose.

As a patient-centered organization, we are committed to providing exceptional care experience to all our patients and families regardless of mitigating factors such as high census. The resources listed in the Appendix provide a framework for integrating Exceptional Care Experience themes throughout the hospital experience. **The resources have been ranked below in accordance with the NCAL Care Experience team's recommendation for an implementation strategy.**

1. High Census Preparation Training
2. Service Recovery Training
3. Support Rounders for Care Experience
4. Care for our Caregivers
5. ED Borders Rounding Plan
6. Traveler & Campus Support RN Training
7. Temporary Unit Preparation & Operations
8. Service Recovery Gifts Tips
9. Additional Resources: Welcome Letter, Thank You Cards, COVID-19 Resource Document, Patient Transfer Talking Points

Hospital Quality & Patient Safety

During periods of high census in the hospital, high-quality care and patient safety remain priorities for our patients. The creation of systems that allow medical centers to recognize, monitor, and maintain high-quality care is critical. In partnership with Hospital Quality Leadership, this section of the playbook is developed to support medical center operations, exceptional quality, and patient safety.

To prevent drift and maintain focus on Patient Safety and Quality outcomes during periods of high census recommended practices include daily monitoring of reports ***(Please see Appendix for list of reports to monitor)***, adherence to care bundles ***(Please see Appendix for list of care bundles)*** and leadership rounds.

Data Monitoring:

Monitoring of Quality and Patient Safety process measures and reports is recommended during periods of high census ***(Please see Appendix for list of reports to monitor).***

Attendance at Huddles:

Leadership attendance at staff huddles is recommended to engage with frontline staff, share data from daily reports ***(Please see Appendix)***, highlight the importance of care bundle compliance ***(Please see Appendix)***, and address any patient safety or quality concerns.

For medical centers with a Daily Quality Huddle, it is recommended for leaders to participate in the huddle, review reports, identify drift or gaps and partner with staff to maintain patient safety and quality.

Leadership Rounding in the Hospital:

During periods of high census, it is recommended that hospital quality leaders including AQLs, APICs of Hospital Quality, Hospital Quality Physician Leaders, and Quality Nurse Consultants round as partners in patient care units in collaboration with Patient Care Services (PCS). Rounding represents an opportunity for leaders to observe the delivery of safe patient care, review the implementation of care bundles, and engage with frontline staff in their work environment.

Stroke Care Path:

It is imperative to maintain high quality evidence-based stroke care during periods of high census. Timely identification of patients presenting with stroke symptoms, acquisition of imaging and consultation with Teleneurology are foundational aspects of stroke care.

For **appropriate** stroke patients:

- TNK within 30 minutes (Door to Needle)
- Transfer to a facility for clot retrieval within 75 minutes (Door-in Door-out, DIDO)

Sepsis Care Path:

Rapid identification and treatment of patients presenting with Sepsis improves patient outcomes. Physician and nurse partnership for adherence to the Severe Sepsis and Septic Shock bundles is supported in real time with the Clinical Decision Support Alerts in Health Connect. Non-ICU adult sepsis patients can be found on the Patient Safety Net Dashboard on KPHC. This real time reporting of patients can be seen in the Sepsis sections of the dashboard. The reports identify patients on the sepsis pathway and show if the sepsis bundle is completed or not for real time intervention or feedback ***(Please see Appendix).***

Risk Management: Electronic Responsible Reporting Form (eRRF)

During high census, the Electronic Responsible Reporting Form (eRRF) process will be utilized to capture risk events that are related to surges in various census categories.

- Each medical center should have a member of the RMPS team review all events related to census surge.
- All events validated as census surge event will be reported at the Daily Safety Briefing. Non-census surge events will be re-classified in MIDAS as soon as the investigation is complete.
- If the census surge event is determined to be a potentially significant or sentinel event, it will be communicated to local and regional leadership using the current practice.

A report will be sent to regional leadership daily with the census surge events entered in the last 24 hours. There will also be a weekly summary report generated for the weekly leadership influenza meeting report outs when requested.

Inpatient Pharmacy

The Inpatient Pharmacy helps ensure that patients who are hospitalized are provided discharge medications. Some key activities for Inpatient Pharmacy during high census include:

Flexing staff to meet increased demand

- Ask staff to flex-up and utilize short hours and on calls, as needed
- Cross train pharmacy teams for additional support

Increase centralized inpatient order verification

- Verify orders for hospitalized patients to manage medication volume during an inpatient stay

Discharge Support

- Prioritize resources to assist with efficient hospital throughput for discharging patients
- Triage high-risk hospital to home discharges and assist in reviewing discharge medication orders

Inpatient Rehabilitation

Revised scheduling to provide additional coverage during peak hours, potentially extending pharmacy hours and streamlining discharge workflows with Inpatient Rehabilitation Services are key during high census.

Additional demand for physical therapists during high census is managed through increasing hours for part-time employees, shifting hours of clinic therapists to a hospital, and utilizing on-calls. Ability to flex staff is dependent on the local medical centers' level of on-call staff, clinic access, and clinic therapist competencies in the acute setting.

In addition, to facilitate hospital throughput, Inpatient Rehabilitation Departments use internal workflows to triage caseload and create a priority order of patients to be seen when demand exceeds available resources. Generally, the focus shifts to evaluating patients whose hospital throughput is dependent on an evaluation by Rehab Services.

Mental Health

The first step escalation in cases of an increased volume of Behavioral Health patients is to the Regional Psychiatric Call Center, which is available 24/7 to assist in bed finding and providing advice. Care for behavioral health patients should occur in a manner that promotes patient and staff safety, patient dignity and comfort, and maximized therapeutic impact- this should occur in the least restrictive setting allowable.

Behavioral Health Alternate Care Space

ED Behavioral Health alternate care space usage may be activated when significant ED boarding exists or is at risk of developing in the setting of a census surge. Activating the use of this space should be done in conjunction with other measures to ease crowding, such as opening surge tents for medical patients, transferring eligible patients to other medical centers, discharging appropriate medical patients with home monitoring, among other levers used to facilitate safe patient care. ED leadership should confer with the Hospital Command Center to determine when appropriate conditions exist to open ED BH alternate care space. Use of alternate ED care space for behavioral health patients should serve to:

- Create additional treatment capacity in EDs to serve all patients
- Improve the patient experience by moving BH patients out of the chaotic ED environment, reducing exposure to noise
- Promote patient privacy and confidentiality
- Facilitate active treatment of patient through intensive behavioral health interventions
- Focus on patient and staff safety, with safety a key principle guiding staffing plans and workflow development

If a behavioral health alternate care space is open, please keep in mind the following:

- Patients should receive care in high visibility area with direct line of site by care staff
- Patients should wear designated hospital gowns for patients on mental health holds
- Belongings should be searched and placed in a secure location
- Security should be present for continuous line of sight observation
- A safety tray shall be ordered for all patients at risk for self-injury
- Nursing conducts an environment of care risk assessment for ligature risk/self-harm items that can be removed as out lined in existing policies.
    - Bathrooms require focused attention due to fixed ligature risks and challenges with line-of-sight observation.

Alternate Care Space Staffing

- **Nursing:** Standard ED RN nursing requirements are a 1:4 RN: patient ratio. All standard nursing assessment and documentation requirements apply and should be completed at usual intervals.
- **Security:** 1:1 security observation for patients with CSSRS scores 4-6 and 1:2 security observation for CSSRS score of 3. Medical centers should consider a minimum security presence in alternate care space; for example, based on patient volume, at least two security officers should be present in alternate care space to support crisis response. All security officers in the medical center should be made aware of the use of ED alternate care space and the location to assist with Code Gray responses as needed.
- **Physician:** Each patient must have an assigned ED physician. At minimum, a daily physician progress note is required for all behavioral health patients. Usual practice in ED handoffs should occur between physicians to assure the treating physician is aware of the patient's history and current status. Prior to transferring a patient to alternate care space, the physician should clearly document that the patient is medically clear for mental health evaluation.

Patient Selection

Patients must be carefully assessed to choose the most appropriate location for ongoing care and observation. Existing local workflows should continue to guide the initial evaluation and medical clearance process of patients. Once a patient is deemed medically clear by the treating physician, the patient may be relocated to the chosen alternate care space for ongoing monitoring. ED BH patients should be considered for COVID testing prior to cohorting in shared space. The term "medically clear" is defined for these purposes when the examining physician can verify that the patient:

- Has no acute medical condition requiring further emergency or inpatient hospital care OR
- Has medical condition(s) that have been stabilized and can be treated on an outpatient basis.

Patients cleared from mental health holds and converted to voluntary status may remain in the alternate care space while awaiting discharge or transfer. Additional criteria may be considered based on local needs, such as cohorting by age group, severity of symptoms, or other criteria as determined by local needs.

Exclusion Criteria

Not all medically clear patients can be treated in alternate care space.

- Those with homicidal ideation or otherwise expressing desire to harm others
- Agitated, acutely psychotic, or otherwise disorganized patients
- Patients with medical equipment or DME that can be used as a weapon
- Crutches, foley catheter, etc
- Patients requiring frequent nursing care
    - Eg, brittle diabetics requiring intensive sliding scale insulin
- Patients requiring physical restraints during initial ED evaluation are likely not suitable for observation areas until they have been stable and have not required restraints or involuntary medications for at least 24 hours.

Work Stoppage

During a work stoppage, Regional Psychiatry will pull the appropriate levers to support impacted EDs. Contracted provider networks will be contacted to ensure prioritized admission for our behavioral health patients.

Labs

Complexities of proficiency testing for laboratory staff do not make registry a viable option for meeting staffing needs. Instead, to prepare for staffing needs throughout the year, the labs have a "hire ahead program," in which they aim to hire Clinical Lab Specialists (CLS) and Lab Assistants ahead of operational needs so as not to fall behind with vacancies during challenging recruitment intervals. Ensure adequate supply of COVID-19 and Influenza testing kits.

Medical Imaging

Imaging leadership may, by the facility, choose to supplement staff with contracted workers, as needed. The principal activities are to:

- Ensure appropriate staffing by reviewing current staffing models weekly.
- Provide mobile equipment to meet ongoing patient demand.
- Utilize staffing partners, KP Registry when needed to close and gaps.

Local leadership support will be required to flex and add imaging staffing as needed to address ED/Inpatient surges to assist with faster TAT and reduce the length of stay (LOS).

Equipment & Supply Plans

Additional supplies (consumables and durable medical equipment), including laboratory and pharmaceutical products, will likely be required during a census surge.

Therefore, in anticipation of high census, each department or group should:

- Assess its anticipated equipment and supply needs to meet demand.
- Determine a trigger point for ordering extra resources.
- Evaluate the existing system for tracking available supplies in the hospital to ensure it can detect rapid consumption and respond to surge in requests for supplies.
- Establish a contingency plan for situations in which primary sources of supplies become limited.

In preparation for high census, Supply Chain Services has identified 123 core products and partnered with KP's distribution and manufacturing partners to ensure demand is properly forecasted and incremental safety stock built accordingly. Substitute items have also been proactively identified for these products. Additionally, Supply Chain Services ensures that supply allocations for KP are put in place for products that are in short supply and meet with key manufacturers on a weekly basis to track service, identify possible supply disruptions and communicate action plans to all facilities.

Due to ongoing COVID-19 conditions, Supply Chain Services is also stockpiling 90 days of supply of key personal protective equipment (PPE) to be compliant with California Bill AB2537. This stockpile includes N95, PAPR, isolation masks, isolation gowns, face shields, and shoe covers that will be available across the program in case of supply disruptions or demand surges.

Core Product Categories:

- Bandages
- Inhalation Solutions
- Basin
- IV Solutions
- Bed Pans
- Lotion
- Blankets
- Masks
- Bottle Collector
- Nebulizer
- Cotton Balls
- Needles/Syringes
- Influenza Kits
- Sharp Containers
- Gloves
- Alcohol Pads
- Hand Sanitizer
- Tissue
- Cold Packs
- Under pads

EVS & Support Services

The EVS budget flexes-up during high census, enabling medical centers to increase staffing. Considering this, the EVS Manager in conjunction with the Support Service Administrator should work to **ensure that EVS per diem pools are sufficient to support high census.** In addition, the **EVS Manager should ensure that he or she has a plan for reallocating staff from the outpatient to Inpatient setting when capacity constrained.** This plan should be stress tested and staff should be cross trained in advance of high census to ensure the viability of the plan and staff competencies.

Beds maintenance should be updated, and all available bed supply should be deployed or ready to be deployed. Engineers should ensure that any broken beds are repaired expeditiously. Ensure there is a full complement of beds available. A process for renting beds in case of census outnumbering bed availability should be reviewed and operational.

Launch of Medical Center Based Influenza Testing

Medical center-based influenza testing for patients suspected of having influenza and with a reasonable likelihood of inpatient admission was implemented for the 2017-18 Influenza season. Patients suspected of influenza or respiratory syncytial virus (RSV) infection require droplet precautions/isolation in the ED and inpatient units. Medical Center laboratories found turnaround times to be 2 – 5 hours with a reported associated reduction in isolation bed hours along reductions in ED boarder hours, length of stay and positive impact antimicrobial stewardship and antimicrobial use.

All medical center labs can perform patient influenza testing locally during flu season.

Respiratory Syncytial Virus (RSV)

Respiratory syncytial virus (RSV) is a common respiratory virus that usually causes mild, cold-like symptoms, but can be serious, especially for infants and older adults. RSV is the most common cause of bronchiolitis and pneumonia in children younger than 1 year of age in the United States. RSV-associated emergency department visits and hospitalizations should be monitored for high census planning. Below are key considerations for addressing RSV surge.

Work with Outpatient Teams to decompress ED/Hospital census

- Consider how to extend outpatient access to meet demand of RSV patients
- Survey outpatient clinical space and appropriate equipment availability for outpatient treatment rooms
- Evaluate ability to schedule virtual appointments to allow for in-person visits for critically ill
- Build on existing workflows for asthmatic patients to apply towards RSV care delivery

Ensure equipment and supplies can meet the needs of RSV patients

Regional RT leaders work with local facilities to ensure each facility has a plan to order adequate supply of appropriate equipment.

Assess nursing staff capacity to meet demand

- Consider RSV trajectory in anticipation of seasonal/surge staffing requests
- Escalate staffing needs through existing pathways to support increased bed capacity

Monitor inpatient pediatric bed capacity & consider moving adolescents to adult inpatient floors

If pediatric bed capacity is reached and there is sufficient adult bed capacity and staffing to accommodate, consider moving adolescent patients (14-18 years old) from pediatric floors to adult inpatient floors (e.g. Medical/Surgical or Intensive Care Unit/Critical Care) to preserve pediatric beds.

- Maintain continued communication structure to Pediatrics Intensive Care Unit (PICU)
- Where possible, ensure a staffing model of Pediatric Hospital Based Specialist and Adult RN staffing to support pediatric patients
- Consider utilizing teleconsultation to round on pediatric patients when no Pediatric Hospital Based Specialist is on shift

Consider Alternative Care Areas (Expanded Care Areas) preparation

Utilize existing medical center plans for alternative care space preparation in times of surge to support ED census decompression including the following general strategy:

- Ensure that regulatory requirements are met
- Should be opened under the purview of hospital command center
- Used when there is a significant risk to patient safety
- Potential sites include hospital space (preferred), outpatient space, and surge tents
- Staffing may include ED Tech, Nurse, ED physician; RN staffing ratios apply

Utilize KP Insight Census Planning Tool to monitor local RSV rates

This KP Insight tool shows a monthly regional forecast with daily historic census. See "Census Planning Tool" in the Tools and Technology section for additional information.

Post-Hospital

Northern California High Census Action Plan

2023 - 2024

Continuum

Area	Strategy	Plan
	Access	▪ 5 additional beds live at KFRC (VAL) as of July 2023 ▪ Two 50-bed facilities in Sacramento area, and one 50-bed facility in Stockton to provide additional overflow access in September 2023
Acute Rehabilitation (KFRC SharePoint)	Efficiency	▪ KFRC to send out daily census to SNF directors, COCSDs, UM managers, and CAs to monitor waitlist ▪ Standardizing referral, placement, and case management workflows with education to KP acute and OURS on criteria ▪ Promote use of KFRC SharePoint for admission criteria, FAQs and other resources Kaiser Foundation Rehabilitation Center - Home (kp.org) ▪ Reiteration on the importance of early escalation of any anticipated complex discharges ▪ Complex case rounds with patients' home facility leadership when transition plan to community is not feasible ▪ Quarterly and ad hoc meetings with IRF contracted partners for case escalation and monitoring of operations workflows for timely placement ▪ Work with IRF contracted partners on receiving bed availability

Continuing Care Advice Program (CCAP)	Efficiency	▪ Assess incoming call volume daily. Monitored on a shift basis and trending data. Trigger >10% sustained increase. ▪ Flex staffing levels based on call volume according to union rules. Part time, on call, and OT only with prior approval from director (Denise Johnson) ▪ Close collaboration with SNF, Hospice, and DME leaders as part of CCAP standard work to address trending issues that impact patient care.
Durable Medical Equipment (DME)	Efficiency	▪ Flex staffing based on volume and continue with use of temporary staff
Extended Length of Stay (ELOS) Management	Efficiency, Quality, and Compliance	▪ Reiteration on the importance of early escalation of any anticipated complex discharges ▪ Dedicated legal support for timely review of complex cases ▪ Routine huddles with SNF Strategic Partners for case escalation and monitoring of operations workflows for timely placement ▪ Biweekly in-person Complex Care Coordination meetings at all hospitals with consistent ELOS census (SFO, OAK, SCH, SJO, WCR, SAC, SSC, ROS) ▪ Implementation of a new ELOS Taskforce Escalation ▪ Process R.E.S.E.T (Regional Extended length of stay Subject Matter Expert Team)

Medical Transportation	Efficiency and Quality	▪ Monthly and ad-hoc meetings with all contracted vendors to evaluate utilization with demand analysis ▪ Provided high census 2022/2023 utilization for baseline planning for transportation demand surge ▪ Identify opportunities for real time evaluation for needed adjustment of ambulance resources ▪ Monitoring of timeliness standards is ongoing
Outside Services (EPRP/OURS)	Efficiency	▪ KFH Trauma meetings to improve non-KFH trauma repatriations ▪ Close collaboration and communication with SNF/HH/IRF departments to facilitate timely transition to appropriate LOC. ▪ Provided education regarding EPRP/OURS ▪ Repatriation and Escalation Process all House Supervisors. Local teams to manage the communication in routine huddles depending on workloads adapting to census and capacity ▪ Obtain and utilize on-call and contingent staffing as needed based on the anticipated surge, vacancies and backfill. ▪ Realign the work of managers, quality coordinators, and Admin staff, to assist with managing patient surge.

Skilled Nursing	Access	▪ Work with SNF preferred partners on receiving bed availability ▪ SNF Hub daily calls with UM & SNF partners to improve access ▪ KPPACC census flex capabilities ▪ Reviewing custodial census for opportunities to transition to a lower level of care. ▪ Continuing to add additional non-contracted SNF sites with Tier 1 SNF partners ▪ Monitor and action plan hospital AVD related to SNF placement
	Quality	▪ SNF Readmission Reduction Interventions spread throughout NCAL

Home Health (HH) & Hospice

- Assess incoming referrals and prioritize patient needs daily.
- Evaluate and maximize internal KP capacity and outside agency capacity. Agencies all have HC dashboard access to monitor daily. Leaders to receive weekly report.
- Obtain travelers in advance, as needed, based on internal agency vacancies. If there are vacancies, internal agencies request travelers to backfill. During the COVID-19 surge, travelers were not considered as elective surgeries and HH referrals dropped.

Area	Plan
After Hour Coverage	▪ Plan and be prepared for after-hours coverage - telephone calls and home visits (i.e., pronouncements, infusion management)

Communication with Ambulatory Care Departments and Skilled Nursing Facilities (SNFs)	▪ Contact Coagulation Clinic to adjust PT/INR orders to confirm and adjust PTINR visits as needed. ▪ Work with the ambulatory care setting regarding the decrease capacity the agency has. Establish an agreement that no patient will be referred to the agency unless a verbal communication takes place. Plan alternative sites of care/providers which are safe and appropriate. ▪ Contact Surgery Scheduling Departments like orthopedics - determine if cases are being cancelled/rescheduled to project the week's needs. ▪ Work with clinics to obtain access for patients with wounds, rehab needs or infusion.
Quality/Compliance	▪ Ensure all current clinical notes and POC's on active patients are processed/locked. Audit and ensure completion of all visit notes.

Divert Agency Strategies	▪ Work with and maximize capacity of current contracted Divert vendors. Daily huddles with the divert agency for continued capacity assessments. Strategies to consider:
	  ▪ Determine agency capacity to take additional cases. One referral can make a difference.
	  ▪ Divert infusion cases requiring admissions by using Infusion Companies - i.e., Coram, Crescent
	  ▪ Guarantee referrals/ visits or days of work with local divert agencies to have their staff available to work.

Travelers	▪ Obtain travelers in advance and provide the formalized education, training, and competency onboarding.

Internal Staffing Plan	▪ Clinicians reporting to work:
	  ▪ Clinicians should be prepared to start and finish their time from home.
	  ▪ Clinicians should call their supervisor in the morning to report in.
	  ▪ Clinicians report off to a supervisor on their patients at end of day.
	▪ Realign the work of clinical managers, supervisors, quality coordinators and clerks, to assist with managing patient surge. Identify and Plan for Alternate Staff for Home Health and Hospice Intake thus allowing the Clinicians to stay in the field providing visits.
	▪ Maximize clinical staff availability and provide overtime

Patient Referrals/Census	▪ KNOW your patients and new referrals. Huddle and review referrals and HH and HO census on a routine basis with referral sources. For triage patients, are there other sites and providers that could provide patient care?
	▪ Identify patients that are new SOC's and the required discipline to see them.
	  ▪ Communicate with patients about their needs, home support, etc.
	  ▪ Communicate with attending physicians about alternate care providers/sites.
	▪ Identify patients with complex needs such as IV's, wounds, ventilators, trach tube, etc.
	▪ Prioritize visits.

Supplemental Staffing Agencies	▪ Maximize capacity with current contracted Supplemental Staffing agencies.
	▪ Obtain coverage for extended days. Guarantee days of coverage.
	▪ Consider the following:
	  ▪ Guarantee payment for agency on days of use.
	  ▪ Have RNs/PT's report to agency their first day to onboard them, competency train and educate regarding agency P&P.
	  ▪ Have documentation packets for Staffing prepared in advance - documentation, MD orders, demographics, pertinent clinical information.

Tools & Technology

Northern California High Census Action Plan

2023 – 2024

Technological tools are being continuously developed to assist hospital operations with better oversight of patient throughput, identify bottlenecks, remove barriers in a timely fashion and to plan. In addition, these tools are important to monitor performance and identify improvement opportunities.

NEDOCS

- NEDOCS score is an objective and quantitative early warning score that allows for a standardized approach for times of high volume and reduces ambiguity.
- The NEDOCS score is available on your facility's "Hospital Dashboard," "ED Dashboard," and "Operations Watch List Dashboard" within KP Health Connect.
- Individual alerts can be set for when the NEDOCs score exceeds a predefined threshold that the user can set.
    - Refer to the Job Aid in the Appendix for further information.

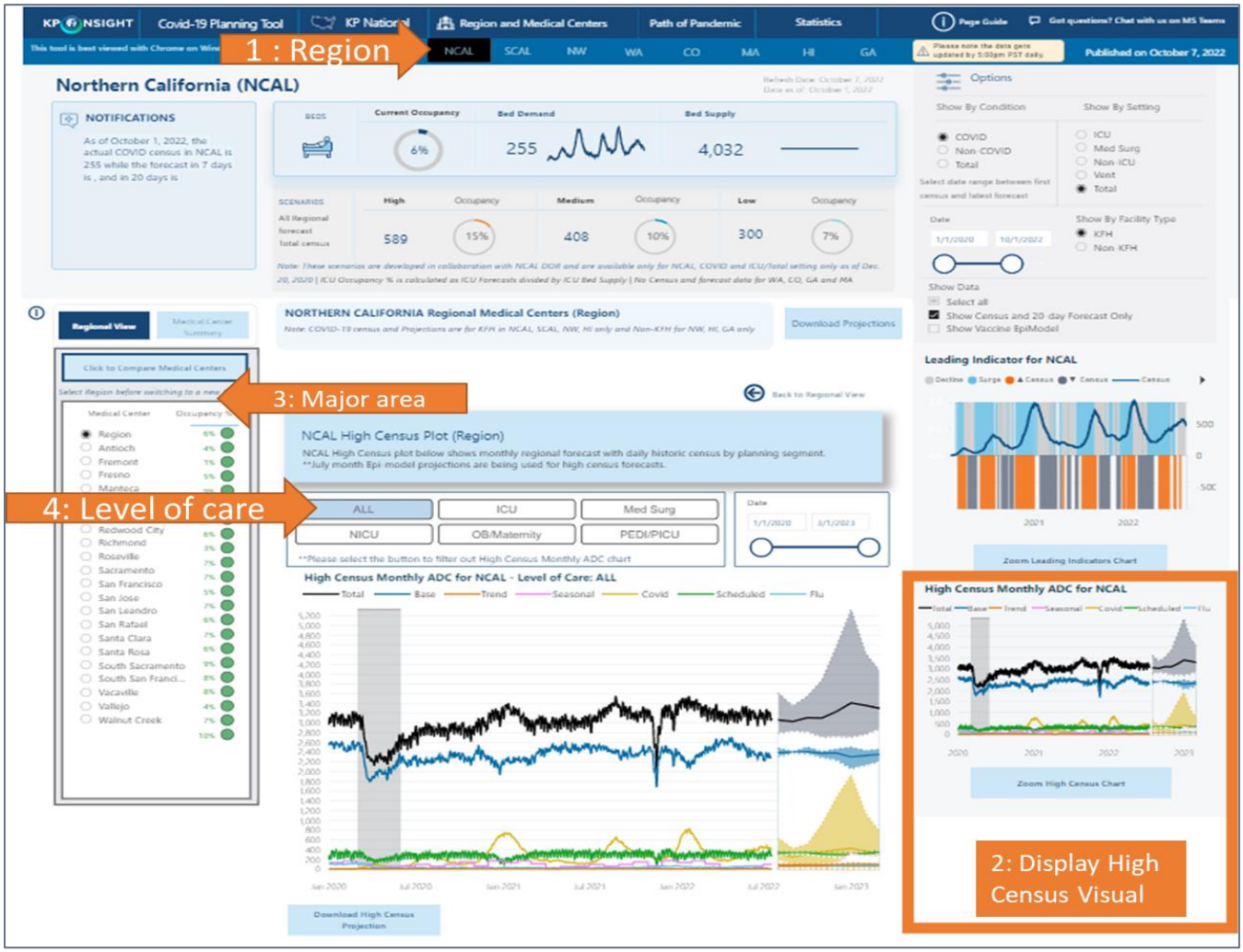
Average Daily Census (ADC) & COVID-19 Report

- Provides daily information on Average Daily Census (ADC) performance for all Kaiser Permanente Regions with hospitals.

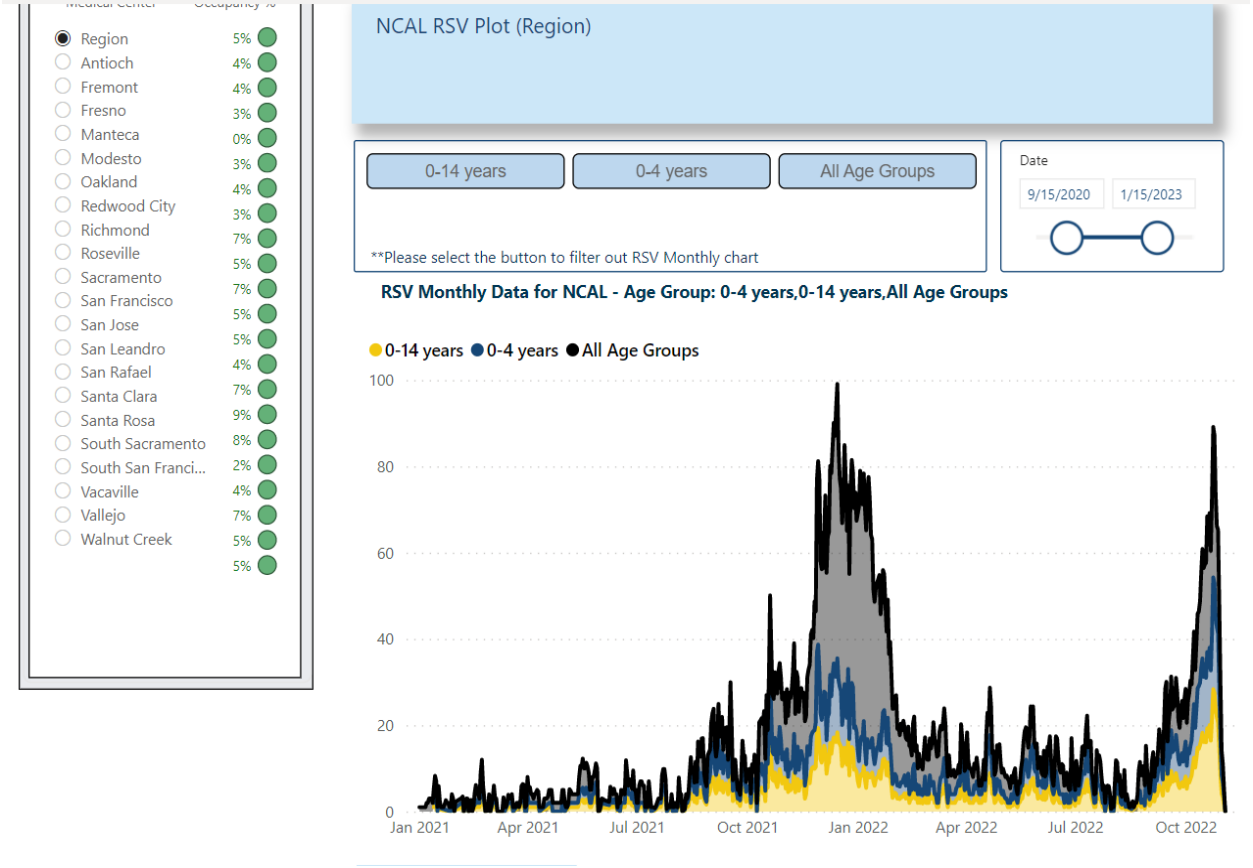
Census Planning Tool

[Link: Census Planning Tool]

- Predicts the average daily census 6 months into the future using past activity and membership growth projections to inform the model.
- COVID-19 predictions are performed using a specific model informed by epidemiological data at the regional level.
- **Predictions can be viewed on a facility level,** calculated by proportionally allocating the regional total COVID-19 census projected for each month within each facility and level of care based on the fraction of total COVID-related activity they have seen in the past 12 months.
- Follow prompts in KP Insight to request access
  - If there are any problems with getting access to the tool, please reach out to Fred Alfredo (Frederick.J.Alfredo@kp.org) for assistance
  - Refer to the Job Aid in the Appendix for further information



- Tool can now be utilized to monitor local RSV rates across the region
  - Includes PEDI/PICU sort option for predictions by facility
  - Includes 0-4 years, 0-14 years sort options for data by age group (see below)



Hospital Throughput Dashboard

[Link: Hospital Throughput Dashboard]

- Provides line of sight of patient flow performance and includes a tool that can define clear areas of opportunity with patient flow via technology thus reducing significant manual time to assess patient flow bottle necks.
- The retrospective data supports local hospital operation leaders by giving them the technology and tools to optimize resource, identify gaps and opportunities, and enable performance improvement to improve oval patient flow.

OWL/HTM

- Insight Driven OWL and Hospital Throughput Monitor applications transforms hospital throughput, patient safety, and staffing decisions with near-real time, predictive, and easily accessible information on your KP mobile device and/or computer.
- The OWL/HTM should be used harness and optimize data to enable better & faster decisions for all decision makers for improved, consistent performance outcomes by increasing operational decision maker's access to and use of timely, accurate data as they manage patient flow and staffing needs to solve operational challenges.

Hospital Monitoring Tool (HTM)

[Link: Hospital Throughput Monitor]

- Provides a consolidated summary of census and capacity for all hospitals in the NCAL region. It allows users to view the census and capacity for all KP Hospitals in one view. Additionally, the HTM Facility view has forecasts of the hospital census for the next 48 hours.

Hospital Throughput Simulation (HTS)

**Tool available soon to all medical centers*

[Link: Hospital Throughput Simulation]

- The goal for Hospital Throughput Simulation (HTS) project is to develop a "digital twin" of the hospital, mirroring hospital operations. This will allow operational and regional leaders to model scenarios and observe impact to the system.
- HTS will provide the hospital operational leaders and EVS managers an ability to do what-if analysis. Hospital operational Leaders and line managers can use simulation tool to bring speedy insight and will help them to mitigate risk in their capacity planning and staffing. HTS will provide enhanced user experience by enabling intuitive scenario analysis to remove guess work from key decisions.

KP Insight and Health Connect Tools

	Retro Analysis	Near Real Time & Predictive Tools for Day-to-Day Decision Making		What if & Prescriptive Analysis (Future Planning)
	Hospital Throughput Dashboard	OWL Mobile Application	Hospital Throughput Monitor (HTM)	Hospital Throughput Simulation (HTS)
Best for	**Service Area at Desktop** *Retrospective trending, deep dive analysis, encounter level reviews, process improvement tracking, facility performance comparisons, and identifying areas of opportunity.*	**Service Area On-the-Go** *Quickly see the current state of the total hospital and drill down to view patient detail (no PHI). Set preferences to customize near real-time & predictive throughput, quality, and staffing information.*	**Regional and Service Area** *Holistically view near real-time^ capacity across all facilities to enable patient placement and planning at the regional or facility level.*	**Regional and Service Area** *This tool is best for planning out scenarios, asking what-if questions based on levers update to identify bottle necks, latency and deadlocks.*
Main Audience	**Local & Regional Decision Makers** *Currently available to 4 pilot sites, but will be available to all facilities on KP Insight in near future*	**Local Decision Makers** *Approved operational and physician front line leaders from Supervisor to Area Manager*	**Local & Regional Decision Makers** *Open to all on KP Insight*	**Local & Regional Decision Makers** *Approved operational and physician front line leaders from Supervisor to Area Manager*
Level of Detail	***PHI Level Detail***	***Patient Level (No PHI)***	***Level of Care in Units***	***Hospital level***
Unique Features	• *MRN level detail* • *Process improvement charts* • *Facility comparisons* • *Built with direct collaboration with the employees who are actually performing the work to help them identify & solve throughput bottlenecks*	• *On-demand NEDOCS alert* • *Customized experience* • *Intelligent Role-Based Alerts & Recommendations** • *In app secure messaging* • *Predictive measures, forecasting, and trends* • *KPHC, KP Schedule, OWL Web App, & HTM integration^*	• *Program wide data* • *View all KP Hospitals on one page* • *Unit type roll up (Med/Surg, ICU, MCH)* • *Forecasts up to 48 hours ahead* • *KPHC, OWL Web App, & OWL Mobile App Integration^*	• *Ability to simulate patient flow (arrival to discharge), perform what-if analysis and optimize throughput.* • *Predictive model to project discharges by shift and unit at hourly rate and up to 24 hours.* • *Data Driven Automated opportunity Analysis.*
Regions Supported	*Northern California & Southern California (near future)*	*Northern & Southern California, Hawaii, & Northwest*	*Northern & Southern California, Hawaii, & Northwest*	*Northern California (2022), Southern California (2023)*

Appendix

Northern California High Census Action Plan

2023 – 2024

NEDOCS Communication

Hospital Operations Leadership Team (HOLT)
LEADERSHIP MESSAGE

Area Managers, CNEs, COOs, Hospital Ops APICs, RM chiefs, MGAs, ED Chiefs, and HBS Chiefs,

As we continue to experience high census in our emergency departments and hospitals, it is important for us to closely examine our current NEDOCS (National Emergency Department Overcrowding Score) plans for continual readiness. NEDOCS is a warning system built to identify in real-time issues related to ED overcrowding and hospital capacity. This allows hospital leaders an opportunity to respond before the overcrowding reaches a crisis level. NEDOCS measurements for your specific medical center can be found on your hospital dashboard, Operations Watch List, and ED Dashboard in Health Connect.

The NEDOCS plan is an interdependent tool that assists us in identifying strategies to deploy during times of high census. This interdependent surge plan requires an interdisciplinary review, updating, and tabletop exercises between the ED and hospital leaders to be ready for unexpected high census in our medical centers. Please partner with your medical center's accountable leaders (APIC of Hospital Ops, CNE, COO, and AMGA) to ensure there is a clear and actionable response plan. The interdisciplinary teams should update and adopt the NEDOCS plans no later than **November 15th, 2022.**

For your reference, we have provided the link to a NEDOCS planner on One Drive, which contains a blank plan template, some examples of completed NEDOCS plan, a NEDOCS calculator, and a high-level scoring grid. These resources are also available below for your convenience.

If there are any difficulties accessing any links, don't hesitate to contact Jordan Johnson via email at Jordan.K.Johnson@kp.org.

NEDOCS PLAN TEMPLATE: Link
NEDOCS CALCULATOR: Link
NEDOCS SCORING GRID:

Normal Operations *Green*	Busy *Yellow*	Overcrowded *Orange*	Severely Overcrowded *Red*	Critically Overcrowded *Black*
0 - 60	61 - 100	101 - 140	141 - 180	180 <

Documents and Weblinks

Name	Resources
NCAL EPRP / OURS Workflows	NCAL OURS EPRP Repatriation
Perioperative Contingency Plan	Perioperative Contingency Plan
KPI Resources	Census Planning Tool Hospital Throughput Dashboard Hospital Throughput Monitor Hospital Throughput Simulation
Hospital Model of Care	HMOC SharePoint
ED & IP Surge Playbook	KP NCAL ED & Inpatient Playbook
OWL / NEDOCS Job Aid	OWL NEDOCS Job Aid
Census Planning Tool Job Aid	Census Prediction Tool Job Aid
Census Planning Tool User Guide	Census Prediction Tool User Guide
Inpatient Pediatrics Documents	AFL - RSV+Pediatric Surge (2022).pdf KP Santa Clara Pediatric Disaster Plan (3.16.22).docx KPNC Pediatric Surge Preparedness (5.12.16).docx

	KPNC Pediatric Surge Preparedness Appendix (6.9.16).docx KPNC Pediatric Surge Preparedness Tier 3 Template (6.9.16).docx
Mental Health Playbook	ED Behavioral Health - Alternate Care Space Playbook Dec 24 2020.pdf
L&D / OB Playbook	LD High Census and Capacity Management Plan.docx

Care Experience Resources

Tactic	Description	Resources
High Census Preparation Training	▪ Each department with patient facing employees delivers presentation to their staff via team huddles, virtually, or staff meetings ▪ Plan train- the- trainer sessions for Senior leaders, Directors, Managers, Assistant Managers and Supervisors for hospital and ED, Radiology and Lab (co-facilitate with your local Caritas Coach when possible). ▪ Length of session: 1 hour, or small segments over a period of time ▪ Includes: Right words at right times, creating a welcoming environment, self-care, service recovery ▪ Attachment: High Census Preparation Class PowerPoint	High Census Training
Service Recovery Training	▪ Plan sessions for Senior leaders, Directors, Managers, Assistant Managers and Supervisors for hospital and ED, Radiology and Lab. ▪ All new PCS leaders shall review the PowerPoint ▪ Length of session: approximately 1 hour minimum ▪ Review the content 1:1 with Care Experience Leader, via Teams virtually, or independently ▪ Includes: AHEART Model overview, simulation, and practice of model by all participants, when possible, guidelines for use of gifts ▪ Attachment: Service Recovery with AHEART PowerPoint	Service Recovery A-HEART Training
Service Recovery Gifts	▪ Purpose: thank patients for their feedback ▪ Serves as a visual cue to other staff to provide extra attention ▪ Provide training to those providing Service Recovery gifts ▪ Suggestions for departments to obtain gifts ▪ Attachments: Service Recovery Gifts Word Doc	Service Recovery Gift Tips

Traveler and Campus Support Nurse training	▪ Assure that all travelers receive training in CE that is equivalent to non-traveler staff, including: fundamentals for CE (NKE, AHV, Service Recovery with AHEART, My Meds Matter, Discharge folder Seasonal High Census (winter preparation) ▪ Ensure travelers are supported at unit level by ANM's and leaders ▪ Length of session: 1.5 hour minimum ▪ Attachments: Traveler Onboarding PPT; Traveler Welcome Packet PPT	Traveler Onboarding Traveler Nurses Welcome Packet
Care for our Caregivers	▪ Plan and provide opportunities for staff recognition ▪ Examples include Tea for the Soul (packaged cookies & tea bags), offer HeartMath instructor to lead Quick Coherence at huddles, electronic massagers for staff lounge chair, Cup of Gratitude coffee card for the cafeteria, Gratitude Wheel with spa prizes, written notes of gratitude or E-Card Caring Moment ▪ Schedule leadership rounding during the week and on Saturdays for all shifts ▪ Share patient comments and caring moments stories ▪ Utilize Direct Report Rounding to support staff and remove barriers. Don't cancel because of high census, it is important to connect to our staff. ▪ Evaluate staffing up in support areas ▪ Connect with your local Caritas Coach to support initiatives ▪ Promote the Enhancing a Culture of Care modules to connect staff back to purpose (contact Linda Ackerman, RN – Regional Director for Caring Science)	n/a

Temporary Unit – Preparation and Operations (Overflow Units)	▪ Ensure that any unit that is being open for temporary use (due to high census) meets same Regulatory and operational standards as an existing unit (i.e., same level of nurse leader rounding, supplies, etc.) ▪ Assemble all key stakeholder prior to opening the unit (infection, volunteer, nursing, support services, security, clinical case management, and physicians) few days before opening and daily until process is ironed out including a checklist ▪ Utilize Daily Debrief for nurse leader rounding report-out to address service issues and concerns. ▪ Refrain from calling unit the "overflow" unit as it creates perception issues for staff, patients, and families; consider calling it one of the ECX service standards: Safety Care Unit, Integrity Care Unit, Compassion Care Unit, etc. ▪ Ensure leaders round on staff in these units to see that their needs are met for supplies/ issues, inclusive of weekends and off shifts ▪ Remove extraneous clutter and equipment, create a welcoming environment ▪ Consider having CNE, directors, and managers in scrubs during high census as a show of solidarity on the units ▪ Review how these units are cascaded on HealthStream especially with Page Operators to respond to patient locations/inquiries ▪ Provide service amenity items during rounding as a gesture of gratitude for the patient's patience.	n/a

ED Borders Rounding Plan	▪ Prepare a distinct schedule for rounding on patients that are bordering in the ED, inclusive of weekends and off shifts ▪ Recommend Senior leaders or others in ED hospital leadership are knowledgeable of the wait times ▪ Be prepared to deliver service recovery gifts (see Service Recovery Gifts document above), and/or comfort amenities such as ear plugs and eye masks ▪ Attachments: ED RWRT	ED Rounding - RWRT
Support Rounders for Care Experience Support Rounding	▪ Consider utilizing senior leaders, campus support nurses, volunteers when appropriate, and light duty staff as trained Care Experience Support Rounders to perform rounds on patients in overflow units ▪ Connect with your local Caritas Coach to support this initiative ▪ Attachments: Care Experience Support Rounding Talking Points; Care Experience Support Rounding Form	Care Experience Support Rounding Talking Points Care Experience Support Rounding Form
Additional Considerations for Providing Exceptional Care Experiences	▪ Ensure patients receive the Welcome Letter ▪ Reinforce the Connection Bundle and Thank You cards for patients, see ordering information attachment ▪ Review Patient Transfer Talking Points	Customizable Welcome Letter NCAL Thank You Cards OneLink Order Patient Transfer Script

Hospital Quality and Patient Safety Resources

Name	Care Bundles	Reports to Monitor / Resources
Mobility	▪ Follow mobility protocols including completing PLOF and CLOFs to inform patients' daily maximum mobility goals; leverage the Regional Mobility Protocol Roadmap ▪ Use the Daily Mobility Dashboard ▪ Refer to Key Mobility Messages for physicians, PAs, RNs, PCCs	Daily Mobility Dashboard (LINK HERE) Regional Mobility Protocol Map (LINK HERE) Key Mobility Messages for physicians, PAs, RNs, PCCs (LINK HERE – Under "Training Materials)
Catheter Associated Urinary Tract Infection (CAUTI) Prevention	▪ Consider alternatives first (intermittent catheterization, condom catheter, external female catheters). ▪ Use aseptic techniques. ▪ Keep catheter bag below the bladder with unobstructed urine flow and no dependent loops. ▪ Review urinary catheter necessity daily and remove promptly.	n/a
Central Line Associated Bloodstream Infection (CLABSI) Prevention	▪ Follow approved central line catheters insertion indications. ▪ Follow aseptic elements of the Central Line Insertion Practices. ▪ Change dressing once a week, change tubing per policy, scrub the hub before each access, and bathe patient with CHG once a day. ▪ Review central line catheter necessity daily and remove promptly.	n/a

Clostridium Difficile Infection (CDI) Prevention	▪ Identify 3 loose stools in 24 hours. ▪ Immediately place patient into contact plus isolation. ▪ Send 3rd loose or liquid stool in 24 hours that met testing criteria. ▪ Clean the environment daily and more frequently as needed.	n/a
Fall Prevention	▪ Assess risk using approved tool and nursing judgment. ▪ Identify individualized interventions based on risk factors. ▪ Implement Universal Fall Precautions. ▪ Educate patient on risk of falls/bed alarm/assistive devices/toileting.	n/a
Hospital Acquired Pneumonia (HAP) Prevention	▪ Keep lungs clear through incentive spirometry and chest physiotherapy. ▪ Perform regular oral care with teeth brushing for all patients, and oral chlorhexidine for high-risk patients. ▪ Keep moving. Ambulate daily. Keep head of bed > 30 degrees. Ensure feeding tube optimal if present. ▪ Encourage patient to turn, cough or deep breath at least once hourly. Family participation encouraged.	HAP Report – Emailed daily; twice daily teeth brushing and out-of-bed for meals
Hospital Acquired Pressure Injury (HAPI) Prevention	▪ Assess skin using Braden and take photos of skin discolorations/wounds. ▪ Identify individualized interventions based on risk factors (subscore). ▪ Ambulate daily, reposition patient including medical devices, and protect skin from moisture. ▪ Educate patient and family on skin care and nutrition.	n/a

Enhanced Recovery	▪ Routinely consider all elements of ERM Pathway including focus on utilizing multimodal analgesia (MMA) and completion of assessment bundle (Admission PLOF & CLOF, Malnutrition Screen, CAM, Sleep Assessment, and Discharge CLOF) ▪ Routinely consider all elements of ERAS Pathway including utilizing multimodal analgesia (MMA), administering the carb drink, and ambulating and feeding patients early after surgery	ERM Pathway LINK HERE ERM Dashboard LINK HERE ERAS Pathway LINK HERE ERAS Dashboard LINK HERE
Sepsis	▪ Follow Sepsis ED Clinical Decision Support in KPHC ▪ IP Clinical Decision Support went live 12/7/22	Patient Safety Net Dashboard on KPHC – Go to ED sepsis and /or IP Sepsis Sections; IDs patients on Sepsis Pathway, Bundle Completion status

Document History

Author / Editor	Department	Date Approved	Approved by	Published
Jordan Johnson	Resource Stewardship	2023	▪ Sunil Bhopale, MD ▪ Chethana Vijay, MD ▪ Niraj Singh ▪ Stephanie Woods ▪ Michael Scates ▪ Nathalie Archangel-Montijo	November 2023
Jordan Johnson	Resource Stewardship	2023	▪ Abdul Wali, MD ▪ Chethana Vijay, MD ▪ Niraj Singh ▪ Stephanie Woods ▪ Nathalie Archangel-Montijo	August 2023
Kalyanasundaram Rajan	Resource Stewardship	2022	▪ Abdul Wali, MD ▪ Chethana Vijay, MD ▪ Mitchell Winnik ▪ Stephanie Woods ▪ Julie Gist	October 2022
Jordan Johnson	Resource Stewardship			
Monica Guo	TPMG Business & Solutions Consulting			
No update due to COVID-19	N/A	2021	N/A	N/A
Jennifer Witt	Resource Stewardship	2020	▪ Abdul Wali, MD ▪ Vivian Reyes, MD ▪ Jo-Ann Griffin	August 2020

Jennifer Witt	Resource Stewardship	2019	▪ Abdul Wali, MD ▪ Vivian Reyes, MD ▪ Jo-Ann Griffin ▪ Serge Teplitsky	October 2019
Jennifer Witt	Resource Stewardship	2018	▪ Abdul Wali, MD ▪ Vivian Reyes, MD ▪ Jo-Ann Griffin	October 2018
Julie Whorton	Regional Portfolio Management Office	2017	▪ Vivian Reyes, MD ▪ Jo-Ann Griffin	October 2017