

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

Wednesday, December 15, 2022 – 7:00 pm
El Camino Hospital 2500 Grant Road Mountain View, CA 94040

PURSUANT TO GOVERNMENT CODE SECTION 54.53(e)(1), EL CAMINO HEALTH WILL NOT BE PROVIDING A PHYSICAL LOCATION TO THE PUBLIC FOR THIS MEETING. INSTEAD, THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION MEETING VIA TELECONFERENCE AT:

MEETING CODE: 994-5583-9449# No participant code must press

To watch the meeting Livestream, please visit: www.elcaminohealth.org/about-us/leadership/board-meeting-stream
Please note that the Livestream is for meeting viewing only and there is a slight delay; to provide public comment, please use the phone number listed above.

MISSION: To heal, relieve suffering, and advance wellness as your publicly accountable health partner.

AGENDA ITEM	PRESENTED		ESTIMATED TIMES
CALL TO ORDER ROLL CALL	Lanhee Chen, Board Chair		7:00 – 7:05 pm
POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Lanhee Chen, Board Chair		information 7:05 – 7:10
PUBLIC COMMUNICATION a. Oral Comments <i>This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes, on issues or concerns not covered by the agenda.</i> b. Written Correspondence	Lanhee Chen, Board Chair		information 7:10 – 7:15
<u>BOARD ASSESSMENT</u>	Dan Woods, Chief Executive Officer George Anderson, Consultant		information 7:15 – 7:20
ADJOURN TO CLOSED SESSION	Lanhee Chen, Board Chair	public comment	motion required 7:20 – 7:25
POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Lanhee Chen, Board Chair		information 7:25 – 7:30
Health & Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: MEDICAL STAFF REPORT VERBAL	Apurva Marfatia, MD, Enterprise Chief of Staff; Michael Chan, MD, Los Altos Chief of Staff		information 7:30 – 7:35
Report involving Gov't Code Section 54957(b) for discussion and report on personnel performance matters: BOARD ASSESSMENT a. Board Effectiveness Report b. Summary of Recommendations & Draft Action Plan	Dan Woods, Chief Executive Officer George Anderson, Consultant		possible motion 7:35 – 7:40
Report involving Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management: EXECUTIVE SESSION	Lanhee Chen, Board Chair		discussion 7:40 – 7:45
CONSENT CALENDAR <i>Any Board Member may remove an item for discussion before a motion is made.</i>	Lanhee Chen, Board Chair		motion required 7:45 – 7:50

AGENDA ITEM	PRESENTED ☐☐		ESTIMATED TIMES
<p>Approval Gov't Code Section 54957.2:</p> <ul style="list-style-type: none"> a. Minutes of the Closed Session of the Hospital Board Meeting (11/10/2021) b. Chief Quality Officer Base Salary <p>Reviewed and Recommended for Approval by the Quality, Patient Care and Patient Experience Committee Health & Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:</p> <ul style="list-style-type: none"> c. Credentialing and Privileges Report 			
<p>☐☐☐ Report involving Gov't Code Section 54957(b) for discussion and report on personnel matters: CEO REPORT</p> <ul style="list-style-type: none"> a. Update (verbal) b. Pacing Plan 	Dan ☐ oods, Chief Executive Officer		discussion ☐:☐☐ – ☐:☐☐
<p>☐☐☐ ADJOURN TO OPEN SESSION</p>	Lanhee Chen, Board Chair		motion required ☐:☐☐ – ☐:☐☐
<p>☐☐☐ RECONVENE OPEN SESSION ☐ REPORT OUT</p> <p>To report any required disclosures regarding permissible actions taken during Closed Session.</p>	Lanhee Chen, Board Chair		information ☐:☐☐ – ☐:☐☐
<p>☐☐☐ CONSENT CALENDAR ITEMS: Any Board Member or member of the public may remove an item for discussion before a motion is made.</p>	Lanhee Chen, Board Chair	<i>public comment</i>	motion required ☐:☐☐ – ☐:☐☐
<p>Approval</p> <ul style="list-style-type: none"> a. Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 301 for Teleconference Meetings b. Minutes of the Open Session of the Hospital Board Meeting (11/07/21) c. Policy Revisions <p>Reviewed and Recommended for Approval by the Finance Committee</p> <ul style="list-style-type: none"> d. FY21 Period 4 Financials e. Intent to Reimburse: Resolution f. Mountain View OB/GYN Call Panel Renewal (Physician Contract) <p>Reviewed and Recommended for Approval by the Executive Compensation Committee</p> <ul style="list-style-type: none"> g. Executive Compensation Committee Community Member Composition & new Community Member Appointments <p>Reviewed and Recommended for Approval by the Medical Executive Committee</p> <ul style="list-style-type: none"> h. Medical Staff Report 			
<p>☐☐☐ CEO REPORT</p>	Dan ☐ oods, Chief Executive Officer		information ☐:☐☐ – ☐:☐☐
<p>☐☐☐☐ BOARD COMMENTS</p>	Lanhee Chen, Board Chair		information ☐:☐☐ – ☐:☐☐
<p>☐☐☐ ADJOURNMENT</p>	Lanhee Chen, Board Chair	<i>public comment</i>	motion required ☐:☐☐ – ☐:☐☐pm

Upcoming Regular Meetings: February ☐, 2022; March ☐, 2022; April 13, 2022; May 11, 2022; May 23, 2022 (Joint with Finance Committee); June ☐, 2022

Upcoming Special Meetings ☐ **Education Retreat:** Date TBD (Joint Board and Committee Education); February 23, 2021 (Retreat); April 27, 2022 (Board Education)

Getting the Most From Your Board

Prepared for the El Camino Health Board

Open Session

December 8, 2021

The Importance of El Camino's Board

- » Your board plays a vital role in El Camino's success and upholds its mission and purpose.
- » Healthy leadership and governance are the cornerstone of your performance.
- » Your board is invigorated by a common boardroom dynamic:
 - Board oversight and decision-making call for the application of collective wisdom, in the best interest of the organization and community, through dialogue and shared commitment.
 - Boards are made up of people whose judgment is exercised individually, through thoughtful preparation and participation as well as understanding of the board's role.



KEY QUESTION FOR ANY BOARD:

Does our board have the right people focused on the right issues using the right processes?

Your Board Review – Opportunity Areas

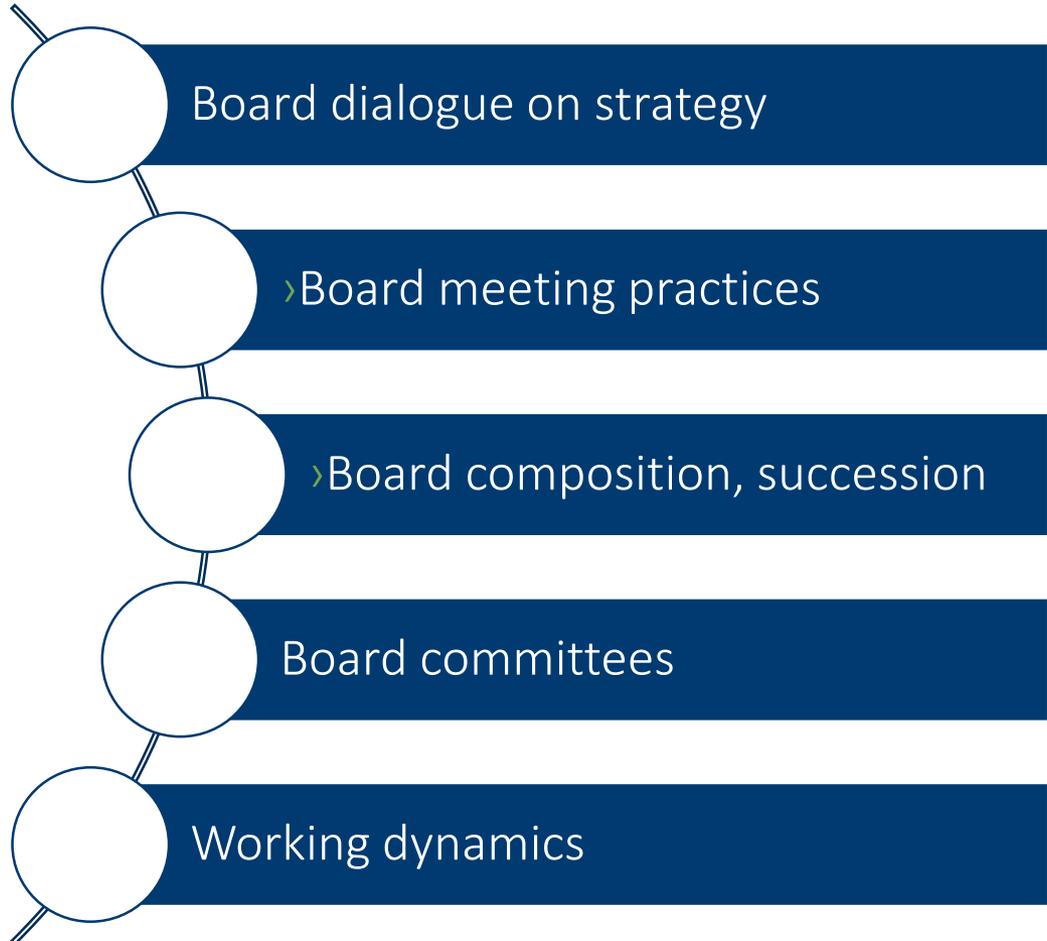
SpencerStuart

 El Camino Health

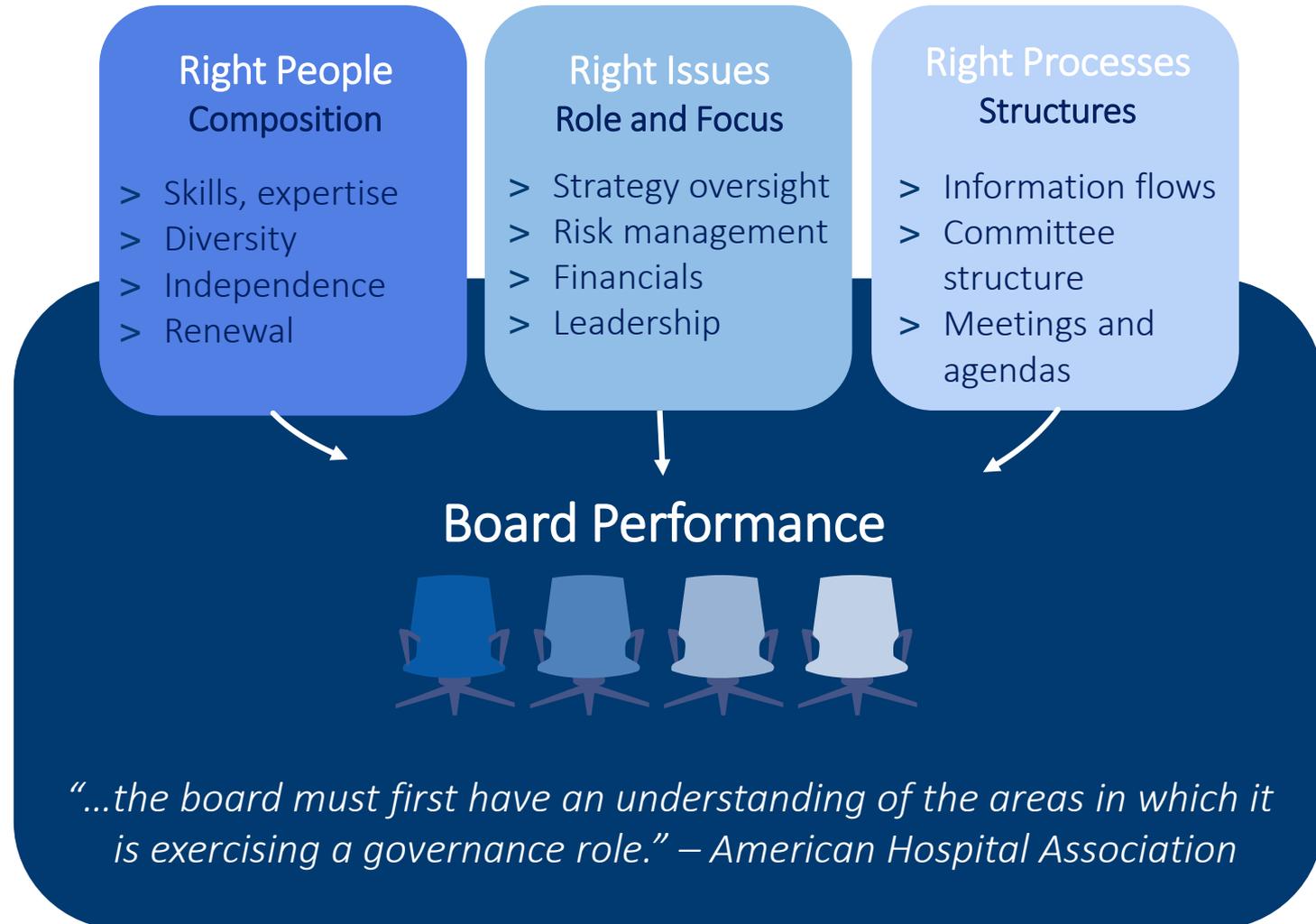
Board Effectiveness Report

Prepared for the El Camino Health Board of Directors
2021

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What Makes a Great Board



Key Areas of Focus for Hospital Boards

Board Role

Strategic Planning

- Ensures strategic planning is done; oversees execution
- Participates with management in strategy formulation
(Management: develops and implements the strategic plan)

Quality of Care and Services

- Monitors performance against commitments and goals
(Management: sets goals, executes on commitments)

Financial Oversight

- Approves financial policies and budget
- Monitors performance against budget
(Management: develops budget; ensures integrity of financial controls)

Executive Performance

- Conducts annual CEO evaluation
- Ensures succession planning is in place for the CEO
(Management: CEO supervises senior leadership team)

Risk Management

- Ensures plans are in place to manage risk
- Monitors remediation of significant risks
(Management: puts in place programs to protect the hospital from risk)

Communication

- Ensures mechanisms are put in place to facilitate stakeholder communication
(Management: communicates with stakeholders)

Governance

- Adjusts boardroom practices for effective governance (orientation, evaluation, etc.)

“With respect to each of the areas identified above, the board has a governance role, not a management role. The board is not responsible for day-to-day management. The board governs and management manages.” – American Hospital Association

What Makes a Great Hospital Board Member?



- ✓ Bring passion for the mission
- ✓ Devote the necessary time, energy
- ✓ Actively listen, participate in meetings
- ✓ Set healthy “tone at the top”
- ✓ Give the CEO space to lead
- ✓ Ask probing questions; avoids those previously answered
- ✓ Put the organization first; does not push personal agenda
- ✓ Assess management’s processes for decisions
- ✓ “Debate then commit”

Sources: Spencer Stuart research; BoardSource: What Makes a Good Board Member

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

To: El Camino Hospital Board of Directors
From: Mary Rotunno, General Counsel
Date: December 1, 2021
Subject: Continuation of Resolution 2021-10 of the Board of Directors Making Findings and Determinations Under AB 361 for Teleconference Meetings

Recommendation: To continue the determination made by the Board of Directors at its meeting on October 13, 2021 in Resolution 2021-10 acknowledging that there still exists a state of emergency due to the COVID-19 pandemic and to continue the findings by the Board of Directors to allow continued public participation by teleconference in Board and Advisory Committee meetings in accordance with the recommendation of the Santa Clara County Health Officer.

Summary:

- Situation:** At the October 13, 2021 Board Meeting, the Board of Directors adopted Resolution 2021-10, which made findings to continue holding virtual public meetings under the Ralph M. Brown Act based on the continued state of emergency due to the COVID-19 pandemic and that either (a) the state of emergency continues to directly impact the ability to meet safely in person, or (b) state or local officials continue to impose or recommend measures to promote social distancing.

This Resolution relies on the September 21, 2021 recommendation by the Health Officer of the County of Santa Clara that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings.
- Authority:** On March 17, 2020, in response to the COVID-19 pandemic, Governor Newsom issued Executive Order N-29-20 suspending certain provisions of the Brown Act in order to allow local legislative bodies to conduct meetings telephonically or by other means. On June 11, 2021, Governor Newsom issued Executive Order N-09-21, which placed an end date of September 30, 2021, for agencies to meet remotely. On September 1, 2021, Governor Newsom signed Assembly Bill 361 (2021) ("AB 361") which allows for local legislative and advisory bodies to continue to conduct meetings via teleconferencing if the Board of Directors, by majority vote, make the findings set forth in paragraph 1 above, not later than thirty (30) days after teleconferencing for the first time under the AB 361 rules, and every 30 days thereafter.
- Legal and Compliance Review:** ECH outside counsel at Best Best & Krieger, LLP ("BB&K"), reviewed the legislation and prepared Resolution 2021-10.

Attachment:

- Resolution 2021-10 - Resolution of the Board of Directors of El Camino Hospital Making Findings and Determinations Under AB 361 for Teleconference Meetings

RESOLUTION 2021-10

**RESOLUTION OF THE BOARD OF DIRECTORS OF
EL CAMINO HOSPITAL
MAKING FINDINGS AND DETERMINATIONS
UNDER AB 361 FOR TELECONFERENCE MEETINGS**

WHEREAS, all meetings of the El Camino Hospital's Board of Directors and Advisory Committees are open and public, as required by the Ralph M. Brown Act (Cal. Gov. Code §§ 54950 – 54963), so that any member of the public may attend, participate, and watch the Board of Directors and its Advisory Committees conduct their business;

WHEREAS, such meetings ordinarily take place on the campus of the Hospital, located at 2500 Grant Road, Mountain View, California, 94040, in the County of Santa Clara;

WHEREAS, ordinarily, the Ralph M. Brown Act imposes certain requirements on local agencies meeting via teleconference;

WHEREAS, the Legislature recently enacted Assembly Bill 361 (AB 361), which amended Government Code section 54953 to allow local agencies to use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) of section 54953 of the Government Code if the legislative body holds a meeting during a proclaimed state of emergency and determines by majority vote that, as a result of the emergency, either (a) meeting in person would present imminent risks to the health and safety of attendees, or (b) state or local official continue to impose or recommend measures to promote social distancing;

WHEREAS, the Governor issued a proclamation declaring a state of emergency on March 4, 2020 due to the COVID-19 pandemic, pursuant to section 8625 of the California Emergency Services Act, and this proclaimed state of emergency currently remains in effect;

WHEREAS, on August 2, 2021, in response to the Delta variant, the Health Officer of the County of Santa Clara ordered all individuals to wear face coverings when inside public spaces;

WHEREAS, on September 21, 2021, the Health Officer of the County of Santa Clara issued a recommendation that public bodies continue to meet remotely due to their unique characteristics, such as the increased mixing associated with bringing together people from across the community, the need to enable those who are immunocompromised or unvaccinated to be able to safely continue to fully participate in public governmental meetings, and the challenges with fully ascertaining and ensuring compliance with vaccination and other recommendations at such meetings;

WHEREAS, AB 361 requires compliance with separate procedures for teleconference meetings during a state of emergency, found in subdivision (e) of Government Code section 54953;

WHEREAS, AB 361 requires that the legislative body using the teleconferencing procedures of AB 361 make renewed findings by majority vote, not later than every thirty (30) days, that the legislative body has reconsidered the circumstances of the state of emergency, and that either (a) the state of emergency continues to directly impact the ability of the members to meet safety in person,

or (b) state or local officials continue to impose or recommend measures to promote social distancing;

WHEREAS, the Board of Directors of the Hospital desires to make findings and determinations for meetings of the Board of Directors and its Advisory Committees consistent with AB 361 to utilize the special procedures for teleconferencing provided by AB 361 due to imminent risks to the health and safety of attendees, as well as Hospital staff and patients;

WHEREAS, in response to the COVID-19 pandemic, Hospital staff has set up hybrid in-person/teleconference public meetings, whereby members of the Board of Directors and Advisory Committee members and staff that can attend the meeting in-person on the campus of the Hospital can do so, while members of the public have the full ability to observe and comment on the meetings off-campus through the Hospital's virtual meeting platforms;

WHEREAS, the Board of Directors fully supports the public's right to participate in all meetings of the Board of Directors and its Advisory Committees, but acknowledges that it cannot require members of the public who wish to attend meetings in-person to submit proof of vaccination or negative test results;

WHEREAS, it is important that the Board of Directors ensure that Board members, Advisory Committee members and Hospital staff have a safe workplace and Hospital patients have a safe environment to receive care, to the maximum extent possible; and

WHEREAS, the Board of Directors desires to balance the rights of members of the public to participate in meetings of the Board of Directors and its Advisory Committees with the rights of the Board of Directors, Advisory Committee members and Hospital staff to conduct the meetings in a safe environment.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of El Camino Hospital, that:

1. The Board of Directors finds and determines that, as a result of the COVID-19 pandemic emergency, meetings of the Board of Directors and its Advisory Committees in which the public attends in-person on the campus of the Hospital would present imminent risks to the health and safety of the Board of Directors, Hospital staff, members of the public and patients of the Hospital.
2. The Board of Directors finds and determines that conducting such meetings in a hybrid in-person/teleconference model provides the safest environment for the Board of Directors, Advisory Committee members and Hospital staff to conduct business, while allowing for maximum public participation.
3. The Board of Directors finds and determines that the Health Officer of the County of Santa Clara has recommended measures to promote social distancing as one means to reduce the risk of COVID-19 transmission.

4. The Board of Directors and its Advisory Committees shall conduct teleconference meetings under AB 361 in accordance with the requirements of AB 361, found in subdivision (e) of Government Code section 54953.
5. Through the duration of the state of emergency, if the Board of Directors desires to continue utilizing teleconferencing meetings under the special provisions of AB 361, the Board of Directors will make findings by majority vote not later than thirty (30) days after this meeting (or, if there is no meeting within thirty (30) days of this meeting, at the start of the next meeting), and not later than every thirty (30) days thereafter (or, if there is no meeting within thirty (30) days thereafter, at the start of the next meeting), that the Board of Directors has reconsidered the circumstances of the state of emergency and that either (a) the state of emergency continues to directly impact the ability of the public to meet safely in person, or (b) that state or local officials continue to impose or recommend measures to promote social distancing.
6. The findings of the Board of Directors set forth above apply to all meetings of the Board of Directors and its Advisory Committees, including, without limitation, the October 4, 2021 meeting of the Quality, Patient Care and Patient Experience Committee, which predated this Resolution.

PASSED AND ADOPTED at the regular meeting of the Board of Directors of El Camino Hospital held on October 13, 2021 by the following vote:

AYES: Chen, Fung, Kliger, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin

NOES: None

ABSENT: None

ABSTAIN: None

ATTEST:

DocuSigned by:

Lanhee Chen

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Chair,
El Camino Hospital Board of Directors

DocuSigned by:

Julia Miller

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Secretary,
El Camino Hospital Board of Directors



**Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday November 10, 2022**

Pursuant to Government code section 54950.1, El Camino Health will not be providing a physical location to the public for this meeting. Instead, the public is invited to join the open session meeting via teleconference at:

Board Members Present

Lanhee Chen, Chair
 Peter Chung, MD
 Julie Higer, MPA, S
 Julia E. Miller, Secretary/Treasurer
 Mac Po, MD, PhD
 Bob Reiter, Vice-Chair
 George O. Ting, MD
 Donatters
 John Oglin
 via teleconference

Board Members Absent

Carol A. Somersille, MD

Members Excused

None

Agenda Item	Comments/Discussion	Approvals/Action
<input type="checkbox"/> CALL TO ORDER <input type="checkbox"/> ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:32 pm by Chair Chen. A verbal roll call was taken. All Board members were present at roll call, excluding Director Somersille. Chair Chen reviewed the logistics for the meeting. A quorum was present pursuant to State of California Executive Orders N-25-20 dated March 12, 2020, and N-26-20 dated March 13, 2020.	
<input type="checkbox"/> POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Chen asked the Board of Directors for declarations of conflict of interest with any items on the agenda, and none were reported.	
<input type="checkbox"/> PUBLIC COMMUNICATION	None	
<input type="checkbox"/> FINANCIAL RESULTS	Carlos Bohorquez, CFO, presented the Summary of Financial Results Q1 FY 2022 and highlighted the following: <ul style="list-style-type: none"> • Q1 FY2022 results reflect a full recovery from the effects of the Covid pandemic • Revenue has been particularly strong, which is attributed to record volumes across most inpatient / outpatient service lines, strategic pricing initiative implemented on July 1, and stable payor mix • Higher than expected volumes are resulting in unfavorable to budget trends for total FTEs, salaries/wages, and other expenses, but not significant enough to impact margins negatively • Despite strong Q1 financial results, we anticipate staffing shortages and higher than expected inflation to negatively impact operating EBITDA margins in the 2-3% range in Q2 & Q3 • Underperformance by our investment portfolio has resulted in unfavorable to budget net margin Mr. Bohorquez committed to getting back to 40 days in AR by the end of FY 2022 and further disclosed that he will also look into what caused the minor change in depreciation.	

<p>QUALITY COMMITTEE REPORT</p>	<p>Director Liger debriefed the Board of Directors on the Quality Committee meeting that was held on November 1 and disclosed the following items of note:</p> <ul style="list-style-type: none"> FY22 Quarterly Dashboard El Camino Health Quality Report <p>Dr. Adams shared that Leapfrog released their latest safety results, and both Los Altos and Mountain View campuses received an "A" safety grade.</p>	
<p>ADJOURN TO CLOSED SESSION</p>	<p>To adjourn to closed session at 6:03 pm pursuant to Gov't Code Section 54957.2 for approval of the Minutes of the Closed Session of the Hospital Board Meeting (10/22/21); pursuant to Health and Safety Code Section 32155 for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: Medical Staff Report (Medical Staff Credentials and Privileges Report); pursuant to Gov't Code Section 54957 for discussion on personnel matters, the FY21 Audited Financial Report; pursuant to Gov't Code Section 54957, for a conference with Real Property Negotiator; pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, FY21 Individual Performance Incentive Scores and Payouts and FY21 CEO Incentive Individual Score & Payout; pursuant to Gov't Code Section 54957 for discussion on personnel performance matters, an Executive Session with the CEO and a CEO Report.</p> <p>Motion: to adjourn to closed session at 6:03 pm</p> <p>Movant: Miller Second: Ting Ayes: Chen, Fung, Liger, Miller, Po, Rebitzer, Ting, Atters, Oglin Noes: None Abstentions: None Absent: Somersille Recused: None</p>	<p>Adjourned to closed session at 6:03 pm</p>
<p>AGENDA ITEM RECONVENE OPEN SESSION REPORT OUT</p>	<p>Open Session reconvened at 7:44 pm by Chair Chen. Agenda items 7-15 were addressed in the closed session.</p> <p>During the closed session, the Board approved the Minutes of the Closed Session of the Hospital Board Meeting (10/13/21) and the Credentialing and Privileges Report by a unanimous vote in favor of all members present and participating in the meeting (Director Chen, Fung, Liger, Miller, Po, Rebitzer, Ting, Atters, and Oglin). Director Somersille was absent.</p>	
<p>AGENDA ITEM CONSENT CALENDAR ITEMS</p>	<p>Chair Chen asked if any member of the Board or the public wished to remove an item from the consent calendar. Chair Chen requested to pull item 17c – Policy Revisions.</p> <p>Motion: To approve the consent calendar minus 17c.</p> <p>Movant: Miller Second: Fung Ayes: Chen, Fung, Liger, Miller, Po, Rebitzer, Ting, Atters, Oglin Noes: None Abstentions: None Absent: Somersille Recused: None</p> <p>Chair Chen called for discussion regarding agenda item 17c. Clarification was raised to Ms. Rotunno regarding the number of</p>	<p>Consent calendar approved</p>

	<p>motions required to take item 17c off the table and approve.</p> <p>Ms. Rotunno responded that it would be two separate motions to take item 17c off the table and approve the motion.</p> <p>Motion: to take 17c – Policy Revisions off the table.</p> <p>Movant: Miller Second: Fung Ayes: Chen, Fung, Liger, Miller, Po, Rebitzer, Ting,atters,oglin Noes: None Abstentions: None Absent: Somersille Recused: None</p> <p>Motion: to approve 17c – Policy Revisions.</p> <p>Movant: Miller Second: Liger Ayes: Chen, Fung, Liger, Miller, Po, Rebitzer, Ting,atters,oglin Noes: None Abstentions: None Absent: Somersille Recused: None</p>	
<p>AGENDA ITEM CEO REPORT</p>	<p>Dan Woods, CEO, advised the Board of Directors on the following organizational updates:</p> <ul style="list-style-type: none"> • El Camino Health has not reported a Stage 3 or 4 pressure ulcer related to HAPI in the past months. • ECH is 100% compliant with Covid-19 vaccination requirements mandated by the CDPH. Additionally, El Camino is focused on recruiting and retaining medical staff. As a result, 700 additional shifts are covered with the Critical Pay Bonus shift program. • "MyCare Now" Digital Front Door App has implemented new features to engage and prepare patients for Surgery and Childbirth with over 1000 active users. • Fulfilling the Promise fundraising initiative for mental health & addiction services event was held. This was the first in-person fundraiser in 2 years. • Auxiliary staff donated over 3,500 hours for the month of August. 	
<p>AGENDA ITEM BOARD COMMENTS</p>	<p>Director Miller shared she has been asked to join the Philanthropy counsel and has brought in two additional people to join the council as well.</p>	
<p>AGENDA ITEM ADJOURNMENT</p>	<p>Motion: adjourn at 7:54 pm.</p> <p>Movant: Need Second: Fung Ayes: Chen, Fung, Liger, Miller, Po, Rebitzer, Ting,atters,oglin Noes: None Abstentions: None Absent: Somersille Recused: None</p>	<p>Meeting adjourned at 7:54 pm</p>

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

Lanhee Chen
Chair, ECH Board of Directors

Julia E. Miller
Secretary, ECH Board of Directors

Prepared by: Nicole Hartley, Executive Assistant II

EL CAMINO HOSPITAL BOARD OF DIRECTORS

December 8th, 2021

Policy Revisions

Dept.	Policy Name	Type of Change	Type of Document	Notes	Committee Approvals
Environment of Care	Fire Prevention Management Plan	Revised	Plan	Updated for FY22 Goals	Central Safety, Patient and Employee Safety Committee
Risk & Patient Safety	Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)	Revised	Policy	Changes made in accordance with Legal	Dr. Cook, Medicine Department Executive Committee & MCH Exec.
Patient Experience	Interpreting Services	Revised	Policy	Added Medical Staff to coverage, added Patient Guidebook information and added documentation and refusal of interpreter	Risk Management
Medical Staff	Ongoing Professional Practice Evaluation (OPPE)	Revised	Policy	Updated to align with regulatory compliance	Leadership Council
Nursing	Plan for Provision of Nursing Care Scope of Practice for Nursing Services	Revised None	Plan Scope of Service	Updated job titles to current, Updated committee structures, added Direct Care Informatics Council, APRN and CNO Advisory Cabinet, updated hospital and MSO committees	Medical Executive Committee



Origination: 02/2018
Effective: Upon Approval
Last Approved: N/A
Last Revised: 11/2021
Next Review: 1 year after approval
Owner: John Folk: Director
 Engineering Svcs
Area: Fire Safety Management
Document Types: Plan

Environment of Care Fire Prevention Management Plan

COVERAGE:

This Fire Prevention Management Plan applies to hospital functions at all hospital-operated facilities including the Mountain View and Los Gatos campuses and outpatient clinics.

PROGRAM OBJECTIVES AND SCOPE:

El Camino Hospital Health is committed to providing a safe, accessible, effective and efficient Environment of Care consistent with its mission, services and applicable governmental mandate. This includes the provision of environment of care that protects patients, employees, visitors and property from fire and smoke. The intent of this plan is to describe a comprehensive, facility-wide management system, the objectives of which are to:

1. Anticipate, identify, assess and adequately control risks to human health, safety and the care environment relative to fire prevention and life safety;
2. Ensure processes, operations, work practices and behaviors remain conducive to continued fire prevention, safety, and conform to applicable standard and governmental mandate (i.e. Fire prevention Code 101, Title 8, Title 19, various fire codes);
3. Provide education and training that fosters an acceptable level of continuous readiness and emergency preparedness through safety training and fire drills;
4. Maintain the structural and systemic features of fire protection with a level of integrity and functionality that is adequate and compliant; and
5. Implement interim life safety activities to protect occupants during periods when a building does not meet the applicable provision of the life safety code.

A. Goals:

Based on areas of improvement noted in the FY-202021 Annual Evaluation, the performance improvement indicators for FY-212022 will be:

- Staff knowledge of horizontal and vertical evacuation (defend in place strategy, move to next smoke compartment).

Staff knowledge of the acronym RACE for responding to a fire situation

Staff knowledge of the acronym PASS for using a fire extinguisher

- Staff can locate the nearest location of extinguishers and fire alarm pull stations and can articulate how to use them.
- Staff ~~knowledge on the Hospital~~know the facility emergency phone number (55)

B. Objectives:

Specific objectives of the FY-~~21~~2022 Fire Prevention Management Plan include the following:

~~Complete certification of fire doors in Hospital and associated outpatient clinics as applicable~~

- Continue to educate all Engineering staff on new fire protection systems such as fire pump, sprinklers and alarm systems in the new Sobrato and Taube buildings.
- Identified supervisory staff will attend NFPA code classes to further their knowledge and applications of fire safety codes.

~~Develop an internal auditing process to ensure contract fire system companies are meeting all of their contractual obligations.~~

~~Ensure a process is in place to provide oversight on all contractors working in electrical and IDF closets or rooms.~~

- Increase oversight ~~and~~an improve mechanisms for the monitoring of above ceiling work that includes contractors, project management and facilities. Look at developing a above ceiling permit policy.

~~Continue to implement the required High Rise Emergency Action Plan for the Sobrato building.~~

~~Upgrade the NVR in the Central Utility Plant.~~

- Complete the upgrade to the audible fire alarm system to digital, which will further improve communication quality and response times.

REFERENCES:

1. Joint Commission Accreditation Manual for Hospitals, Environment of Care Standards, EC .02.03.01, .02.03.03, .02.03.05, Code of Federal Regulations, Title 29, Sections 1910.101-106, 155;
2. California Code of Regulations, Title 8, Sections 3203, 3220, 3219, 3221, 6151, 6184;
3. Title 19, Chapters 1 and 5;
4. California Code of Regulations, Title 22, Sections 70741, 70743, 70745;
5. NFPA 101 (Fire prevention Code), Chapters 5, 6, 7 and 13;
6. NFPA 13, 72, 96.

AUTHORITY

In accordance with its bylaws and administrative protocols, the El Camino ~~Hospital~~Health Leadership Team has given authority to the Safety and Facility Directors and Chief Engineer to ensure this plan is formulated, appropriately set forth and implemented. Program implementation and day-to-day operational management has been delegated to the Chief Engineer.

The authority and responsibility for fire prevention response education has been delegated to the Facility and Safety Directors/Officer & the Chief of Engineering under the supervision of the Chief Administrative Officer (CAO).

PROGRAM ORGANIZATION AND

RESPONSIBILITIES

A. Leadership Team

The El Camino Hospital Health Leadership Team (i.e. the organization's governing body) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of business fundamentals relative to environmental health and safety.

B. Facilities Engineering Department

The El Camino Mountain View and Los Gatos Engineering Department, in partnership with the Facility and Safety/Security Director, is responsible for the overall management of the fire prevention management program. This includes:

1. Coordinating the initial assessment of risks (including assistance with construction/remodel project risk assessments);
2. Program design and developing the facility's written plan;
3. Monitoring ceiling and wall penetrations for fire prevention;
4. Identifying training needs;
5. Tracking/interpretation of relevant fire codes; and
6. Technical consultation; assistance with implementation; initial response investigation and reporting of emergency events; and evaluation of program efficacy and improvement.

C. Environmental Health & Safety Manager/Clinical Laboratory Chief Engineer

The EH&S Manager works together with the Laboratory Departments and Chief Engineer to assess life safety issues and fire hazards within the Pathology and Clinical Laboratories, and ensure that these hazards are addressed through appropriate procedures, processes, and systems.

D. Central Safety Committee

The Central Safety Committee (CSC) ensures the fire prevention management program remains in alignment with the core values and goals of the organization by providing direction, determining priority and assessing the need for change. The CSC also ensures coordination, communication and appropriate integration of performance improvement, strategic planning and injury prevention activities, including those of existing committees, sub-committees and organizational units and establishes and /or approves infrastructures to support Performance Improvement techniques.

The Central Safety Committee meets regularly and as part of the standing agenda, receives and reviews reports and summaries of action taken relative to Fire Prevention Management on a quarterly basis.

Agenda items include:

- Issues requiring action, recommendations or approval;
- Issues requiring monitoring/periodic or ongoing review; and
- Needs that are multi-disciplinary in nature.

E. Department Managers/Directors

Department Managers are responsible for the development and management of department-specific fire prevention programs that include:

- Procedures for fire prevention, where applicable;
- Basic fire response plan; equipment and procedures for the movement of patients to areas of refuge;

- Evacuation procedures;
- Fire safety training for employees; and
- Emergency/incident reporting and investigating procedures.
- Engineering to provide consultative services to dept. managers around fire safety.

F. Employees

Employees (including contract employees) are responsible to participate in required fire prevention training and fire drills, and must demonstrate core competencies in the subject matter. Employees must ensure their behaviors, work practices and operations are fire safe, responsible and in alignment with the facility and departmental procedures (including the no smoking policy), applicable training, and provisions of this plan.

IRIS ASSESSMENT

Risks associated with fire are typically identified and assess through facility-wide processes described within this plan, such as:

1. Routine Hazard Surveillance (daily rounding)
2. The examination of the building's fire protection features and assessment of LSC compliance, conducted as part of the completion of the **Statement of Conditions (SOC)**.
3. A **Building Inspection/Maintenance Program** to identify and resolve operational/non-structural LSC deficiencies;
4. Comprehensive project evaluations and site assessments to determine the need for **Interim Life Safety Measures**;
5. **Safety Trends Spreadsheet** – Central Safety Committee review of pertinent data/information; incident reports; evaluations, and risk analysis.

The risk profile with respect to fire and life safety includes, but is not limited to: risk of fires; explosions; exposure to smoke and toxic combustion by-products; life safety system failure; risk of harm to patients, staff, and visitors; legal exposures.

Key factors driving the level of relative risk are likelihood of an unwanted event coupled with the magnitude of the consequences. These factors are typically affected by the existence and management of ignition sources (such as smoking and heat producing elements), volume and type of ignitable substances, combustible fuel load, high risk activities, integrity and efficacy of fire prevention systems.

In light of this, high risk areas where additional resources and attention are directed, as appropriate, include the clinical laboratory/pathology, oxygen enriched environments (such as the O.R.), Facility Services, storage areas, construction projects (ILSM), corridors and stairwells, and waste storage.

These resources include:

- The application and maintenance of effective fire prevention features and systems (compartments, automatic suppression, early warning, portable extinguishers, etc.),
- The development and implementation of comprehensive fire prevention procedures
- Interim Life Safety Measures (ILSM) where identified deficiencies and construction compromise fire prevention systems, and
- Effective response procedures, the efficacy and appropriateness of which are evaluated through Fire Drills.

PROGRAM IMPLEMENTATION

The text that follows highlights the fire prevention management plan implementation processes:

A. **Assessment of the building's structural and mechanical features of fire protection** - The life safety features of the building are periodically evaluated in an effort to assess and ensure compliance with the applicable NFPA 101 (LSC) standards and to preserve their integrity and effectiveness. To this end, processes of inspections, testing, maintenance, interim measures, and repairs are coordinated through the Facility Services Department (and construction services, as appropriate), in concert with the Safety/ Security department. Life Safety Code deficiencies and areas of non-compliance are identified and documented through the on-going **Statement of Conditions (SOC)** process. This evaluation process gives rise to a single source document that adequately reflects the overall condition of the building and systems, as it relates to the Life Safety Code. Any LSC deficiencies are immediately corrected.

1. In addition to the SOC assessment and correction processes, this facility has established and implemented a **Building Maintenance Program (BMP)** to identify and resolve the more ongoing, mechanical and operational deficiencies (e.g. door latches, exit lights, penetrations, corridors, etc.), in lieu of creating PFIs for their resolutions.
2. A comprehensive Life Safety Code **Building Inspection Program** is the primary component of the BMP. Most of this program element is incorporated into and conducted through the Hazard Surveillance and Facilities Services Rounds. The Hazard Surveillance and engineering inspection protocols (Instruction Sets) address required elements set forth in the Joint Commission standards.
3. The frequency of the Life Safety Code Building Inspections will coincide with the established Hazard Surveillance Rounds and engineering rounds schedule. However, Plant Engineering is responsible for conducting additional inspections if it is so indicated through direct observation of deficiencies, additional projects involving remodeling, structural changes, electrical work or activities that are likely to change or compromise the condition of the life safety features.
4. The Engineering Department is responsible for periodic inspections of the integrity of the fire and smoke stop partitions, including follow up inspections once a construction project is completed.
5. The table below describes the common types of LSC deficiencies to be addressed through the BMP, and the responsible functions:

LSC Compliance Item	Responsible Functions
<p>Rated Doors, including stairwell and occupancy separation doors have:</p> <ul style="list-style-type: none"> a. Functioning positively latching assemblies b. Properly functioning self-closing devices c. Gaps of less than an 1/8" between double leaf doors d. Less than 3/4" undercuts e. (LSC 5-2.1.5.4, 13-3.2.1) 	Engineering to assess, repair and maintain
<p>Rated Partitions (smoke and fire):</p> <ul style="list-style-type: none"> a. Have properly functioning self-closing or automatic closing devices (LSC 5-2.6; 5-2.1.5.3) 	Engineering to assess and make repairs.

<p>b. Are maintained to preclude the transmission of smoke/fire (e.g. penetrations sealed with approved rated materials) (LSC 6/3.6.1).</p> <p>c. Corridor wall penetrations are properly sealed with materials capable of maintaining intended resistance (LSC 6-3.6.1)</p>	
<p>Means of Egress lighting properly functioning (LSC 5-8.1).</p>	<ul style="list-style-type: none"> ▪ Engineering ▪ Safety ▪ Security ▪ Hazard Surveillance team
<p>Exit signs and Directional signs clearly show emergency exit routes (LSC 5-10.1.2)</p>	<ul style="list-style-type: none"> ▪ Engineering ▪ Safety ▪ Security ▪ Hazard Surveillance team
<p>The following Grease Producing Devices are properly maintained:</p> <p>a. Exhaust hoods</p> <p>b. Duct systems</p> <p>c. Grease removal devices</p> <p>d. (LSC 7-2.3; NFPA 96)</p>	<ul style="list-style-type: none"> ▪ Hazard Surveillance ▪ Safety ▪ Engineering ▪ Nutritional Services

B. **Testing of the life safety systems**, as well as annual preventive maintenance of all components and initiating devices are conducted by internal engineering personnel on a pre-determined, cyclical schedule that ensures optimal coverage with minimal disruption of care and business activities. (Resources may be supplemented by personnel from a licensed contract firm).

1. Maintenance and testing requirements include:

- a. Inspection and testing of all Initiating Devices at prescribed intervals (including smoke detectors, flow and tamper switches, duct detectors and manual pull stations) and supervisory devices.
- b. Five year hydrostatic testing of standpipes
- c. Annual testing of audible alarms, strobes, PA systems, etc.
- d. Visual inspections of fire department connections
- e. Weekly fire pump testing under no flow conditions
- f. Annual fire pump testing under flow conditions
- g. Operation of smoke and fire dampers (every 6 years)
- h. Annual testing of roll down doors
- i. Maintenance of any cooking facility exhaust hood systems (to include filter changes, hood cleaning and degreasing, and duct maintenance). **02.03.05)**

j. Inspection of water based fire suppression systems; including pumps, drains and connection are coordinated through Engineering.

2. Engineering coordinates the testing of other automatic fire suppression systems (such as kitchen hood system, pre-action, Halon, etc.), through a licensed contractor.
3. Included in the foregoing inspection, testing and maintenance processes are detection and early warning devices that, upon actuation, triggers systems designed to slow the movement of fire and the transmission of smoke such as designated fans, in-duct dampers, and self-closing rated doors. Engineering will ensure that the functionality of the dampers themselves are tested and verified every six years.
4. Fire alarms are monitored externally by a compliant proprietary supervising station (per NFPA 72, 4-4.2.1). Upon activation, the signal enunciates locally and is immediately transmitted to the monitoring agency that notifies the fire department having jurisdiction. This system is periodically tested as part of the fire drill processes.
5. The Security Department is responsible for inspecting portable fire extinguishers monthly and coordinating annual servicing.

C. **Fire Drills** - In an effort to enhance training and reinforce fire readiness, the Security Department, in concert with engineering, will ensure fire drills are scheduled and conducted at the frequency of one drill per shift per quarter. Each drill will be observed and critiqued to help determine the overall level of emergency preparedness, discern areas requiring improvement, and assess the effectiveness of the fire prevention training efforts. Additional fire drills are coordinated as necessary for compliance with Interim Life Safety Measures (ILSM).

In lieu of observing all areas during a drill, a sample of areas will be selected, including the point of alarm/drill origin, an adjacent area, a smoke compartment above and/or below (as applicable) the point of origin. Part of the fire drill process includes an on-the-spot educational component to compliment life safety and fire prevention training efforts. Fire Drill scenarios are designed to simulate fires and ensuing emergency events and to evaluate staff knowledge of the following:

- Use and functioning of fire alarm systems (e.g. manual pull stations)
- Transmission of alarms
- Smoke and fire containment
- Transfer to areas of refuge (horizontal and vertical evacuation)
- Extinguishment
- Specific fire response duties
- Preparing for building evacuation

All personnel are trained in the facility fire response plan and the effectiveness of such training is evaluated as part of the Fire Prevention Program performance measure (**EC .02.03.03**)

D. **Interim Life Safety Measures** □Where conditions during construction/remodel projects and or identified life safety code deficiencies impair any existing life safety system, appropriate interim systems are implemented in lieu of the impaired system in an effort to compensate for the temporary loss and ensure continued integrity of the program. The Safety and Facility Director will work in partnership with the Construction Project Manager, Chief Engineer and the local fire authority having jurisdiction, as indicated. They will ensure that, prior to the start of any project, risks are adequately assessed, and the appropriate

interim measures are selected and implemented, as the level of risk decreases.

If a life safety system is to remain impaired, or if the Chief Engineer feels that the impaired Life safety System is vitally critical, then the Chief Engineer (designee) will instruct the Security department or Construction Services to institute a fire watch and will ensure the local Fire Authority is notified and institute ILSM per code requirements.

E. **Education and Training** □ All employees attend General Hospital Orientation (GHO) at the time of hire, where general information and education regarding the basic fire response plan, fire prevention, the smoking policy, and life safety features of the building are provided. Licensed Independent Practitioners (LIP) receive training at the time of credentialing and with each renewal. Additionally, subsequent training and practical application are provided during fire drills. Department managers will also ensure that subsequent training is given that is specific to departmental procedures, processes, behaviors and precautions, to include:

1. Specific roles and responsibilities at the fire or alarm's point of origin, including:
 - Relocation of those close to the source or otherwise in immediate danger;
 - Activate emergency notification procedures, including alarm systems and phone numbers;
 - Confinement of the fire, including closing doors and compartments, management of flammables and oxidizers;
 - Proper use of extinguishing equipment.
 - Location and proper use of equipment for evacuating patients to areas of refuge, points of assembly, etc.;
2. Specific roles and responsibilities if a fire alarm actuates and the employee and/or LIP is away from the point of origin, i.e. respond if appropriate, stand by and await further instructions, prepare to close doors and relocate occupants.
3. Other relevant aspects of life safety, fire prevention, as well as any substantive changes, adjustments and improvements of the subject matter, based upon:
 - Assessment of educational needs, coordinated through the department manager;
 - Organizational experiences and learning's;
 - Results of risks assessments, hazard surveillance, inspections, etc.;
 - Central Safety Committee recommendations;
 - EH&S Manager, Facility Director or the Safety/Security Director's input.

PROGRAM PERFORMANCE

The standards and indicators by which performance relative to this plan will be measured are developed based upon organizational experiences, discerned risks, inspection results, observed work practices, and Integrated Safety Committee recommendations. They include:

A. Intent/Requirement:

Staff knowledge, skill and competency necessary for their role(s) in the event of a fire or fire alarm. As part of the facility's ongoing efforts to improve staff knowledge, the average percentage of correct responses to subject questions will be tracked.

B. Performance Standard:

Acceptable Staff performance with respect to the facility's fire prevention program requires that employees understand their roles and responsibilities relative to the use of fire prevention systems, emergency notification, relocation of occupants, etc.

Based on opportunities for improvement identified in FY-~~20~~2021 annual EOC evaluation the FY-~~21~~2022 Performance Improvement Indicators are as follows:

EOC Area	Indicator	Responsible Dept/Function	Target
Fire Prevention	Staff knowledge of the acronym RACE for responding to a fire situation Staff can locate the nearest location of extinguishers and fire alarm pull stations and can articulate how to use them	Engineering, Security and Department Managers	>90%
Fire Prevention	Staff knowledge of the acronym PASS for using a fire extinguisher Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%
Fire Prevention	Staff knowledge on the Hospital of the facility emergency phone number (55)	Engineering, Security and Department Managers	> 90%
* Percentage of employees surveyed during fire drills who knew the requested information.			

C. Process and Frequency of Measurement:

Progress for this project will be reported out quarterly at the Central Safety Committee. Data will be collected during hazard surveillance rounds and fire drills.

PROGRAM EFFECTIVENESS

The effectiveness of the fire prevention program, including the appropriateness of the program design, training, equipment and behaviors will be monitored and assessed on an ongoing basis through the Central Safety Committee. Relevant documents, reports, as well as concurrent and retrospective statistical data will be tracked through the facility's Safety Trends spreadsheet. The Central Safety Committee will receive periodic fire prevention reports and make recommendations as indicated. Reports include:

- Significant, relevant information gleaned from fire drill reports
- The results of inspections by regulatory agencies
- Reports of actual emergencies

- Interim Fire Prevention Measures that may affect building occupants
- Reports of fire prevention code deficiencies that may require additional time and/or resources to correct.

ANNUAL PROGRAM EVALUATION

On an annual basis, the fire prevention management program is evaluated relative to its **objectives, scope, effectiveness and performance**. The continued appropriateness and relevance of program **Objectives** are assessed, as well as whether or not these objectives were met.

The **Scope** is evaluated relative to its continuing to comprise meaningful aspects, relevant equipment, technology and systems, items that add value and elements conducive to continuous regulatory compliance.

The year is reviewed retrospectively to determine the extent to which the program was **Effective** in meeting the needs of the customer, the patients and the organization, within the parameters of the given Scope and Objectives. This analysis includes initiatives, accomplishments, problem solving, examples and other evidence of effectiveness.

The **Performance** dimensions are reviewed to evaluate expectations of performance attainment, measurement techniques, process stability and improvement efforts and outcomes, secondary to performance monitoring results.

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued applicability of program objectives.

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2021
Patient and Employee Safety Committee	Delfina Payer: Projects Coordinator [JH]	11/2021
Central Safey Committee	Matthew Scannell: Director Safety & Security Services [JH]	10/2021
Central Safey Committee	Steve Weirauch: Mgr Environmental Hlth&Safety	09/2021
Fire Safety Management Work Group	John Folk: Director Engineering Svcs	09/2021
	John Folk: Director Engineering Svcs	09/2021



Origination: 03/2012
 Effective: Upon Approval
 Last Approved: N/A
 Last Revised: 11/2021
 Next Review: 3 years after approval
 Owner: Sheetal Shah: Dir Risk Mgmt & Patient Safety
 Area: Emergency Department
 Document Types: Policy

Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)

~~I. COVERAGE:~~

COVERAGE:

All El Camino Hospital (ECH) Employees and Medical Staff

~~II. PURPOSE:~~

PURPOSE:

Provide guidance to ECH staff and physician on obligations under the Emergency Medical Treatment and Labor Act (EMTALA).

~~III. POLICY STATEMENT:~~

POLICY STATEMENT:

It is the policy of El Camino Hospital to comply with state and federal laws regarding EMTALA in accordance with the policy below. ECH will provide emergency services and care without regard to an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender orientation), preexisting medical condition, physical or mental condition, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical disability, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

~~IV. DEFINITIONS~~

DEFINITIONS

Full glossary of terms used in this policy is found in Appendix A.

~~V~~ ~~APPLICABILITY~~

APPLICABILITY

- A. This policy applies to ~~anyone~~ individuals who ~~requests~~ request or are in need of an evaluation for ~~an~~ medical condition who presents to the Emergency ~~Medical Condition~~ Department (EMC ~~see Appendix A for definition~~ ED) ~~who presents to the~~ OB Emergency Department, ~~OB Emergency Department~~ (OBED) or the Labor and Delivery (L&D) units on campus.
- B. Individuals requesting or in need of evaluation and treatment for a potential Emergency Medical Condition (EMC) who present in areas on hospital property other than the ED, OB ED and L&D units are governed by *Administrative policy: EMTALA-Providing Emergency Services to Individuals outside the Emergency Department.*
- C. This policy does not apply to inpatients or outpatients receiving treatment in the hospital or licensed hospital clinic. If an ~~emergency medical condition~~ EMC develops during an outpatient encounter, appropriate policies should be followed which may include referring the patient to the nearest Emergency Department.

~~This EMTALA policy does not apply when the Secretary of HHS declares a public health emergency and the hospital has received a waiver of EMTALA requirements for the area in which the Hospital is located. The waiver of the Hospital's EMTALA requirements applies only for the period during which the waiver is in effect. Refer to procedure: EM Surge Plan 03.07 Alt Care Sites 1135 Waiver for more information.~~

~~VI~~ ~~PROCEDURE: EMTALA RE~~ ~~QUIREMENTS~~

PROCEDURE: EMTALA RE QUIREMENTS

A. Screening Requirements:

1. All individuals who come to the ED, OB ED or L&D unit requesting or in need of examination or treatment ~~effor~~ for a medical condition shall receive an appropriate medical screening examination (MSE). An MSE is provided without discrimination to ~~the~~ any individual requesting or in need of evaluation and is the same examination provided to any individual coming to the ED/OBED/L&D unit with similar signs and symptoms. The hospital shall not delay in providing the MSE or necessary stabilizing treatment in order to inquire about an individual's method of payment or insurance status.
2. ~~A~~ An MSE is performed by a physician or a ~~qualified medical professional~~ Qualified Medical Professional, as defined in the Medical Staff bylaws, rules and regulations, as a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competency (per hospital policy) in assessing the laboring patient.
3. ~~A~~ An MSE is performed to determine within reasonable clinical confidence, whether an EMC exists. The scope of the examination must be tailored to the presenting complaint and the medical history of the patient.
4. The MSE includes the provision of all services available within the capabilities of the Hospital, which, in the judgment of the ED physician or other treating Physician or ~~qualified medical professional~~ Qualified Medical Professional are necessary to screen and/or stabilize an individual with an EMC. The process may range from simple examination such as brief H&P to complex

examination that may include lab tests, diagnostic imaging and the use of on call specialty Physicians. If the physician or ~~qualified medical professional~~ Qualified Medical Professional determines that the patient requires the services of an on call physician, the on call physician shall be contacted. Documentation to support the process and evaluation taken as part of the MSE shall be appropriately documented in the EHR.

B. Registration

1. The hospital shall not delay in providing a MSE or necessary stabilizing treatment in order to inquire about an individual's method of payment or insurance status. Requests for any payment or payor authorization are not to be made prior to the MSE and initiation of any stabilizing treatment.
2. If a patient asks whether the hospital accepts their health plan or raises other financial matters, staff may answer the patient's inquiry. However, staff should reaffirm (and so document) the offer to provide a MSE and take reasonable steps to encourage the patient to remain for the examination. If after this discussion a patient is unwilling to proceed with the MSE for any reason, the patient's refusal to be examined should be documented in the medical record and the *EMTALA-Refusal of Medical Screening* policy should be followed.

C. Patients who Do Not have an EMC or whose Condition has been Stabilized

Once the MSE is completed and there is a determination the patient does **not** have an EMC or the EMC has been stabilized, the patient, in accordance with applicable policies governing the situations below, may be:

1. Treated;
2. Discharged so long as the patient has reached a point clinically where further care is not needed or may be reasonably performed on an outpatient basis or later scheduled on an inpatient basis and the patient is given a reasonable plan for appropriate follow up care and discharge instructions; or
3. Transferred for continued care.

D. Patients who have An EMC

1. When a Physician or Qualified Medical Professional determines that the patient has an EMC, the Hospital shall:
 - a. Within the capability of the staff and facilities, provide further medical examination and treatment as required to stabilize the patient's condition to the point where the EMC is stabilized (see Paragraph C above for further treatment, discharge or transfer); or
 - b. Admit the patient as an inpatient, or if the hospital does not have the capability or capacity to stabilize the EMC, provide for an appropriate transfer of the unstabilized patient to another medical facility pursuant to Section E below.

E. Transfer of Patients with Unstabilized EMC

1. Eligibility for Patient Transfer. The hospital may not transfer a patient with an unstabilized EMC except under the following circumstances:
 - a. The patient or surrogate requests the transfer after being informed of the hospital's obligations and the risks of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he/she is aware of the risks and benefits of the transfer.
 - b. With physician certification documenting that the medical benefits expected from transfer outweigh the risks.

- c. Complete documentation regarding the transfer shall be in EHR.
- 2. Transfer Requirements for Patients with an Unstabilized EMC.
 - a. The hospital shall provide that treatment which is within the capacity of the hospital to minimize the risk of transfer to the patient.
 - b. Contact a receiving hospital that has the capacity and capability (available beds and personnel) and has agreed to treat the patient and receive acceptance of the patient. It is recommended that communication between accepting physicians and nursing staff occur.
 - c. Transfer all medical records of the encounter
 - d. Use qualified personnel, equipment, and mode of transport based on the clinical presentation of the patient, including use of necessary and medically appropriate life support measures during the transfer. The physician is responsible for determining the mode of transport.
 - e. A physician has signed the transfer certification that the benefits of the transfer of the patient to another facility outweigh the risks and provide the medical reason for the transfer, the risk and benefit analysis upon which the decision is based. It is not necessary to repeat information in the medical record, however, the certification must provide a complete picture of the expected benefits from appropriate care at the receiving facility, and risks associated with the transfer. The certification shall be timed and dated close to the time of actual transfer.
 - f. The patient's vital signs are taken at time of transfer.

F. Refusal of Medical Screening Exam Treatment or Transfer

- 1. If the patient or surrogate refuses the MSE, staff shall follow the ***EMTALA-Refusal of Medical Screening Exam policy***.
- 2. If the patient with an unstabilized EMC refuses recommended treatment or transfer after the MSE, the physician should be contacted to inform the patient or surrogate of the risks and benefits of performing the further examination and stabilizing treatment **AND** document a statement to this ~~effect~~ in the patient's medical record, and take all reasonable steps to secure the patient's or surrogate's written informed consent to refuse further examination and treatment following appropriate hospital procedures.

On-Call Physician Obligation:

- 1. The hospital shall maintain a list of Physicians who are on-call to provide service after the initial examination for providing consultation or treatment necessary to stabilize the patient with a potential EMC. The physician or ~~qualified~~ Qualified Medical Professional performing the medical ~~professional performing the medical~~ screening examination has the ultimate authority to decide whether an EMC is present and that there is need for the immediate services of the on-call specialist and whether onsite presence of the on call specialist is required.
- 2. Once the on call physician is contacted, the on-call specialist is to respond within the defined response time pursuant to the applicable on call contract with the hospital.
- 3. The on-call physician has the responsibility to inform the ED if unable to respond when on-call and should make effort to find coverage. Valid examples include:
 - a. Circumstances beyond his/her control
 - b. Currently performing elective or emergency surgery and cannot respond in person within a clinically timely manner to evaluate or treat the patient

- c. On-call MDs can attend to their private practices, but may not "stack" surgeries on their on-call day. The physician would be expected to interrupt the schedule or arrange for a back-up physician to be on-call
 - d. It is the responsibility of the on-call physician to notify the ED when s/he has made changes to the schedule. The on call physician must provide the ED with his/her replacement's name
 - e. The hospital should make appropriate arrangements to safely care/transfer the patient when there is not an on-call physician available.
 - f. Physicians can be on call simultaneously at other hospitals, but the on-call physician has the duty to inform all hospitals involved of his/her schedule.
 - g. The medical staff by-laws, rules and regulations should state the allowed exemptions for on-call duty.
4. On-call physicians shall not engage in:
- a. delay tactics such as debating with the ED physician or ~~qualified medical professional~~ Qualified Medical Professional on the necessity of coming to the hospital
 - b. asking about payment status or any other non-clinically relevant information about the patient
 - c. only offering office follow-up
 - d. insist on another specialist consult before coming to the hospital
5. Concerns regarding on call physician compliance with responding to ED requests for service shall be reported through appropriate chain of command and incident reports.
- EMTALA obligates the transferring emergency physician to report if an on-call physician neglects to fulfill his/her on-call duties. EMTALA requires that the patient's medical record be sent along with the patient transfer. That medical record must contain "the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment."

H. General Policies:

1. **Signage:** The hospital shall post required signage conspicuously in required areas in the required form required by CMS that specifies the rights of individuals to examination and treatment for EMCs and that ECH participates in the Medicaid program.
2. **Central Log:** Each department where a patient may present for emergency services (e.g., Emergency Department, OB-ED, Labor and Delivery unit) shall maintain a central log recording the names of individuals who come to the applicable department for services. In addition, the log shall contain information about whether the person refused treatment, was refused treatment by the hospital or whether the individual was stabilized and transferred, admitted to the inpatient area, or discharged.
3. **Maintenance of Records:** Medical and other records (such as transfer logs, on-call lists and changes to the on-call list and central logs) will be maintained in accordance with ECH record-retention policies, but not less than five years.
4. **Disputes:** In the event of any concern over emergency services to an individual, or a dispute with another facility regarding a transfer or a concern about ECH compliance with EMTALA, staff and physicians will refer the dispute to the Director, Regulatory and Accreditation or Compliance Officer.
5. **Reporting EMTALA Violations:** ECH will report to CMS or the Department of Public Health if it has

a reason to believe that it has received an individual who has been transferred in an unstabilized EMC from another facility within 72 hours of . All hospital personnel who believe that an EMTALA violation has occurred will report the violation to the Emergency Department Manager, Compliance Officer or Director, Regulatory and Accreditation.

- ❑ **Retaliation:** ECH will not retaliate, penalize or take adverse action against any physician or qualified medical person for refusing to transfer an individual with an emergency medical condition that has not been stabilized, or against any ECH employee for reporting a violation of EMTALA or state laws to a governmental enforcement agency.

Applicable Regulations:

EMTALA Statute: United States Code, Title 42, Section 305dd.

EMTALA Regulations: Code of Federal Regulations (CFR) 42, Sections 400.20 and 400.24, 2000.

California Licensing Laws on Emergency Services and Care: California Health and Safety Code, Sections 1317, 1317.2, 1317.2a, and 1317.4.

Appendix A

DEFINITIONS:

1. **Appropriate Transfer:** Means a transfer of an individual with an emergency medical condition that is implemented in accordance with EMTALA standards.
 2. **Campus:** The buildings, structures and public areas of the hospital located on hospital property (see definition of hospital property below). Off-Campus means the buildings, structure and public areas of the hospital that are located off-site of the hospital property but are owned or operated by the hospital.
 3. **Capability:** Refers to the physical space, equipment, staff, supplies and services (e.g., surgery, intensive care, pediatrics, obstetrics, and psychiatry), including ancillary services available at the hospital.
 4. **Capacity:** The ability of the hospital to accommodate an individual requesting or needing examination or the treatment of a transferred individual. Capacity encompasses the number and availability of qualified staff, beds, equipment and the hospital's past practices of accommodating additional individuals in excess of its occupancy limits.
 5. **Central Log:** All dedicated emergency departments (DED) must maintain a log that documents each individual who comes to the DED, or individuals referred to the DED that arrived at another location on the hospital property seeking emergency assistance.
- ❑ **Comes to the Emergency Department:** Under the EMTALA regulations a person is considered to come to the emergency department under any of the following circumstances:
 - a. A person who presents to a dedicated ED and:
 - i. Requests examination or treatment for a medical condition; or
 - ii. Has a request made on his/her behalf for examination or treatment for a medical condition; or
 - iii. A prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition
 - b. A person who presents on hospital property (other than a dedicated ED)
 - i. Requests examination or treatment for what may be an emergency medical condition; or

- ii. Has a request made on his/her behalf for examination or treatment for what may be an emergency medical condition; or
- iii. A prudent lay-person observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for what may be a emergency medical condition
- c. Is in a ground or air ambulance owned and operated by the hospital regardless of the location of the ambulance. Except:
 - i. If the ambulance is operated under a community wide emergency medical service (EMS) protocol that direct the ambulance to transport the patient to another hospital
 - ii. The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance
- d. A person who is a patient in an ambulance not owned or operated by the hospital, but is on hospital property for the purpose of examination or treatment for a medical condition at the hospital's dedicated ED.

~~**Compliance:** A Medicare participating hospital that has a dedicated ED must comply with EMTALA. The Federal Regulations Code states: A participating hospital has entered into a provider agreement mandated by Section 1861 of the Social Security Act, as amended, and regulations adopted by the Centers for Medicare and Medicaid Services (CMS), and applicable state laws governing the provision of emergency services and care." (Moy, 2003).~~

7. Dedicated Emergency Department (DED) A hospital department or facility, either on or off the main hospital campus, and meets one of the following requirements:

- a. The department or facilities is licensed by the state as an emergency department
- b. The department is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- c. During the immediately preceding calendar year, it provided (based on a representative sample) at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Department of the Hospital: A hospital facility or department that provides services under the name, ownership, provider number, financial and administrative control of the hospital. For purposes of EMTALA, a department of the hospital does not include a skilled nursing facility, home health agency, rural health clinic, free-standing ambulatory surgery center, private physician office or any other provider or entity that participates in the Medicare program under a separate provider number that is different from the hospital provider number.

Emergency Medical Condition (EMC) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably expect to result in:

- a. Placing the individual (or, with respect to a pregnant woman), the woman or her unborn child in serious jeopardy
- b. With respect to a pregnant woman who is having contractions:
 - i. that there is inadequate time to effect a safe transfer to another hospital before delivery; or

- ii. that transfer may pose a threat to the health or safety of the woman or unborn child
 - c. Serious impairment to bodily functions
 - d. Serious dysfunction of any body organ or part
10. **EMTALA:** Means the Emergency Medical Treatment and Labor Act codified in §1303 and 1307 of the Social Security Act (42 U.S.C. §1305dd), and the regulations and interpretive guidelines adopted by CMS hereunder. EMTALA is also referred to as the "patient anti-dumping" law.
 11. **Enforcement:** CMS and the Office of the Inspector General (OIG) of the U. S. Department of Health and Human Services are responsible for the enforcement of EMTALA. Violations of EMTALA may be reported to other federal and state agencies and to the Joint Commission (TJC).
 12. **Hospital Property:** Means the entire main hospital campus, including areas and structures that are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office, to be part of the main hospital's campus. Hospital property includes offices that are part of the main hospital's campus. Hospital property includes the parking lots, sidewalks, and driveways on the hospital main campus.
 13. **Inpatient:** Means an individual who is admitted to the hospital for bed occupancy for purposes of receiving inpatient services with the expectation that he/she will remain at least overnight and occupy a bed, even though the individual may be later discharged or transferred to another facility and does not actually use a hospital bed overnight. The EMTALA obligation does not apply once the patient is admitted from the ED, when sent from the MD office or nursing home as direct admissions to the inpatient setting. CMS and the state agree with this definition of inpatient.
 14. **Labor:** Labor includes the latent or early phase of labor and continues through the delivery of the placenta. A woman experiencing contractions is in true labor, unless a physician, certified nurse mid-wife, or other qualified medical person acting within his/her scope of practice as defined by the hospital medical staff by-laws and State law, certifies that, after a reasonable period of observation, the woman is in false labor.
 15. **Medical Screening Examination (MSE):** The process required to reach within reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. The MSE is an ongoing process, including monitoring of the individual, until the individual is either stabilized or transferred. The basics of the MSE are:
 - a. To determine if an emergency medical condition exists
 - b. The medical staff by-laws, rules and regulations state who can perform the MSE
 - c. Is an ongoing process and must be provided in the same manner to all individuals presenting with similar complaints. It is a screening process that is reasonably calculated to determine whether an emergency medical condition exists.
 - d. It is part of the permanent medical record
 16. **Non-Discrimination:** ECH will provide emergency services and care without regard to an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), preexisting medical condition, physical or mental disability, insurance status, economic status or ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.
 17. **On-Call List:** A list of physicians who are "on-call" after the initial medical screening examination to

provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.

- 1 **Outpatient:** An individual who has begun to receive outpatient services as part of an encounter, other than an encounter that triggers the EMTALA obligations. An "encounter" is a direct personal contact between an outpatient and a physician or qualified medical person who is authorized by state law to order or furnish hospital services for the diagnosis or treatment of the outpatient.
- 1 **Physician:** Means: a doctor of medicine or osteopathy; a doctor of dental surgery or dental medicine; a doctor of podiatric medicine; a doctor of optometry, each acting within the scope of his/her respective licensure and clinical privileges.
20. **Physician Certification:** Means the written certification by the treating physician ordering a transfer and setting forth, based on the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer.
21. **Qualified Medical Person:** Means an individual other than a physician who is licensed or certified by the state; practices in a category of health professionals that has been designated by the hospital and the medical staff bylaws, rules and regulations, to perform medical screening examinations; has demonstrated current competence in the performance of medical screening examinations within his/her health profession; and as applicable, performs the medical screening examination in accordance with protocols, standardized procedures or other policies as may be required by law or hospital policy. A qualified medical person may include registered nurses, nurse practitioners, nurse midwives, psychiatric social workers, psychologists and physician assistants.
22. **Sanctions:** Failure to comply with EMTALA may result in termination by CMS of the hospital's participation in the Medicare and Medicaid programs, as well as civil monetary penalties imposed by the OIG for both the hospital and physicians ~~of up to \$104,200~~ and possible exclusion from Medicare/Medicaid. Failure to comply with state laws on emergency services is subject to licensing enforcement action. A violation of EMTALA is also subject to civil lawsuits against the hospital for damages
23. **Signage:** Signs will be posted by the hospital in its dedicated emergency department(s) and in a place or places likely to be noticed by all individuals entering the dedicated emergency department(s) (including waiting room, admitting area, entrance and treatment areas), that inform individuals of their rights under EMTALA.
24. **Stabilized:** Means, with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual from the hospital or in the case of a woman in labor, that the woman delivered the child and the placenta. An individual will be deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.
25. **To Stabilize:** ith respect to an emergency medical condition, to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the hospital, in the case of a woman in labor, that the woman has delivered the child and placenta.
- 2 **Stable for Discharge:** Following a determination by the treating physician within reasonable clinical confidence, that an individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient,

provided the individual is given a plan for appropriate follow-up care with the discharge instructions.

27. **Transfer:** The movement (including the discharge) of an individual outside the hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or who leaves the hospital against medical advice or without being seen.
28. **Triage:** A process to determine the order in which individuals will be provided a medical screening examination by a physician or qualified medical person. Triage is not the equivalent of a medical screening examination and does not determine the presence or absence of an emergency medical condition.

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Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2021
MCH Exec	Nikki Le Bautista: Medical Staff Coord [JH]	11/2021
Medicine Department Executive Committee	Nathalie Garcia: Medical Staff Coord [JH]	11/2021
Medicine Department Executive Committee	Annette Cruz: Medical Staff Coord [JH]	11/2021
UPC	Chuck Bryan: Clinical Manager	01/2021
	Sheetal Shah: Dir Risk Mgmt & Patient Safety	01/2021



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Next Review: 1 year after approval
Owner: Christine Cunningham: Exec Director Patient Exp & Perf Improvement
Area: Patient Experience
Document Types: Policy

Interpreting Services

I □ COVERAGE:

All El Camino Hospital staff and ~~medical-staff~~ Medical Staff

II □ PURPOSE:

To ensure that effective communication is facilitated for all patients in a manner consistent with state and federal law.

III □ POLIC □ STATEMENT:

~~□ whenever~~ Communication is a cornerstone of patient safety and quality care, and every patient has the right to receive information in a manner s/he understands. Effective communication allows patients to participate more fully in their care. It is the policy of El Camino Hospital that whenever a language or communication barrier prevents effective communication, interpreting services will be facilitated. This policy includes non-English speaking patients, limited English speaking patients, ~~visual~~ and hearing impaired patients. ~~The~~ Every patient is informed of the availability of interpreter services ~~or may choose to use a family member or friend who volunteers to interpret.~~

Hospital employees will be notified of the hospital commitment to provide interpreters to all patients who need and request them through hospital-wide communications, such as employee newsletters, and department communications. New employees will be informed during the New Employee Orientation Process.

IV □ PROCEDURE:

- A. The Patient □uidebook which is given to patients on admission contains information about interpreting services. □ whenever possible, patients are asked to notify Patient Registration staff of interpreting needs prior to admission.
- B. The need for an interpreter is assessed at the time of admission and throughout the patient's stay and documented □□□□. Any patient who requires or requests interpreting services will be informed of the availability of the interpreter service.
- C. Primary consideration will be given to the individual's chosen communication method or interpreter. P
~~Information on interpreting services shall be given to patients on admission. □ whenever possible, patients are asked to notify Patient Registration staff of interpreting needs prior to admission.~~

~~Use of interpreting services shall be documented in the EHR or on relevant consent forms.~~

- D. ~~The hospital has a contractual agreement with the following for language interpretation:~~an Interpreter Services Vendor to provide certified interpreter services as follows.
- ~~Language Line which provides video and audio interpreting services, including American Sign Language. Directions on how to access Language Line can be found on the Toolbox.~~The vendor will provide video and audio interpreting services including American Sign Language. Directions on how to access this vendor can be found on the EC Toolbox using search Interpreter Services.
 - ~~In-person Mandarin language translation: Information on how to access this person is available on the ECH Toolbox.~~In-person Mandarin language translation: Information on how to access this person is available on the EC Toolbox.
 - Dual headset phones can be found in many departments. If a dual headset phone is needed and not available in a particular area of the hospital, please contact the Assistant Hospital Manager/Hospital Supervisor.
- E. Hearing Impaired Patients:
- At the patient's request, a T.D.D. phone will be installed at the patient's bedside for use during the hospital stay. It is obtained from the Telecommunications Department.
 - ~~Sign Language Interpreting Services are listed in the ECH Toolbox under "Hearing Impaired Patients". Language Line also offers American Sign Language interpreting.~~Sign Language Interpreting Services are listed in the EC Toolbox under Hearing Impaired Patients. Our Interpreter Services Vendor also offers American Sign Language interpreting.
 - Hearing impaired patients will also be identified on admission and documented in the patient's medical record. The patient's ability to use other forms of communication will be recorded in the medical record, including lip reading, written notes and hearing devices.
 - Document the name of the person or agency used to interpret for consent issues on the consent form, as well as the interpreter's ID number (when using ~~Language Line~~our vendor).
 - For additional services related to interpreting services, please contact Patient Experience and/or Assistant Hospital Manager/Hospital.
- F. Documentation and Refusal of Interpreter
1. The need for an interpreter is assessed at the time of admission and throughout the patient's stay. All use of interpreters shall be documented in the patient's EHR in the appropriate area.
- H. 2. Patients may refuse to use the hospital interpreter service and request that an adult family member be used. Minor children are never allowed to be used as an interpreter regardless of patient preference. Staff should document in the EHR flow-sheet in Appendix A that the patient has been offered the use of hospital interpreter services, refused and requested an adult family member.

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MEC	Catherine Carson: Senior Director Quality [JH]	11/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2021
	Christine Cunningham: Exec Director Patient Exp & Perf Improvement [JH]	11/2021

COPY



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Owner: Raquel Barnett: Director
 Medical Staff Services
Area: Medical Staff
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Ongoing Professional Practice Evaluation OPPE

I COVERAGE:

All members of the medical staff and allied health practitioners.

II PURPOSE:

To define the process for ongoing professional practice evaluation (OPPE) of medical staff members and allied health practitioners at El Camino ~~Hospital~~Health. The primary goal of OPPE is to ~~use OPPE as a tool to~~ identify professional practice trends that impact the quality and safety of patient care and to ensure current clinical competence of medical staff members and allied health practitioners as part of El Camino ~~Hospital~~Health's commitment to quality.

III DE FINITIONS:

1. **Practitioner:** The word Practitioner used throughout this policy means both licensed independent practitioner and allied health practitioner.

2. **OPPE:** Ongoing Professional Practice Evaluation (OPPE) monitors and evaluates professional practice trends that impact on quality of care and patient safety for medical staff members and allied health practitioners under medical staff supervision. Ongoing professional practice evaluation differs from other quality improvement processes in that it evaluates the strengths and opportunities of an individual practitioner's performance rather than appraising the quality of care rendered by a group of professionals or a system. The evaluation is based upon generally recognized standards of care and multiple sources of information, including but not limited to the review of individual cases, the review of aggregate data per El Camino Hospital Medical Staff Bylaws and Rules and Regulations, and other relevant criteria as reasonably determined by the hospital's Medical Staff. Through this process, practitioners receive feedback for clinical improvement or confirmation of clinical achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

3. **FPPE:** Focused Professional Practice Evaluation (FPPE) establishes and confirms an individual practitioner's privilege-specific competency at the time when he/she requests new privileges, either at initial appointment or as a current member of the medical staff or allied health practitioner staff, and is also used to evaluate and monitor a practitioner's ability to provide safe, high quality care. FPPE is a time-limited period or process in which a designated number of procedures, admissions, or consults, etc., are reviewed, during which the Medical Staff evaluates and determines a practitioner's professional competence.

4. **OPPE Indicators:** Specialty-specific data, both quantitative and qualitative, that has been approved by the medical staff as an evaluation tool for competent and quality care of patients. OPPE includes but is not limited to evaluation of patient care, medical clinical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and system-based practice.

5. **Quantitative Data:** Quantitative data reflects a certain quantity, amount, or range and is generally expressed as a unit of measure in quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, time frames, etc.

6. **Qualitative Data:** Qualitative data reflects data that approximates and characterizes' and is often non-numerical in nature. This type of data may be collected through methods of observations, discussions with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc.

7. **Triggers thresholds:** OPPE indicator thresholds/triggers are established by the medical staff and indicate the need for performance monitoring. Triggers can be single incidents or evidence of a clinical practice trend.

8. **Designee:** A Vice Chair or appointed Medical Director of a medical specialty or a person identified by the Chief of Staff.

IV POLICY STATEMENT:

Ongoing Professional Practice Evaluation (OPPE) is conducted on an ongoing basis and will include review of performance data for all practitioners with clinical privileges at ECH. This process includes concurrent and/or retrospective review of an individual practitioner's performance of clinical professional activities by Department Chair and/or their designee through the procedures outlined in this policy.

The Medical Staff Services Department manages, compiles, and evaluates OPPE data in coordination with Department Chairs and designees.

V REFERENCES:

1. Comprehensive Accreditation Manual for Hospitals, ~~January 1, 2017~~, Medical Staff Chapter.
2. FPPE/OPPE Booster Pak - The Joint Commission.
3. Ongoing Professional Practice Evaluation (OPPE) - Understanding the Requirements, The Joint Commission
4. National Practitioner Data Bank (NPDB) Guidebook

VI PROCEDURE:

- ~~A. OPPE will be conducted every eight (8) months.~~
- ~~B. The Medical Executive Committee (MEC) will establish criteria for the ongoing professional practice evaluation which may include mortality and complication data, blood and medication usage data, length of stay, use of tests and procedures, use of consultants and other pertinent data. All practitioners will be part of this ongoing evaluation, not only those with performance issues.~~
- ~~C. Duties and responsibilities: Each medical staff department chief (or one of the department officers, if designated by the chief) shall be responsible for:~~
- ~~1. Establishing additional criteria for the specialty that will be included in the ongoing evaluation and is approved by the department executive committee. MEC and the Board will review and approve or make recommendations for revision.~~

2. Review, investigate, and address any concerns regarding the information in each department practitioner's OPPE report. The department chief will sign off each report in a timely manner.
3. Information resulting from the evaluation will be used to determine whether to continue, limit, or revoke any existing privileges at the time the information is analyzed.
 - a. Continue privileges Practitioner is performing well or within desired expectations and no further action is warranted – department chief may make this decision and the record of the decision, along with the data, will be filed in the practitioner's credentials file.
 - b. Determine that issues exist that require a focused practitioner performance evaluation (see Medical Staff Policy on FPPE) – department chief may make this decision.
 - c. Determine whether zero performance of a privilege should trigger FPPE (i.e. proctoring) department chief may make this decision.
 - d. Determine that the privilege should be continued because the organization's mission is to be able to provide the privilege to its patients and there are no competence issues in the other data available for this practitioner department chief may make this decision.
 - e. Limit or revoke privileges department chief will make a recommendation to the MEC and the corrective action procedure will be invoked (Medical Staff Bylaws, Article 7).

D. Medical Staff Executive Committee (MEC) will be responsible for:

1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.
2. Determining how often the data will be reviewed.
3. Acting upon recommendations for corrective action as described in Medical Staff Bylaws, Article 7 & (Corrective Action and Hearings and Appellate Reviews Section)

E. Board of Directors will be responsible for:

1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.
2. Acting upon recommendations for corrective action as described in Medical Staff Bylaws Articles 7 & (Corrective Action and Fair Hearing Sections).

F. Methodologies for Collecting Data

1. Quality indicators selected and approved by medical staff
2. Quality review reports
3. Periodic chart review
4. Direct observation
5. Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.
7. Peer recommendation from a peer who is in the same professional discipline and is knowledgeable about the applicant's professional performance and competence.
- Quality data obtained from a practitioner's primary hospital (when the primary hospital is not ECH). It will be the practitioner's responsibility to obtain such data. The department chief, upon review of this

~~data, will determine whether the data is sufficient to assess ongoing clinical competence.~~

~~☐ National Practitioner DataBank (NPDB) ECH obtains reports from NPDB at the time of initial appointment, reappointment, and addition of privileges and ongoing via the NPDB Continuous Query Service.~~

~~10. Medical Board of CA Disciplinary Action Reports ☐ ECH reviews actions taken regarding all licensed practitioners.~~

A. Ongoing Professional Practice Evaluation review will be conducted every eight (8) months and applies to any privilege granted to be exercised in the hospital

B. The Medical Executive Committee (MEC) will establish criteria for OPPE in consultation with Department Chairs and Medical Directors. All practitioners will be part of this ongoing evaluation.

C. Department Chair or designee will be responsible for:

1. Establishing criteria for the specialty that will be included in the ongoing evaluation.

2. Review, investigate, and address any concerns regarding the information in each department practitioner's OPPE report. The Department Chair, or designee will sign off each report within sixty (60) days.

3. The Department Chair may recommend the following but not limited to:

a. Continue privileges ☐ Practitioner is performing well or within desired expectations

b. Targeted chart review - Concerns exist

c. Trend for next OPPE cycle - Concerns exist

d. FPPE Recommended - Concerns exist

e. Recommend limit or revoke privileges - Significant concerns exist (Physician has the right to appeal as per Article 10 of the Bylaws)

D. Upon review of relevant information, the Department Chair in coordination with the Credentials Committee and/or the Department Executive Committee may do any of the following: chart review, track and trend, FPPE, recommend limitation or revocation of privileges to the Medical Executive Committee and Board of Directors.

E. The Credentials Committee will be responsible for:

1. Review and either accept or revise recommendations

2. Any changes to OPPE recommendations are communicated to the Department Chair and the practitioner.

F. Medical Staff Executive Committee (MEC) will be responsible for:

1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.

☐. Board of Directors will be responsible for:

1. Reviewing and approving recommendations from each department with regard to the type of data and amount of data that will be reviewed.

H. OPPE Data:

1. The Medical Staff Services Department manages, compiles, and evaluates OPPE data in coordination with Department Chairs and designees.

2. The Professional Practice Evaluation Manager will review OPPE Indicators with Department Chairs and designees at least annually.
3. All documentation related to FPPE and OPPE will be stored in the practitioner's confidential electronic file which is stored in MD-Staff/MD-Stat database.
4. Professional practice evaluation information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities.

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Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2021
Medical Staff Leadership Committee	elli Bruns: Supv Medical Staff Svcs	10/2021
	Raquel Barnett: Director Medical Staff Services [B]	10/2021



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Area: Patient Care Services
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Plan for Provision of Nursing Care

COVERAGE:

All El Camino Hospital staff

PURPOSE OF PLAN

El Camino Hospital's (ECH) plan for providing nursing care is designed to clearly outline the system of nursing practice utilized. The plan for providing nursing care supports both the Hospital's and Nursing's mission and philosophy, and is based on the needs of the patients and their families, the physicians, the interdisciplinary team, and the nursing staff.

MISSION STATEMENT

El Camino Hospital Nursing Services espouses the philosophy that the patient is at the center of its business. We are dedicated to providing the best healthcare possible to our patients. We believe in the dignity and respect of each patient as an individual. Nursing services exist to provide the professional practice of nursing to El Camino Hospital patients, as well as to assist in the coordination of all services delivered to patients.

DEFINITION OF NURSING

Nursing is the diagnosis and treatment of human responses to actual or potential health problems. Nursing is further defined as those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill.

VISIONS FOR NURSING

- Decision making at the bedside. Managers as support to the staff.
- Support services at the point of care delivery, enabling nurses to stay at the bedside.
- Interdisciplinary approach to care planning and care delivery through patient-centered care coordination.
- Service excellence through selection, training, and system support. Service excellence depends on effective systems, technical skills and interpersonal skills.

NURSING PHILOSOPHY

- El Camino Hospital's Nursing Division is committed to excellence in patient care through competence,

confidence and caring. We believe that:

- Caring is the essence of nursing.
- Our patients and their needs are our central focus.
- Each person is unique and is characterized by his/her own life patterns.
- It is essential to consider the patient's age, nationality, race, creed, and cultural background in planning for and providing care.
- Individuals interact with their environment; therefore, patient care must reflect consideration for the psychosocial, spiritual and cultural variables that influence the perception of their illness.
- Our patients have the right to live and die with dignity.
- Patient care is optimized when accountability for decisions and actions is shared between patient and caregivers.
- Patients, families and/or significant others contribute to the patient's well being.
- An environment with clear expectations of professional practice and established standards of care ensures optimal patient care.
- Quality patient care can best be provided in an atmosphere of continuing staff development, clinical research, and professional growth.
- Professional growth and staff development is a responsibility shared by the individual employee and the organization.
- Nursing is both an art and a science, a professional discipline that requires a sound education and is grounded in its own research base.
- Nursing as a clinical discipline employs physiological, psychosocial, physical and technological means for human comfort, sustenance and improved well-being.
- We, as nurses, and our nursing colleagues have a right to be recognized and rewarded as professional practitioners.
- Patient care is enhanced by providing continuity of care through thoughtful patient assignments and relevant communication between caregivers.

RESPONSIBILITIES AND ACCOUNTABILITIES

A. Registered Nurses (RNs)

ECH RNs perform the following:

1. Assess patients' needs considering physiologic, cognitive, and psychosocial factors. Assessments specifically address age-specific needs, environmental factors, cultural factors, self-care ability, educational needs and discharge planning requirements before assigning care to other members of the healthcare team.
2. Involve the patient and the patient's significant others in determining patient care needs and nursing interventions.
3. Plan and coordinate patient care in collaboration with physicians, other clinical disciplines, patient and the patient's significant others. The planning and delivery of care shall reflect all aspects of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy with the initiation of these processes at the time of admission.
4. Educate the patient and significant others regarding specific health care needs of the patient.
5. Document initial assessments, reassessments, interventions, responses to interventions, outcomes of interventions, and the ability of the patient or significant others to manage continuing care needs after discharge.

6. Utilize standards of care and standards of practice in providing and supervising patient care.
7. Work collaboratively with the medical staff and other health care disciplines to carry out diagnostic and therapeutic functions related to the evaluation and treatment of patients.
8. Evaluate care by utilizing performance improvement monitoring activities based on patient outcomes.
9. Prescribe, administer, supervise, and evaluate nursing activities. Perform these functions within the parameters of his/her educational background, experience, cultural, and ethical values.
10. Perform their duties in compliance with all regulatory agencies and in compliance with the Hospital's mission, goals, and policies and procedures.
11. Behavioral Health serves as the consultative liaison for crisis intervention services.

B. Licensed Vocational Nurses (LVNs)

ECH LVNs, with direction from a RN, perform the following:

1. Use and practice basic data collection, participate in planning, execute interventions in accordance with the plan of care or treatment plan and contribute to evaluation of individualized interventions related to the care plan or treatment plan.
2. Provide direct patient care.
3. Administer medications as allowed by the LVN practice act.
4. Demonstrate professional communication skills for the purpose of patient care, education, and multidisciplinary team collaboration.
5. Contribute to the development and implementation of a teaching plan related to self-care for the patient.
6. Perform their duties in compliance with all regulatory agencies and in compliance with the Hospital's mission, goals, and policies and procedures.

C. Clinical Support (CS) Staff Certified Nursing Assistants (CNAs)

ECH CS staff/CNAs with the direction from an RN perform the following:

1. Gather and document data.
2. Recognize and report abnormal data values.
3. Report data to the RN on a timely basis.
4. Assist patients in performing activities of daily living.
5. Actively collaborate with and take direction from the RN about the patient's plan of care.

D. Administrative Support (AS) Staff

ECH AS staff performs the following:

1. Provide clerical and communication functions.
2. Maintain a complete and accurate medical record.
3. Actively collaborate with all staff to promote efficient workflow within the unit and other departments.

E. Administrative Support (Monitor Technicians) (MTs)

ECH MTs perform the following:

1. Duties as outlined in D. above.
2. Monitor and interpret EKG rhythms and visual monitoring consistently and correctly.

3. Notify the RN of EKG changes or concerns.

F. Licensed Psychiatric Technicians □ LPTs □ Dialysis Patient Care Technicians □ ED Technicians □ OR and L&D Technicians □

ECH LPTs, Dialysis Patient Care Technicians, ED Technicians, OR and L&D Technicians with direction from a RN, perform the following:

1. Use and practice basic data collection, participate in planning, execute interventions in accordance with the plan of care or treatment plan and contribute to evaluation of individualized interventions related to the care plan or treatment plan.
2. Provide direct patient care
3. LPT may administer medications as allowed by the LPT practice act.
4. Demonstrate professional communication skills for the purpose of patient care, education and multidisciplinary team collaboration.
5. Contribute to the development and implementation of a teaching plan related to self-care for the patient.
6. Perform their duties in compliance with all regulatory agencies and in compliance with the Hospital's mission, goals, and policies and procedures.

G. Behavioral Health Workers

ECH behavioral health workers, with direction from a RN, perform the following:

1. Use and practice basic data collection, participate in planning, execute interventions in accordance with the plan of care or treatment plan and contribute to evaluation of individualized interventions related to the care plan or treatment plan.
2. Demonstrate professional communication skills for the purpose of patient care, education and multidisciplinary team collaboration.
3. Contribute to the development and implementation of a teaching plan related to self-care for the patient.

AREAS WHERE NURSING IS PRACTICED

◦ Acute Inpatient Areas	◦ Outpatient and Diagnostic Areas
Intensive & Critical Care Unit	Behavioral Services – Outpatient
Progressive Care Unit (PCU) (Stepdown)	Cancer Center
Operating Room (OR)	Cardio Pulmonary Wellness Center
Post-Anesthesia Care Unit (PACU)	Dialysis Services
Telemetry/Stroke	Endoscopy
Medical/Surgical/Ortho	Interventional Services
Pediatrics	Pre-op/ Short Stay Unit (2B)
Emergency Services	Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI)
Labor and Delivery (L&D)	Radiation Oncology

Mother/Baby	Outpatient Surgical Unit
Neonatal Intensive Care Unit (NICU) Level II and Level III	
Behavioral Health Services (Inpatient Psychiatry)	
Acute Rehabilitation	
Ortho Pavilion	

- Other

Care Coordination
Infection Control
Employee Health Services

SCOPE OF SERVICE

The scope of service which includes the types and ages of patients/clients served, assessment methods, scope and complexity of services, staffing/skill mix, level of service and standard of practice for each of the areas where nursing care is provided is included in the Department Specific Scope of Services Section of this document.

ORGANIZATION OF NURSING SERVICES

Nursing services has an organizational structure that maintains a close relationship among the CNO (Chief Nursing Officer), and the staff. This structure ensures that the CNO is aware of issues vital to quality patient care. The philosophy of nursing management is to promote a caring environment and to serve as support to the staff by continually improving patient care systems.

The CNO manages the quality of nursing practice across the organization. In addition, the CNO is responsible for directing the operations of the acute and specialty nursing units, the [Assistant Hospital Managers \(AHM\) and Hospital](#) supervisors and Patient Care Resources/Staffing office, as well as other functions outlined in the job description.

Nursing directors report to the CNO and have responsibility for the fulfillment of the service's mission by the development and achievement of short and long term goals and objectives identified in the goal setting process and working along with the medical staff, medical directors, and managers to provide the collaborative leadership necessary to achieve high quality, cost-effective, and integrated care. Clinical managers' report to a nursing director or to the CNO and have 24-hour responsibility for daily operations, as well as for the quality of care provided on one or more nursing units. The scope of this role includes, but is not limited to education, consultation, planning and administration.

Charge nurses are assigned each shift. Nursing Unit Coordinators (NUC's) are assigned as permanent Charge RN's on some of the nursing units. They report concerns to the clinical manager and/or to the Hospital supervisor. Additionally, the charge nurses/NUC's support the clinical managers in the operational/management activities of the unit on a shift basis. Assistant Clinical Managers and Nursing Unit Coordinators are present on some nursing units. They report to the clinical manager or Director.

Care coordinators are accountable for specific patient populations and are experts in clinical care for those patients. They identify patients who require more intensive care coordination and work with the nursing staff to

facilitate optimal patient outcomes. Care coordinators meet daily with staff from multiple disciplines to communicate issues and solve problems. Through daily meetings with staff, the care coordinators establish mechanisms that assist in the continuous improvement of care delivery, and they facilitate the coordination of a patient's care as the patient moves from one unit to another.

Care coordinators work closely with physicians, clinical managers, charge nurses and staff/clinical nurses in the use of clinical pathways/patient goal attainment and in the management and coordination of care. Additionally, care coordinators set up case conferences to improve patient outcomes through collaboration with the health care team. Multidisciplinary rounds are held at least weekly on each inpatient care unit. Care coordinators are an integral part of these rounds.

Preceptors are selected on each unit to assist with integrating new staff into the ECH system of care. They also assist in the training of staff transferring from another unit or staff being cross-trained. Preceptors serve as clinical role models. They maintain their competency at a high level in order to be effective in demonstrating competencies as well as monitoring the competencies of staff new to the unit.

The CNO is ultimately responsible and accountable for the quality of nursing care throughout the organization. Responsibility for nursing care is retained by nursing services when students and agency nurses are providing the care.

On the off shifts, the Assistant Hospital supervisor/Manager and Hospital supervisors not only manages/manage nursing services, but also serves as the representative for hospital administration. He/she has the authority to make decisions, which relate to the acute functioning of all departments. The Assistant Hospital Manager and Hospital supervisor consults other department managers/directors, clinical managers, nursing director the CNO, the Administrator–On-Call, as needed with off-shift problem/problems.

The Manager, Director of Clinical and Nursing Education, in collaboration with the CNO, coordinates with the schools of nursing. This coordination includes negotiation of contracts, determination of student placement, planning of future student interactions, and problem resolution. The Director of Clinical Education, in collaboration and coordination with appropriate nursing personnel, is responsible for planning and directing orientation for nursing unit personnel.

STANDARDS OF COMPETENT NURSING PRACTICE

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

1. Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
2. Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
3. Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
4. Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

5. Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.
6. Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.
7. Consistent standards for provision of nursing care within the hospital are used to monitor and evaluate the quality and appropriateness of nursing care to meet patient needs. The nursing staff functions according to the general standards of care, standards of competent nursing practice, unit-specific standards of nursing practice, and other standards as specified in the hospital's policy and procedure manuals.
8. All responsibilities, functions, and/or competency checklists of the nursing staff are documented in job descriptions.
9. Interim permittees function at ECH in accordance with the regulation and the direction of the California Board of Registered Nursing. A permittee only practices under the direct supervision of a registered nurse and is only allowed to perform nursing functions taught in the permittee's basic nursing program.

GENERAL STANDARDS OF CARE

SCOPE: All areas of the hospital where nursing care is provided. "Patient" may include family/significant other, where appropriate.

- Patients can expect to receive care within a safe environment.
- During the hospital stay, patients can expect to receive information/education regarding the hospital, nursing units, procedures, medications, and plan of care, plus, information/education regarding continuing health requirements post-discharge.
- Patients can expect to receive communication regarding responses to the care, illness, and therapy.
- Patients can expect to receive care in a supportive environment that facilitates their gradual progress toward independence.
- Patients can expect assistance with activities of daily living (ADLs) if they are unable to perform them.
- Patients can expect to receive care with respect for privacy, individuality, and values.
- Patients can expect to receive information concerning their rights, responsibilities, resources, and options.
- Patients can expect to have effective management of pain.
- Patients can expect that their health care dollars will be managed to optimize/achieve their goals and that patients and their significant others will be involved in the plan of care.

NURSING UNITS MAY HAVE ADDITIONAL STANDARDS OF CARE SPECIFIC TO THEIR PATIENT POPULATION.

STAFFING

A sufficient number of qualified RNs are on duty at all times to give patients the care that requires the judgment and specialized skills of a RN. Staffing is performed using staffing guidelines established from the previous budget year, anticipated patient volume and mix for the coming year and regulatory requirements. Historical data includes patient classification (nursing intensity measurement system) information, from patient and physician satisfaction measurement data, information from the performance improvement system and human resources, and complaints. Daily and shift staffing are adjusted based on assessment of patient nursing intensity measurements and staffing guidelines.

Staffing is sufficient to assure prompt recognition of any untoward change in a patient's condition and to facilitate appropriate intervention. Additionally, the assigned RRT RN's respond to Rapid Response calls initiated by staff in the hospital (See Rapid Response Team Procedure)

There are certain types of rapid response calls based on the condition of the patient. A cardiac alert is called and a specialized team responds if a patient is experiencing chest pain (See Management of the Adult Patient with Chest Pain, Anginal Equivalent Symptoms, Possible Acute Coronary Syndrome, (In-House Cardiac Alert Procedure) A stroke alert is called when a patient is experiencing signs and symptoms of a stroke and a specialized team responds (see In-House Stroke Alert Procedure) A sepsis alert is called when a patient is meeting the SIRS criteria for suspected sepsis (See Sepsis Alert, Adult, In-House and Emergency Department) An OB alert is called when an OB patient experiences a serious change in condition (OB Alert Procedure).

During regular business hours, the Assistant Hospital Manager/Hospital Supervisor is responsible for departments where conflicting needs arise/exist will resolve the conflict and direct staffing resources in a manner that best meets patient needs. Should the conflict not be resolved in this manner, the officer of the day will be responsible for making the final decision.

During other hours, the Assistant Hospital Manager/Hospital supervisor will be responsible for directing the staffing resources in the manner that best meets patient needs.

Staffing resources are evaluated at least annually and modified based on input from physicians, patients and staff. State mandated ratios are maintained on units where applicable. All regulations & processes related to ratio adherence are followed. In addition, new programs, patient populations, volume trends, performance improvement findings, and comparisons with other like facilities, as well as other factors are considered in determining staffing levels. Position control and recruitment & retention data are monitored at least quarterly by the CNO, nursing directors, and clinical managers with subsequent modifications made as indicated.

A patient classification system known as the nursing intensity measurement system (NIMS) is used to guide both planning and utilization of nursing resources and to document trends in patients' nursing resource needs over time. NIMS has five levels of care with a range of nursing care hours prescribed for each level. The ranges were developed by the NIMS committee and a consultant. Each year, the numbers of patients by level and the appropriateness of the nursing hours of care assigned to each level are reviewed by nursing and finance in determining the budget for the next year.

Reliability of the NIMS is performed annually and the reliability data is reviewed with nursing management and the NIMS committee.

In the event of positive variances (too many staff), employees may be required to "float out" to another unit with a negative variance to assist in the provision of patient care, to participate in taking mandatory time off/ cancellation (hospital convenience [HC] time).

In the event of negative variances (too few staff), the following steps may be implemented to correct the variance:

1. Staff on duty with the required competencies may be floated from a unit with a positive variance to the unit where the negative variance occurs.
2. Regular and Per Diem staff not on duty will be called to determine their availability.
3. Volunteers to work overtime will be requested from appropriate staff.
4. Consideration will be given to relocation of patients(s) to another unit where capacity and adequate,

trained staff is available, i.e. GYN patients to Maternity unit; Medical patients to Surgical unit, etc.

5. Consideration will be given to recall staff from off unit committee and educational programs.
6. Assign other appropriate nursing personnel to direct patient care duties, i.e. CNS, Nurse Educator, Clinical Manager, etc.

If the negative staffing variance cannot be corrected by the above actions, the following will be considered:

1. Divert new admissions from the understaffed unit(s).
2. Review OR, Cardiac Cath Lab at Mountain View, and L&D schedules for potential delay or cancellation of scheduled elective cases.

If staffing requirements exceed staffing available or bed capacity is insufficient, the Assistant Hospital Manager/Hospital Supervisor will alert the Charge Nurse in the OR, Cardiac Cath Lab at Mountain View and/or L&D. No cases will be allowed to proceed without the concurrence of the Assistant Hospital Manager/Hospital Supervisor.

If cases are delayed, the AOC, Medical Director and procedural physician will be notified.

Early on each shift, Complex meetings are held enterprise wide in the Med/Surg/Critical Care and MCH regions to report and discuss current and anticipated departmental and patient care activity, any staffing variances for the present shift as well as predicted needs for the next shift, based on expected discharges, transfers and potential patient admissions including planned OR, Cardiac Cath Lab at Mountain View, Radiology interventional, and L&D scheduled cases. Staff attending Complex meetings includes the Assistant Hospital Manager/Hospital Supervisor, charge nurses, staffing office personnel and the Rapid Response Nurse at Mountain View, nursing unit Managers and Directors. Oftentimes, and especially during limited bed capacity, clinical managers, the manager of the Cardiac Cath Lab at Mountain View or designee attend the day shift meetings. Decisions regarding patient flow (admissions and transfers) are addressed as well as problem solving related to patient activity and staffing issues. During high census times and limited bed capacity, key participants of the Complex meeting may reconvene for an update and ongoing planning and problem solving based on the Peak Census Policy requirements. Additionally, the CNO or the Administrator On-Call (AOC) will be apprised of "critical" bed shortages and real or potential cancellation of surgical and/or medical procedures.

Allocation of nursing resources allows for:

- Direct patient care activities
- Coordinating patient care given by nursing as well as other disciplines
- Communicating patient needs to other disciplines
- Participating in nursing, medical staff and hospital committees
- Participating in departmental/unit meetings and in-service education
- Participating in clinical practice standards development, review and revision, policy procedure development and performance improvement activities
- Training and orienting new personnel
- Receiving and acting on reports of committee Councils participating in assigned hospital/ departmental project work/activities

Assignments are commensurate with:

- Patient needs (degree of illness, stability and ability to care for self)
- Minimization of risk of infection
- Staff competency/expertise

- Medical regimen
- Unit geography
- Availability of support services
- Patient care delivery model
- Requirements for special nursing activities

RNs are assigned to the roles of:

- CNO
- Director
- Clinical Manager
- Assistant Hospital Manager/Hospital Supervisor
- Assistant Clinical Manager
- ~~Infection Control Coordinator~~
- Charge Nurse
- Circulating Nurse
- Nursing Unit Coordinator/Clinical Nurse
- Preceptor
- Care Coordinator
- Clinical Nurse Specialists
- Nursing Educators
- Nurse Program Coordinators (e.g., Bariatric, Stroke, ~~Orthopedic~~, etc.)
- Nurse Specialists (e.g., Diabetes Educator, Wound and Ostomy RN, and Vascular Access RN.)

SUPPORT SERVICES

Nursing and other support services are performed by the following categories of personnel in the areas where acute inpatient/specialty nursing care is provided:

CCU/ICU	RN, Clinical Support (MV), Administrative Support (MV), Monitor Technician (LG)
PCU	RN, Clinical Support, Administrative Support
Telemetry	RN, Clinical Support, Administrative Support, Monitor Technician
Med/Surg/Ortho/ Peds	RN, LVN, Clinical Support, Administrative Support (MV)
Psychiatry Services	RN, LVN, LPT, LCSW, OTR, Behavioral Health Worker, Administrative Support
Labor & Delivery	RN, , Administrative Support & OB Technician
Mother-Baby (MBU)	RN, LVN, Administrative Support
NICU/Level II and III	RN, LVN(MV), Administrative Support (MV)
Operating Room/ IS	RN, Administrative Support, Surgical Technician, Operating Room Assistant (ORA), Interventional Technician
PACU	RN, Clinical Support
Endoscopy	RN, Endoscopy Technician
Pre-op/Short	RN, Patient Registrar , Administrative Support, Clinical Support

Stay/OPS	
Emergency Services	RN, Emergency Department Technician (MV), Administrative Support
Inpatient Dialysis	RN, Clinical Support, Admin Support, Patient Care Technician
Acute Rehab (LG)	RN, Clinical Support, Admin Support

ADMISSION AND PATIENT LO PROCESSES

The Assistant Hospital Manager/Hospital supervisor, , will coordinate all direct admissions/transfers to the hospital. Through an interview process with the physician, or with his/her representative or staff from another agency in the case of transfers in, the patient will be assessed to ensure proper placement within the hospital system. Placement decisions will be in collaboration with the unit charge nurses and are based on the patient's diagnosis, infection control issues, the patient's level of acuity and the department's admission, discharge and transfer criteria. Additionally, the availability of staff, staff competencies and unit environment will be considered, as well as patient and physician preference. Based on specific diagnoses, patients will be placed on their primary unit or alternate unit based on the above factors.

The patient assessment, obtained during the initial admission process, will be communicated to the nursing unit staff as well as to other appropriate departments, as appropriate. These departments include, but are not limited to: Care Coordination, Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, Nutritional Services, Respiratory Medicine, Infection Control, and other ancillary departments, as needed. These referrals will be made to support the identified needs of the patient from pre-admission to post-discharge. Triggers for referral to services are identified in the following tables:

Triggers for Referral TABLE A

Data from initial Nursing Assessment call appropriate department document referral in patient record

Care Coordination/Social Services:

- Lives Alone
- Homeless
- Pt over 75
- Pt with chronic illness (i.e. COPD/ ESRD)
- Readmission w/in 14 days
- Admitted from SNF
- Known psycho-social problems
- Pt requiring DME
- Uninsured patients
- Potential for complex discharge
- CVA Diagnosis
- Domestic/Elder/Child Abuse
- Fetal Demise
- Adoptions
- New HIV diagnosis
- Failure to thrive
- Advance Directive follow-up

Diabetic Educator: New dx of diabetes

- Knowledge deficit re: Diabetic Regimen
- No financial resources for supplies or medical follow-up
- Non-adherence to prescribed management plan.
- Co-morbidities of hypertension or CAD
- Admitted for diabetes out of control (DKA, Hank, Hypoglycemia)

Rehabilitation Services

These functional assessment elements require a MD order.

Physical Therapy:

- *Automatic Triggers to PT: Orthopedic & Stroke Clinical Path; compression fx of spine
- Gait/Balance problem
- Recent falls

Occupational Therapy:

- Unable to perform ADLs independently

Speech Therapy:

- New dx of aphasia
- Impaired cognition
- Impaired swallowing

<ul style="list-style-type: none"> • Hospice Service • Transportation Difficulties • Mother/newborn with positive drug screen 	<ul style="list-style-type: none"> • Admitted d/t diabetic related wound 	<p>Palliative Care:</p> <ul style="list-style-type: none"> • Recent terminal disease diagnosis • Patient & family requiring end of life decision making • Patient & family struggling with CPR status decisions • Comfort Care Questions.
<p>Nutrition Services:</p> <ul style="list-style-type: none"> • Stage 3 or 4 pressure ulcer • *Recent weight loss/gain due to illness • *Fluid restriction • *Special Diet • *Problems with eating: increased appetite, decreased appetite, nausea, difficulty swallowing, difficulty chewing, indigestion 		
<p>Infection Control:</p> <ul style="list-style-type: none"> • Positive AFB smears/ Suspected TB • Dx /suspected chicken pox/ shingles, influenza, measles, meningococcus, c-diff; MRSA, Pertussis, VRE, SARS, lice, scabies. 	<p>Pharmacy:</p> <ul style="list-style-type: none"> • Pt. admitted with a medication related event (ADR or med error) • Pt. admitted with complex medication regime • Chronic pain history <p>Pain Management:</p> <ul style="list-style-type: none"> • Chronic pain history • Complicated pain • Medication regime 	<p>Vascular Access Nurse</p> <ul style="list-style-type: none"> • Order for PICC / Mid Line Placement <p>Geriatric NP:</p> <ul style="list-style-type: none"> • Hospital onset delirium • Need for PSA • Polypharmacy • History of Falls
<p>Wound and Ostomy Nurse</p> <ul style="list-style-type: none"> • *Braden ≤ □□ • New or existing ostomy • Stage 3 or 4 pressure ulcer • Significant incontinence management problems • Stage 1 or 2 pressure ulcer 	<p>Pastoral Care:</p> <ul style="list-style-type: none"> • Pt. request for emotional/ spiritual support • End of Life Care • Fetal Demise 	<p>Lactation Consultant:</p> <ul style="list-style-type: none"> • Failure to thrive infant of breastfeeding mothers • Lactating mother admitted with other medical problems • Postpartum difficulty with breastfeeding

*Asterisk indicates automatic trigger generated by Electronic Medical Record reporting system; no need to call department/physician.

Triggers for Referral for Suspected Abuse – TABLE B

Child Abuse	Elder Abuse	Domestic Abuse
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- Unexplained physical injury; physical injury not congruent with explanation
- Sexual assault
- Sexually Transmitted Diseases in child <14
- Pregnant mother <16 and father >18
- No medical treatment for longstanding symptoms (medical neglect)
- Severe malnutrition
- Lack of clothing or shelter
- Newborn suffering the effects of toxic substances ingested by mother
- Newborn with positive drug screen

- Unexplained physical injury; physical injury not congruent with explanation
- Sexual Assault
- Malnutrition, dehydration, low albumin levels
- Pt or family report of stolen or misappropriated money or property
- Physical conditions indicative of poor hygienic care
- No medical treatment for longstanding symptoms (medical neglect)
- Altered mental status in which patient exhibits: fear, depression, confusion, or agitation

- Repeated, unexplained physical injuries; physical injuries not congruent with explanation
- Reported domestic violence by patient

COMMITTEE STRUCTURE

The purpose of the ~~Patient Care Services~~Nursing Division committee structure is to provide a comprehensive and dynamic system that will contribute to meeting regulatory standards, support patient-centered care, and provide effective communication. The Patient Care Services Committee and task force structure will:

- Enable and promote staff involvement in decisions that affect clinical practice.
- Establish a mechanism by which registered nurses can evaluate standards of nursing practice, standards of care, and patient care delivery models, and make changes that will improve the quality and effectiveness of patient care and its outcomes within regulatory guidelines.
- Provide a system where staff, managers, and educators can come together for the implementation of Patient Care Services annual goals.
- Establish a forum in which health care disciplines can resolve system problems that may hinder the delivery of patient care.
- Provide multi-directional communication to ensure a uniform standard of nursing practice throughout El Camino Hospital.

Standing Committees include:

A. ~~PCS~~Nursing Directors Leadership Team Meeting

1. Membership

~~PCS Directors Reporting to the CNO~~

~~Director of Critical Care Services~~

~~Director of Medical/Surgical Services~~

~~Director of Behavioral Health Services~~

~~Director of Maternal Child Health~~
~~Director of Respiratory Care Services~~
~~Director of Perioperative Services (MV)~~
~~Director of Nursing Services Los Gatos~~
~~Director of Care Coordination~~
~~Director of Pharmacy~~
~~Director of Laboratory~~
~~Manager of Patient Experience~~

a. **Directors Reporting to the CNO**

- i. Director of Critical Care Services
- ii. Director of Cardiovascular Services
- iii. Director of Medical/Surgical Services
- iv. Director of Behavioral Health Services
- v. Director of Maternal Child Health
- vi. Director of Perioperative Services (MV)
- vii. Director of Nursing Services Los Gatos
- viii. Director of Care Coordination
- ix. Executive Director of Patient Experience

2. **Function**

- a. Set team goals, objectives and priorities.
- b. Champion, communicate, and clarify the vision, mission, core values, strategies, goals and priorities.
- c. Align discipline/functional strategies, priorities, performance priorities, plans and performance expectations.
- d. Allocate resources and management accountabilities for various resources.
- e. Define and establish the culture based on the organization/team's core values.
- f. Define discipline/functional, team and individual roles and accountabilities.
- g. Develop and implement policies and procedures.
- h. Ensure the diagnosis and resolution of organizational issues and challenges occur.
- i. Define decision-making ownership and processes.
- j. Facilitate the resolution of conflicts between service lines, units, departments, discipline/function or individuals that affect the organization's/team's ability to perform.
- k. Develop successors and succession plans for leadership positions and career development opportunities/programs.
- l. Champion and foster change and development efforts and initiatives.
- m. Establish processes and activities that ensure thorough vertical and horizontal communication,

collaboration, and decision making.

- n. Serve as role models for the core values and related behaviors.
 - o. Achieve positive patient care safety and organizational results.
 - p. Set agenda for PCL meetings
3. Meeting Frequency/Minutes
- a. Monthly
 - b. Minutes are disseminated to all members

B. Patient Care Leadership Council

1. Membership

~~Mountain View~~

- ~~a. CNO~~
- ~~b. PCS Directors~~
- ~~c. Clinical Managers, including ancillary departments~~
- ~~d. Manager, Nursing Education~~

Los Gatos

- ~~a. Directors~~
- ~~b. Assistant Managers~~
- ~~c. Clinical Managers and ancillary managers~~
- a. CNO
- b. Nursing Directors
- c. Clinical Managers
- d. Director Clinical Education
- e. Assistant Clinical Managers
- f. Assistant Hospital Manager

2. Function

- a. Serves as a forum for communication and discussion of hospital systems and policies that may impact nursing and other clinical services.
- b. Serves as a forum for communication and discussion of Nursing and other clinical services management concerns. This committee will allow for multi-directional communication, education and decision-making.
- c. Establishes structure standards for patient services.
- d. Serves as a forum for review and approval of Patient Care Policies.
- e. Initiates the annual goal-setting process, ensuring there is staff involvement and that the goals support the organization's mission and values.

3. Meeting Frequency/Minutes

- a. Scheduled to meet at least monthly or more frequently if necessary.
- b. Minutes are disseminated to all members. Copies of the minutes are maintained electronically by the Administrative Assistant.

C. Central Partnership Council

1. Membership

- a. Direct Care Nurse (Chair)
- b. Direct Care Nurse (Vice-Chair) The Vice-Chair will serve 1 year and then move into the position of Chair. Therefore, the length of term is a full 2 years; one as Vice-Chair and one as Chair
- c. Representatives from the Clinical Managers & directors from all areas nursing is practiced. A manager/director from each service line will be chosen as a representative with one vote each. This appointment will rotate as determined by each service line
- d. Professional Development Council and Nursing Research Council representatives with one vote each and length of service determined by council
- e. Direct Care Nurse (DCN) representatives from all nursing units who represent their constituents from their unit with one vote each and length of service determined by UPCs
- f. CNO

2. Functions

- a. A forum for DCN to communicate and collect ideas and feedback from other DCN's
- b. Foster an environment that supports the reading and utilization of research to validate existing clinical practice or consider the need for change to improve the process or outcomes of care.
- c. Provide feedback to the CNO regarding unit partnership Council decisions and discussions.
- d. Review hospital wide quality and patient satisfaction data.
- e. View presentations on evidenced based practice & research projects
- f. A forum for sharing successes and opportunities for improvement
- g. Input into budget planning
- h. [Input into clinical/nursing policy](#)

3. Meeting Frequency/Minutes Processes

- a. Scheduled to meet monthly.
- b. Meetings are made available to members and copies of minutes are available to all staff electronically by the Administrative Assistant for the CNO.
- c. On issues requiring a vote from the full membership; a consensus or majority vote will be used and declared at the time of the decision

D. Unit Partnership Councils

1. Membership

- a. Direct Care Nurse (chair).
- b. Representatives from all classifications of employees who provide care on the unit.
- c. CNS or Nursing Educator

- d. Medical Director or physician representatives as available.
- e. Clinical Manager

2. Functions

- a. Define, develop, and evaluate the standards of nursing practice and standards of patient care specific to the unit and populations served.
- b. Make recommendations for modifications to patient care delivery, quality improvement activities, and support systems.
- c. Receive and disseminate information, findings, recommendations, and action plans to members, units, departments, and medical staff via their respective representatives.
- d. Reporting up on progress of unit based research projects
- e. Approval of unit based protocols and procedures
- f. Patient and staff safety issues are reported, discussed and action plans are developed.
- g. Budget input especially related to capital equipment purchases

3. Meeting Frequency Minutes Processes

- a. Scheduled to meet monthly.
- b. Meeting minutes are made available to members and copies of meeting minutes are available on the unit to all staff.
- c. On issues requiring a vote from the full membership; a consensus or majority vote will be used and declared at the time of the decision

E. Professional Development Council

- 1. Clinical Nurse Specialists, Unit Nurse Educators, Program Coordinators, Staff members responsible for education in other clinical areas, representative from the Library and Resource Center, General Educator and Nursing rep from Information Systems. The Council is chaired by an elected member of the Committee.
- 2. The Professional Development ~~Education~~-Council supports Evidence Based Practice through oversight, developing standards, innovation, leadership and mentoring as related to education of staff, patients, families and the community of El Camino Hospital.
- 3. Meetings will occur once/month and the minutes are taken by one of the co-chairs of the Council and are disseminated by the co-chairs of the Council.

F. Nursing Research Council

- 1. Members include staff members from each nursing unit in addition to selected management representatives, nurse educators, and CNS's. The Council is chaired by a Nursing Research Chair and elected co-chairs from members of the council.
- 2. The function of the NRC is to lead the implementation of evidenced based practice throughout the organization and to empower nurses with the skills and knowledge to understand and engage in nursing research. The overall mission of the Council is to promote a culture of inquiry that supports the purposeful use of evidence based nursing practice, which drives best individual patient care decisions to achieve high quality outcomes.
- 3. ~~The meeting occurs monthly and the minutes are taken and disseminated by the Administrative Support for Cardiac and Pulmonary Rehabilitation.~~Meeting Frequency/Minutes Processes

- a. Meetings will alternate every other month between virtual and real time.
- b. Minutes are made available to members and are copies of all meeting minutes are available to all staff.
- c. Fifty-one percent (51%) of the occupied Council seats shall constitute a quorum for voting purposes. During the voting process, 51% of the present members must vote in favor of the proposed item. Voting will also be posed electronically and 51% must also vote in favor of the proposed item.

G. **Direct Care Informatics Council**

1. **Membership**

- a. Chair and optional co-chair
- b. Representatives will be invited from the following inpatient divisions:
 - i. Acute Rehabilitation
 - ii. Behavioral Health
 - iii. Critical Care /Intensive Care/ Progressive Care
 - iv. Emergency Services
 - v. Information Technology
 - vi. Medical-Surgical
 - vii. Peri-operative Services
 - viii. Rehabilitation Services (PT/OT/Speech)
 - ix. Telemetry
 - x. Maternal Child Health

2. **Functions**

- a. Direct care clinical staff and Information Technology representatives work collaboratively to problem solve, select best practice, and improve workflow of the use of Health Information Technology. The goals of the council are to streamline, simplify, and standardize clinical documentation systems and processes to improve the safety, quality, and efficiency of patient care.
- b. Participate in formal and informal consultations to address issues at the nexus of Nursing and Information Technology practice in healthcare.
- c. Use evidence based practice and documented best practices when available to increase patient safety and improve the quality of patient care.
- d. Advocate for the increased efficiency, and removal of ineffective, duplicative or otherwise counter-productive work when possible.
- e. Review and offer subject matter expertise recommendations regarding the clinical documentation systems and workflows we use at El Camino Hospital.
- f. Support the Magnet model and goals, as well as applicable organizational goals and regulatory requirements.
- g. Convey information to appropriate staff using communication formats that promote accuracy and accessibility.

3. Meeting Frequency Minutes Processes

- a. Duration is ongoing and the frequency will be monthly for 2 hours
- b. The following will be used to communicate changes made by the committee:
 - i. Present at shared governance groups including Central Partnership Council and Unit Practice Councils when appropriate.
 - ii. Send out emails to our members directly and to larger groups of nurses as appropriate.
 - iii. Disseminate communication to appropriate newsletters.

H. Advance Practice Registered Nurse (APRN) Council

1. **Membership** - The members of the APRN Council include APRN staff functioning as Nurse Practitioners and Clinical Nurse Specialists as well as an appointed representative from Administration. For professional growth, education and mentorship credentialed Nurse Practitioners and Clinical Nurse specialists are invited to join the APRN Committee.

2. Functions

- a. Support APRN professional growth within the APRN Council
- b. Enhance communication and collaboration among other APRNs and other providers
- c. Identify opportunities to improve and standardize nursing practice to current evidence based practice
- d. Form partnerships with the other councils/committees
- e. Support annual promotion, implementation, and evaluation of the Evidence Based Practice Fellowship.
- f. Engage in mentorship activities for direct care nurses

3. Meeting Frequency Minutes Processes

- a. Scheduled to meet monthly for 1 hour.
- b. Meeting minutes are made available to members and copies of meeting minutes are available to all staff.
- c. Decision making is by consensus of a quorum members present, either by phone or proxy vote.

I. CNO Advisory Cabinet

1. **Membership** – The members of the CNO Advisory Cabinet are the chairs and vice chairs of all the shared governance councils including, Central Partnership Council, Professional Development Council, Nursing Research Council, Direct Care Informatics Council, Patient Care Leadership Council and Peer Review Committee. The CNO is the leader of the Cabinet meetings.

2. Functions

- a. The purpose of the CNO Advisory Cabinet is to provide advice and counsel of the nursing division in order to promote alignment and achieve the nursing divisions' strategic goals and objectives
- b. Participate in setting the annual nursing strategic plan
- c. Gaining alignments on all shared governance councils annual goals and objectives
- d. Actively participates in the planning and executing annual events such as nurses week.

e. Actively participates in the ongoing attainment of the Magnet standards.

3. Meeting Frequency Minutes Processes

a. Meetings are scheduled for 1 hour monthly.

b. Meeting minutes are recorded by the CNO.

c. Decision making is by consensus of a quorum of members present, either by phone, Zoom, or proxy vote.

J. GOALS

~~Goals are established and/or reviewed at least annually. The CNO and the nursing leadership establish the goals of Patient Care Services.~~

~~Goals are based on several factors, including:~~

- ~~▫ Hospital's mission, vision, values and strategic plan.~~
- ~~▫ Findings from the performance improvement and human resource systems.~~
- ~~▫ Information on new trends in patient care, nursing, and management.~~
- ~~▫ Patient satisfaction, employee satisfaction, and physician satisfaction measurement.~~
- ~~▫ Standards of practice in the community and / or established database benchmark.~~
- ~~▫ El Camino Hospital Strategic Plan priorities.~~

~~Short and longer-term goals for Patient Care Services include the following:~~

- ~~▫ Implementation of improved staffing controls and cost saving ideas in order to bring the nursing division to break even each fiscal year end while enhancing the professional practice of nursing.~~
- ~~▫ Improvement in the recruitment and retention of registered nurses and other patient care staff.~~
- ~~▫ Review and modification of management structure to support strategic direction.~~
- ~~▫ Implementation of strategies to accommodate the growing demand for inpatient maternity and neonate services.~~

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- Improvement in the recruitment and retention of registered nurses and other patient care staff.

- Review and modification of management structure to support strategic direction.
- Implementation of strategies to accommodate the growing demand for inpatient maternity and neonate services.

K. NURSING PARTICIPATION IN THE HOSPITAL'S DECISION MAKING STRUCTURES AND PROCESS

~~The Chief Nursing Officer, PCS Directors, Clinical Managers and Assistant Hospital Manager/Hospital Supervisors participate with members of the Governing Board, Medical Staff and Administration in the Hospital's decision making structures and process.~~

~~The Nurse Executive of El Camino Hospital is titled the Chief Clinical Operations Officer/CNO, and has been in management for over five years. He/she is a registered nurse, with a Master's degree in nursing or a related field. He/she serves on a full-time basis and is responsible and accountable for all activities within nursing services. He/she reports to the Chief Operations Officer with a matrix reporting relationship to the CEO.~~

~~The Nurse Executive is involved in the organization's corporate decisions that affect nursing care and attends the Board of Directors meetings and other pertinent meetings regarding budget, goals, new services, and institutional planning.~~

~~The Nurse Executive and nursing directors/managers interact with the medical staff by attendance at medical staff meetings, executive committee meetings, and meetings of the Governing Board of the hospital. The Nurse Executive regularly attends the Medical Staff Executive Committee, Medical Staff Planning Committee, the Quality Council, the Utilization Management Committee, Care Review Committee as well as various Medical Staff Department meetings. The Nurse Executive or his/her designee reports on the activities of the Nursing Division to appropriate medical staff committees as well as to the Executive Committee and to the Governing Board.~~

1. The Chief Nursing Officer, Nursing Directors, Clinical Managers and Assistant Hospital Manager/Hospital Supervisors participate with members of the Governing Board, Medical Staff and Administration in the Hospital's decision making structures and process.
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L. NURSING'S MEMBERSHIP ON HOSPITAL AND MEDICAL STAFF COMMITTEES

To facilitate communication between nursing, other hospital departments and the medical staff, and to ensure nursing's involvement in the achievement of the mission and goals of ECH, nursing is represented on specific hospital and medical staff committees.

<ul style="list-style-type: none"> ▪ Hospital Committees ▪ Enterprise 	<ul style="list-style-type: none"> ▪ Mountain View Medical Staff Committees <u>Enterprise</u>
CPR	Department of Medicine
IPIT (Interprofessional InfoTechnology)	Department of Obstetrics/Gynecology <u>Department of Maternal Child Health</u>
Medication Safety	Department of Orthopedics <u>Surgery</u>
Performance Improvement Teams	Department of Pediatrics <u>Infection Control Committee</u>
Performance Improvement and Patient	Department of Psychiatry
Safety Committee	Department of Surgery
<u>Patient and Employee Safety Committee</u>	<u>Operating Room Committee</u>
Central Safety Committee	ECT <u>Pulmonary</u>
Security Workgroup	EKG <u>Quality Council</u>
Service Excellence Team Meeting	Emergency Services Panel Physicians <u>Special Services</u>
Sharps/Safety Workgroup	Gastrointestinal <u>Utilization Review</u>
Value Analysis	Infection Control
Med Safety Committee	OB/Gyn Review
Medical Staff Committees	Operating Room
Cardiovascular Services	Perinatal
Care Review	Pulmonary
Department of Family Physicians	Quality Council
<u>Patient Safety Oversight Committee</u>	
<u>RCA Steering Committee</u>	
Institutional Review Board	Special Services
Interdisciplinary Practice	Utilization Review
Medical Ethics	
Patient Experience Teams	
Pharmacy and Therapeutics	

~~Los Gatos Medical Staff Committees~~

Department of Medicine	Infection Control
Department of OB	Quality Council
Department of Orthopedics	Co-Management of Orthopedics
Department of Surgery Emergency	Perinatal M&M
Services Panel Physicians	Department of Pediatrics

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

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Board	Stephanie Iljin: Supv Exec Administrative Svcs	pending
MEC	Catherine Carson: Senior Director Quality [JH]	11/2021
ePolicy Committee	Jeanne Hanley: Policy and Procedure Coordinator	11/2021
	Cheryl Reinking: Chief Nursing Officer [JH]	10/2021



Origination: 05/1995
Effective: Upon Approval
Last Approved: N/A
Last Revised: 06/2018
Next Review: 3 years after approval
Owner: Cheryl Reinking: Chief Nursing Officer
Area: Scopes of Service
Document Types: Scope of Service/ADT

Scope of Practice for Nursing Services

COVERAGE:

All Patient Care Services Employees

PURPOSE:

The Nursing Practice Act (www.rn.ca.gov - Section 2725) defines the practice of nursing as "those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment thereof which require a substantial amount of scientific knowledge or technical skill." The RN -considered competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nurse process.

The Standards of Competent Performance delineated in Section 1443.5 of the California Code of Regulations require the RN to directly observe and assess the patient, "through interpretation of information of information obtained from the client and others including the health team." RNs provide an ongoing patient assessments and document findings in the patient's medical record. The assessment is to be performed and documented each shift and upon receipt of the patient when he/she is transferred to another patient care area.

STATEMENT:

This policy governs the official role of the Registered Nurse practicing at El Camino Hospital.

PROCEDURE:

RN independently initiates and performs complex thinking strategies in all phases of the nursing process. This includes the ability to formulate a patient specific set of diagnoses when there is uncertain, inconsistent, unique and conflicting patient information.

The RN plays the predominate role in the timely communication of the patients response or lack of response to treatment to others, including physicians.

The RN is responsible/accountable to see actual and potential patient needs/health problems are addressed and get recorded on the plan of care.

The following will be performed only the RN:

- performance of a **comprehensive** assessment

- validation of the assessment data;
- formulation of individualized Plans of Care including problem statement, goal, interventions and progress

Delegation of duties occurs between licensed individuals. The responsibility for the patient(s) accompanies delegation. Acceptance of delegation must occur. Delegation must occur within the individual's scope of practice. RNs ensure delegate has appropriate education, skills, experience and documented competency before delegating a task.

Assignment of duties occurs when tasks are assigned to an unlicensed person by a licensed individual.

Evidence that the RN has advocated for the patient includes:

- Clarification of physician orders & comprehensive plan of care
- Ensure informed consent for treatment
- Appropriate/timely discharge planning
- Ensure safe, timely delivery of all aspects of care
- Recognize/record quality variance reporting of actual or "near misses"
- Monitor & follow-up on patient response to treatment regimen
- Ensure patient care assignments for self & others are appropriate and supervised properly

"Standardized procedures" authorize performance of a medical function by an RN. They are developed through collaboration among administrators and health professional including physicians and nurses and are approved through the Interdisciplinary Practice Committee, Patient Care Management Council, the Medical Executive Committee and the Board of Directors

Interim Permittee

The practice of nursing by a nurse with an interim permit is under the supervision of a registered nurse and is restricted to nursing processes and procedures taught in the nurse's basic course work. Excluded from the practice of nurses are those procedures requiring special validation such as arterial blood gas draws, chemotherapy, and CAPD.

Clinical Supervision

The practice of nursing by unlicensed (assistive) personnel is defined in performance standards. They assume responsibilities and perform acts consistent with their education and training, as assigned by the RN, LVN and as allowed by policy, protocols, procedures and guidelines. The responsibility for the assignment always remains with the licensed person. The registered nurse ultimately decides the appropriateness of assignment of tasks for his/her care team.

As defined by the California Board of Registered Nursing, "unlicensed assistive personnel (UAP)" refers to those health care workers who are not licensed to perform nursing tasks and to those health care workers who may be trained and certified but not licensed. UAP are utilized in the delivery of patient care. Effective supervision of these members of the care team is based on the RN's ability to assess real or potential harm associated with patient care procedures and to determine which tasks may be performed by the UAP. Factors which must be considered are patient safety, the competency of the unlicensed person to perform the task, the number and acuity of patients, the number and complexity of tasks, and the number of staff that the RN is supervising.

The direct care RN will independently make decisions regarding the assignment of tasks, based on individual nursing judgments. Tasks requiring a substantial amount of scientific knowledge and technical skill will not be assigned to the UAP. Tasks that are assigned should meet **all** of the following criteria:

- be considered routine care for the patient;
- pose little potential hazard for the patient;
- involve little or no modification from one client situation to another;
- be performed with a predictable outcome;
- not inherently involve ongoing assessments, interpretations, or decision-making which could not be logically separated from the procedure itself.

UAP can perform procedures that require clean technique. They cannot perform any procedures that require aseptic technique. LVNs are licensed and can perform a number of tasks requiring aseptic technique. UAP can collect data, but cannot assess or interpret the data. UAP and LVNs can monitor patients. Only the RN can manage the patient. Management is defined as the assessment, planning, and prioritization of interventions.

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El Camino Health

Summary of Financial Operations

Fiscal Year 2022 – Period 4

7/1/2021 to 10/31/2021

Operational Financial Results: Period – October as of

PERIOD RESULTS

(\$ thousands)

	Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's A	S&P AA	Performance to Rating Agency Medians
Activity Volume	ADC	203	240	34	13.5%	242	41	100%	---	---
	Total Acute Discharges	1,020	1,000	130	0.2%	1,024	202	12.4%	---	---
	Adjusted Discharges	3,420	3,153	277	0.0%	3,002	330	10.0%	---	---
	Emergency Room Visits	5,175	4,250	925	21.5%	4,171	1,004	24.1%	---	---
	OP Procedural Cases	12,005	10,024	1,981	10.0%	13,431	(440)	(3.3%)	---	---
	Cross Charges (%)	414,012	305,010	109,002	7.4%	300,453	47,550	13.0%	---	---
Operations	Total FTEs	3,001	3,004	(23)	(0.7%)	2,000	253	0.0%	---	---
	Productive Hrs. / APD	20.3	31.7	(2.4)	(7.7%)	31.4	(2.1)	(0.7%)	---	---
	Cost Per CMI AD	10,440	17,052	(1,503)	(0.4%)	10,077	372	2.3%	---	---
	Net Days in A/R	55.0	40.0	15.0	13.5%	40.0	7.0	15.7%	47.7	40.7
Financial Performance	Net Patient Revenue (%)	100,032	07,257	0,370	0.0%	00,554	10,070	17.0%	130,547	02,105
	Total Operating Revenue (%)	111,130	100,702	10,340	10.3%	04,570	10,500	17.5%	152,743	100,002
	Net Operating Margin (%)	000000	000000	000000	0.5.4%	000000	000000	00.3%	000000	000000
	Operating EBITDA (%)	000000	000000	000000	51.0%	000000	000000	45.5%	000000	000000
	Net Income (%)	30,435	15,400	24,027	155.0%	(10,400)	50,043	303.2%	0,124	7,343
	Operating Margin (%)	000000	000000	000000	77.2%	000000	000000	50.5%	000000	000000
	Operating EBITDA (%)	000000	000000	000000	37.0%	000000	000000	23.0%	000000	000000
	DCOH (days)	340	325	21	0.4%	331	14	4.3%	300	355

Moody's Medians: Not-for-profit and public healthcare annual report; September 01, 2021. Dollar amounts have been adjusted to reflect monthly averages.

S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021. Dollar amounts have been adjusted to reflect monthly averages.

DCOH total includes cash, short-term and long-term investments.

Operational & Financial Results: YTD 2021 as of 12/31/2021

YTD 2021 RESULTS

(\$ thousands)

	Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's	S&P	Performance to Rating Agency Medians
								A	AA	
Activity Volume										
ADC	200	241	20	12.0%	230	31	13.2%	---	---	---
Total Acute Discharges	7,003	6,407	500	12.2%	6,204	100	13.1%	---	---	---
Adjusted Discharges	13,752	12,120	1,024	13.4%	11,700	1,004	10.7%	---	---	---
Emergency Room Visits	21,501	19,725	4,030	20.0%	19,253	5,300	32.7%	---	---	---
OP Procedural Cases	50,041	41,203	8,037	22.7%	40,411	1,230	2.5%	---	---	---
Cross Charges (C)	1,050,104	1,470,503	100,521	12.2%	1,300,040	202,404	10.0%	---	---	---
Operations										
Total FTEs	3,001	3,050	(50)	(1.0%)	2,752	240	0.0%	---	---	---
Productive Hrs. / APD	20.7	32.3	(3.7)	(11.4%)	31.1	(2.4)	(7.0%)	---	---	---
Cost Per CMI AD	10,221	17,052	(1,731)	(10.0%)	10,007	(45)	(3.0%)	---	---	---
Net Days in A/R	55.0	40.0	10.0	13.5%	40.0	7.0	15.7%	47.7	40.7	
Financial Performance										
Net Patient Revenue (C)	417,005	377,545	40,120	10.0%	352,103	15,501	10.0%	554,100	320,410	
Total Operating Revenue (C)	432,511	301,020	40,001	10.4%	300,121	33,300	17.2%	07,037	430,400	
Net Operating Margin (C)	0.0000	0.0000	0.0000	121.4%	0.0000	0.0000	130.7%	0.0000	0.0000	
Operating EBITDA (C)	0.0000	0.0000	0.0000	50.5%	0.0000	0.0000	04.0%	0.0000	0.0000	
Net Income (C)	71,270	54,730	10,540	30.2%	42,571	20,700	07.4%	32,400	20,373	
Operating Margin (C)	0.0000	0.0000	0.0000	100.0%	0.0000	0.0000	102.0%	0.0000	0.0000	
Operating EBITDA (C)	0.0000	0.0000	0.0000	43.0%	0.0000	0.0000	40.7%	0.0000	0.0000	
DCOH (days)	34.0	325	21	0.4%	331	14	4.3%	30.0	355	

Moody's Medians: Not-for-profit and public healthcare annual report; September 01, 2021.
 S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 30, 2021
 DCOH total includes cash, short-term and long-term investments.



Unfavorable Variance > 0.000
Unfavorable Variance 1.000 - 4.000
Unfavorable Variance > 5.000

Income Statement: Rolling Monthly Trend (\$000s)

	FY2021												FY2022				YTD FY2022	Rolling 16 Monthly Average	
	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12	Period 1	Period 2	Period 3	Period 4			
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21			
Operating Revenues:																			
Net Patient Revenue	85,868	85,672	90,009	90,554	88,597	92,289	89,795	85,273	97,171	94,903	95,542	112,238	101,774	104,482	104,776	106,632	417,665	95,349	
Other Operating Revenue	4,667	4,331	3,996	4,024	3,234	3,079	4,427	3,352	3,537	3,692	5,385	4,706	3,116	3,746	3,479	4,506	14,846	3,955	
Total Operating Revenue	90,535	90,003	94,005	94,578	91,831	95,368	94,222	88,625	100,708	98,595	100,927	116,945	104,889	108,228	108,256	111,138	432,511	99,303	
Operating Expenses:																			
Salaries, Wages & Benefits	46,431	47,739	48,136	49,061	47,222	48,774	53,636	48,592	52,025	50,616	48,138	48,101	53,000	53,940	53,629	56,001	216,570	50,315	
Supplies	12,820	16,893	12,798	13,496	13,641	14,519	13,888	13,587	15,421	14,256	15,241	15,156	15,109	14,569	14,862	14,502	59,041	14,422	
Fees & Purchased Services	12,918	14,366	14,949	12,982	14,264	14,035	15,825	14,770	15,139	15,761	15,923	19,915	14,390	14,182	14,800	14,760	58,132	14,936	
Other Operating Expenses	3,583	3,596	4,498	3,721	3,512	4,100	3,819	1,097	3,536	3,662	3,496	6,002	3,598	3,577	3,676	3,586	14,437	3,691	
Interest	1,428	1,431	1,428	1,429	1,428	1,428	1,428	1,392	1,399	1,400	1,400	1,367	1,419	1,418	1,418	1,418	5,673	1,415	
Depreciation	5,231	5,328	5,795	5,798	6,068	5,591	5,689	5,903	4,931	5,606	4,808	5,740	4,727	7,157	5,902	5,798	23,583	5,629	
Total Operating Expenses	82,411	89,352	87,604	86,487	86,136	88,446	94,284	85,341	92,450	91,301	89,006	96,281	92,242	94,844	94,286	96,065	377,436	90,408	
Net Operating Margin	8,124	651	6,401	8,091	5,695	6,922	(62)	3,285	8,258	7,294	11,921	20,664	12,648	13,384	13,970	15,073	55,075	8,895	
Non-Operating Income	27,718	28,642	(9,557)	(27,499)	64,968	57,357	39	14,349	18,965	29,151	16,666	20,041	(4,099)	14,319	(18,378)	24,361	16,204	16,065	
Net Margin	35,842	29,293	(3,156)	(19,408)	70,663	64,279	(23)	17,633	27,223	36,445	28,588	40,705	8,549	27,703	(4,408)	39,435	71,279	24,960	
Operating EBIDA	14,783	7,410	13,624	15,318	13,192	13,940	7,055	10,580	14,588	14,301	18,130	27,771	18,793	21,959	21,289	22,290	84,331	15,939	
Operating Margin (%)	9.0%	0.7%	6.8%	8.6%	6.2%	7.3%	-0.1%	3.7%	8.2%	7.4%	11.8%	17.7%	12.1%	12.4%	12.9%	13.6%	12.7%	9.0%	
Operating EBIDA Margin (%)	16.3%	8.2%	14.5%	16.2%	14.4%	14.6%	7.5%	11.9%	14.5%	14.5%	18.0%	23.7%	17.9%	20.3%	19.7%	20.1%	19.5%	16.1%	

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

To: El Camino Hospital Board of Directors
From: Carlos Bohorquez, Chief Financial Officer
Date: December 11, 2021
Subject: Intent to Reimburse Resolution

1. Recommendation:

The Finance Committee is recommending that the Hospital Board approve a resolution which will enable the organization to reimburse itself for capital expenditures associated with the following projects:

Mountain View Campus

- Women's Hospital
- Interventional Radiology and Imaging suite upgrades and equipment replacement

Los Gatos Campus

- Interventional Radiology and Nuclear Medicine suite upgrades and equipment replacement
- Upgrade of Operating Room decontamination area

The resolution does not authorize management to issue any debt to fund these projects.

2. Summary:

- a. **Situation:** In the event that the Board authorizes management to issue new debt, this resolution will enable the organization to reimburse itself for capital already spent for the projects listed above from debt proceeds.

The resolution does not authorize management or obligate the organization to fund any project or issue any debt outside of the required approval process.

3. List of Attachments:

- a. Resolution

4. Suggested Board Discussion Questions:

- a. Does the resolution obligate the organization to issue new debt?
- b. The resolution includes a specific debt amount. Can the organization issue a higher or lower debt amount?
- c. Is there any financial / rate risk associated with this resolution?
- d. Will this resolution negatively impact our credit ratings or key ratios?
- e. Are there any fees / costs associated with this resolution?
- f. Are there any risks associated with not approving this resolution?

SECTION 10.01 CEREBROSCOPIC NO HOSPITAL
RECORDING THE HEALTH SERVICES SOCIETY IN EN

HERE, El Camino Hospital (the Hospital) is a tax-exempt nonprofit public benefit corporation that owns and operates a licensed hospital with two campuses: the Hospital Mountain Campus located at 200 Grant Road Mountain California 94040 Mountain Campus and its Los Altos campus located at 11 Pollard Road Los Altos California 94032 Los Altos Campus and together with the Mountain Campus the Campuses and other facilities

HERE, the Hospital intends to make improvements to its Mountain Campus including the complete renovation & expansion of the Women's Hospital and upgrade of the interventional radiology and imaging suites and equipment and to make improvement to its Los Altos campus including the replacement of equipment and upgrade of suites for interventional radiology Nuclear medicine and Operating Room decontamination area (together the "Project").

HERE, the Hospital expects to pay certain expenditures (the Reimbursement Expenditures) in connection with the Project prior to the issuance of indebtedness for the purpose of financing costs associated with each of those projects on a long-term basis

HERE, the Hospital reasonably expects that debt obligations in an amount not expected to exceed \$200,000,000 will be issued from time to time in one or more series and that certain of the proceeds of such debt obligations will be used to reimburse the Reimbursement Expenditures (such series to be in addition to all previously issued debt obligations)

HERE, 1.102 of the Treasury Regulations requires the Hospital to declare its reasonable official intent to reimburse prior expenditures for the Project with proceeds of one or more subsequent tax-exempt borrowings and

HERE, the Hospital has previously adopted Resolution 2014 delegating authority to the Chief Executive Officer or the Chief Financial Officer as its authorized representation to declare the official intent on behalf of the Hospital pursuant to 1.102(e) of the Treasury Regulations and therefore be it

RESOLVE, the undersigned Chief Financial Officer of the Hospital finds and determines that the foregoing recitals are true and correct and be it further

RESOLVE, the declaration on behalf of the Hospital set forth in this action by the undersigned Chief Financial Officer of the Hospital is made solely for purposes of establishing compliance with the requirements of 1.102 of the Treasury Regulations. This declaration does not bind the Hospital to make any expenditure incur any indebtedness or proceed with the Project and be it further

RESOLVE, that the undersigned Chief Financial Officer of the Hospital on behalf of the Hospital hereby declares the official intent of the Hospital to use a portion of the

proceeds of indebtedness to reimburse itself for the Reimbursement Expenditures for the Project and it further

RESOLVE that this action shall take effect upon its execution by the undersigned Chief Financial Officer.

IN WITNESS WHEREOF the undersigned officer has adopted this action on

December 1, 2021

By: Carlos J. Bohorquez
Title: Chief Financial Officer

CONFIDENTIAL
EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: Board of Directors
From: Armando Ramirez, MD, MChS Chief Medical Officer
Date: December 1, 2021
Subject: Mountain View O/ON Call Panel Renewal

Recommendation: Board of Directors to approve delegating to the Chief Executive Officer the authority to execute renewal agreements for the O/ON Call Panel at the Mountain View campus at an increased rate of \$1,000 per day plus \$200 when a physician responds in person to be effective upon Board approval.

Summary:

1. Situation:

- Currently there are seventeen O/ONs contracted with POC and seven independent O/ONs serving on the O/ON panel at the Mountain View campus for the provision of professional consultation and treatment of patients requiring a specialty consult in obstetrics and gynecology who present to the MV Emergency Department, Hospital's OB Emergency Department (O/E) and Hospital inpatients. The O/ONS on this 24/7/365 call panel provide: 1) backup for the O Hospitalists in the O/E 2) coverage for gynecology patients and 3) coverage for unassigned obstetrical patients less than sixteen weeks of gestation. This coverage is reimbursed at \$600 per day. The O/ON call panel agreements expire November 30, 2021.
- The Hospital is also contracted with a group that provides in-house O and ON coverage for our O/E at both the Los Altos and Mountain View campuses. The O/ON call panel is separate from the O Hospitalist coverage.
- The POC O/ONs are no longer interested in renewing their contract. However, the independent O/ONs have agreed to renew their agreements with an increased rate. The independent O/ONS requested \$1,300 per day and the Chief Medical Officer countered with \$1,100 per day plus \$200 when a physician responds in person. The O/ONs countered with \$1,300 per day stating that East Bay hospitals are paying \$1,400 and \$1,000 per day. The Chief Medical Officer countered with \$1,000 per day plus \$200.00 when a physician responds in person and the O/ONs accepted.
- The call utilization for this panel is high with an average of 3-6 calls per month over six months.

2. Authority: According to Administrative Policies and Procedures 1.00 Board Committee approval is required prior to the Chief Executive Officer signature of physician agreements that exceed the 75th percentile for fair market value.

3. Background: The call panel stipend of \$600 per day has remain unchanged since 2011

4. Fair Market Value Assessment: General Counsel obtained a fair market value opinion from a third party consultant confirming that \$1,000 per day plus \$200 per activation is commercially reasonable and within fair market value. The daily stipend of \$1,000 is at the 75th percentile and the \$200 activation payment capped at one payment per 24 hours is between the 75th and 90th percentiles depending on the estimated activation duration.

Mountain View O/N Call Panel Renewal
December 2021

Other Reviews: Legal and Compliance will review the O/N panel amendments and compensation terms prior to CEO execution.

6. Outcomes: O/Ns will participate in the peer review process for consultations related to obstetrics and gynecology at the Mountain View campus.

List of Attachments: None

Suggested Committee Discussion Questions: None

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

To: El Camino Hospital Board of Directors
From: Board Chair/Executive Compensation Committee
Date: December 12, 2021
Subject: Executive Compensation Committee/ECC/Community Member Composition and New Community Member Appointments

Recommendation:

Executive Compensation Committee recommends that the El Camino Hospital Board of Directors approve the increase to the number of Community Members on the ECC and approve the appointment Estrella Parker and Alessandra McCleson as community members on the Committee.

Situation:

- Authority:** As defined by El Camino Hospital Board Advisory Committee Community Member Nomination and Selection Procedures the ECH Board is authorized to determine the number of Community Members in an Advisory Committee and to appoint Advisory Committee Members in accordance with the Hospital Bylaws.
- Background:** The ECC Ad Hoc Committee consisting of Teri Eyre and Alison Payne developed a recruitment process which yielded a strong and diverse list of candidates. The Ad Hoc Committee reviewed several applications, interviewed seven candidates and selected two finalists for the Executive Compensation Committee to interview.

Upon completion of the final interview the Committee recommended both candidates to be appointed as Community Members. This would increase the number of Community Members on the Committee from four to five. The Governance Committee Chair endorsed the increase with a deferred presentation to the Governance Committee since it would increase the breadth of knowledge in the Committee.
- Assessment:** The two recommended community members are Chief Human Resource Officers in local organizations and will be great additions to the Executive Compensation Committee.
- Other Reviews:** None
- Outcomes:** Alessandra McCleson and Estrella Parker will be appointed to a 1 year term as Community Members on the Executive Compensation Committee. Their first Committee meeting will be on March 3rd 2022.

List of Attachments:

- Candidate Resume and Questionnaire - Alessandra McCleson
- Candidate Resume and Questionnaire - Estrella Parker

Suggested Committee Discussion Questions: None

Alessandra Yockelson,
Ph.D.

CHRO, catalyst for business growth and performance
cultures, stewarding diversity, equity, and inclusion

Senior Global Human Capital Executive, Diversity, Equity & Inclusion Thought Leader, and Independent Board Member who leads business transformation to drive profitable growth for major multinational brands, including Pure Storage, Hewlett Packard Enterprise, Diageo, Avon, Philips, and Volkswagen. International enterprise leader experienced in strategy development across B2C and B2B businesses, evolving governance, culture, organization, and talent to mobilize workforces to win. As a recognized leader in diversity, equity, and inclusion, introduces effective solutions that strengthen environmental, social, and governance performance. Expert in elevating CEO and Executive Committee leadership to drive change. Serves as trusted advisor to boards, CEOs, and top management teams on building high performance cultures. Independent Board Member of iCIMS (a high growth pre-IPO SaaS Talent Cloud platform portfolio company of Vista Equity Partners), serving in the Audit committee.

Highlights:

- **Board Service:** Independent board director at iCIMS (Vista Equity Partners portfolio company).
- **Board Experience:** Trusted advisor to Pure Storage's Board of Directors, directing CEO, EC, and Section 16(b) officers' succession, talent and DE&I strategies, working with the Nominating & Governance committee on skills matrix and board composition and the Compensation Committee on C-suite performance and executive rewards. Similar experience with HPE's Board of Directors.
- **Business Transformation Executive:** Led collaborative complex global organization design interventions at Philips, Avon, Diageo, and HPE to effectively deliver on business growth imperatives, including Philips' shift from high volume consumer electronics to healthcare solutions, Avon's pursuit of strategic alternatives and performance culture, Diageo's digital transformation, and HPE's as-a-Service business model expansion. Experienced in M&A and divestitures, as well as in rapidly scaling up or rightsizing organizations.
- **Award-winning HR and DE&I Thought Leader:** Member of management teams in charge of strategy development, consistently raising the bar on human capital practices to meet business needs. Oversees sizable global HR teams and budgets. Enhances HCM technologies that digitalize employee experience. Introduces data-driven, comprehensive DE&I strategies that enhance ESG performance. Widely recognized through high profile awards, including "50 Out Front for Diversity Leadership."
- **Business Excellence Champion:** Spearheaded the innovation and business excellence program at Avon, leveraging financial acumen, Design Thinking, Agile, and Lean Six Sigma skills to improve time-to-market, customer satisfaction, and cost of non-quality in key processes, resulting in benefits of \$200M in 2 years.

Professional Experience

Pure Storage, (NYSE: PSTG), Silicon Valley, California July, 2021 – Present
High growth enterprise data services and technology company with \$2B in annual revenue.

CHIEF HUMAN RESOURCES OFFICER

Recruited to ready Pure Storage to scale in tandem with its high growth trajectory.

- **HR Transformation:** partnering with CEO and C-suite in rethinking talent, leadership, and organization policies, processes, programs, technology, and capabilities and driving the implementation of a global, best in class human capital function that seeds a growth mindset performance culture.

Hewlett Packard Enterprise, (NYSE: HPE), Silicon Valley, California 2018 – 2021
Enterprise information technology company with \$30B in annual revenue and 60K employees globally.

SVP, HEAD OF HR FOR BUSINESS UNITS AND TECHNOLOGY FUNCTION AND CHIEF TALENT OFFICER

Recruited to lead vision and strategy for HPE's multi-year talent transformation as the company transitions its business model to as-a-Service (aaS).

- **Board, CEO, and EC Advisor:** Valued advisor to Board and Nominating & Governance Committee on strategy for board and Section 16(b) officers' assessment and succession. Proctors the HR & Compensation Committee and collaborates closely on talent and executive rewards. Partners with CEO to enhance EC team effectiveness and operating rhythm. Member of Enterprise Risk Management and ESG committees.
- **Seasoned HR Leader at Scale:** Global SVP of HR for ~30K employees worldwide. Heads DE&I and drives innovations in Recruitment, Performance Management, Succession and Talent Management, and Learning.
- **DE&I Transformation:** Spearheaded the DE&I strategy across Talent, Workplace, Community, and Reputation. Thought leader in establishing a multi-year, data-driven, systemic plan, which halved female attrition and positioned HPE ahead of the industry. Chaired the Women Leaders in Technology network.

Diageo North America, (NYSE: DEO), Norwalk, Connecticut 2016 – 2018
Global beverage alcohol company with \$12.87B in annual revenue and 200+ brands, including Johnnie Walker, Guinness, and Smirnoff.

EXECUTIVE VICE PRESIDENT OF HUMAN RESOURCES

Oversaw organization and talent for a major digital transformation that drove mid-single digit revenue growth.

- **Collaborative Organizational Design:** Drove deep collaboration with key employees and external experts on digital enterprises to address the talent implications of digital transformation. Designed for proper alignment of organizational structures, attracting the necessary staffing and upskilling the legacy workforce. Partnered with distributors on go-to-market setup alignment and to enhance sales effectiveness through insights at POS derived from predictive analytics.
- **DE&I Leadership:** Improved overall representation of diversity in senior leadership roles. Increased people managers' capabilities to lead inclusively. Partnered with CEO and leadership team peers to ensure that Marketing, Category Management, R&D, and Customer Facing roles were held by diverse multicultural talents that reflected Diageo's consumer base.
- **Enhanced HR:** Made bold changes to attract top diverse talents. Introduced scorecards on operational HR metrics, assessed and improved HR practices against industry maturity models, overcame labor relations issues, replaced legacy HR technology, and focused on early career development.

Avon Products, Inc., South America, (NYSE: AVP), São Paulo, Brazil 2013 – 2016
\$10B beauty, household, and personal care direct selling company with 6M representatives in South America.

VICE PRESIDENT OF HUMAN RESOURCES & CHAIR OF AVON FOUNDATION

HR leader of the largest and most profitable market for Avon, hired to introduce HR strategies to rejuvenate the brand, evolve the direct selling model toward digital and omnichannel, and streamline the supply chain.

- **Innovation and Business Excellence:** Spearheaded business excellence to increase innovation, effectiveness, and efficiency via Design Thinking, Agile, Lean Six Sigma methodologies. Focused on streamlining key business processes, resulting in financial benefits of \$200M in 2014-2015.
- **Enhanced Brand:** Orchestrated an employer reputation strategy to position the company as the employer of choice for women, LGBTQ, and millennials. Modernized the value proposition and amplified it internally and externally in a joint effort with Marketing, Communications, Government Affairs/ESG, and Sales.
- **Accountability Culture:** Partnered with CEO and leadership team to lead a multi-year culture shift program that instilled a sense of accountability in the workforce through new rituals, powerful storytelling, leadership training, rewards differentiation, and infusion of high caliber senior and early career talent.

- **DE&I Expert:** Restructured DE&I to improve hiring, retention, promotion, and pay equity processes for gender and ethnic diversity. Leveraged “The Company for Women” purpose, intertwining community, talent, and brand plans. Collaborated with international DE&I think tanks to introduce flexible work arrangements and enhance workplace infrastructure for working parents.
- **Board Service:** Chair of the Avon Foundation for Women in Brazil. Led Board activities and fundraising strategy, increasing from BRL4M to BRL10M.

Philips Healthcare (previously Philips Electronics) (NYSE: PHG), Brazil – The Netherlands – USA 2000 – 2012
Healthcare, consumer electronics, and lighting company with over \$21B in annual revenue.

VICE PRESIDENT OF HUMAN RESOURCES

Held roles in HR M&A, Global Talent Management, VP of HR for LatAm, and Strategy and Business Excellence Lead for LatAm as Philips transformed from a \$37B high-volume electronics business to a leading life science company.

- **Acquisitions and Post-Merger Integrations:** Oversaw HR due diligence and post-merger integration for \$3.4B M&As, including the largest acquisition made by the company at the time. Oversaw culture, executive rewards, talent assessment and retention, and back-office integration of acquired companies.
- **Divestiture Experience:** Executed the HR implications of the divestiture of the Consumer Electronics division (40% of the conglomerate revenue) and implemented a successful 2-year business turnaround program that rightsized the go-forward organization.
- **Emerging Markets:** Led the organization and staffing efforts to rapidly set up and scale Philips Sourcing Groups in Shanghai, China and manufacturing facilities in Eastern Europe. Implemented early career recruitment and development programs in India and Latin America.
- **Creating an Award-Winning HR Strategy:** Fostered and introduced HR and leadership practices to enable Philips to be selected for the first time as one of the “*Best Companies to Work for in Brazil.*”
- **Board Service:** Served as President of the Phillips Pension Fund Management Committee in Brazil.

Earlier career included roles with Volkswagen and Banco de Crédito Nacional (Financial Services).

Education

Doctor in Business Administration (Ph.D.), Fundação Getúlio Vargas,
 Escola de Administração de Empresas, São Paulo, Brazil

Master of Business Administration (MBA), Fundação Getúlio Vargas, Escola de Administração de Empresas, São Paulo, Brazil; Exchange program with University of Chicago Booth School of Business, Chicago, IL, USA

Master of Human Resources Management, Universidade Presbiteriana Mackenzie, São Paulo, Brazil

Bachelor of Science in Information Science, Universidade Paulista, São Paulo, Brazil

Awards, Thought Leadership, & In the News

Speaker, HPE ESG Living Progress Report, Morgan Stanley Investors Webcast, 2020

Chair and Speaker, Women Leaders in Technology, HPE Discover, 2020 & 2019

Speaker, Better Together, Women at Microsoft (WAM), 2019

Alessandra Ginante Yockelson Scouts Tech Talent the Smart Way, Hispanic Executive, 2019

Diageo North America Named to Diversity MBA’s “50 Out Front for Diversity Leadership” List, 2018

Candidate Questionnaire

El Camino Hospital Board of Directors || Executive Compensation Committee Member

Name:	Alessandra Yockelson
Email Address:	[REDACTED]
City of Residence:	[REDACTED]
Do you feel you have adequate flexibility in your schedule for this commitment? (4 ECC meetings & 2 Board Education Sessions annually from 530-730p)	Yes
Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigating for business related issues (e.g. SEC)? (Note: Disclosure of a civil, employment-related, criminal incident(s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe will be taken into consideration.)	No
Would this position create a conflict of interest with any of your other commitments?	No
The El Camino Health Executive Compensation Committee Member position is a non-compensated (i.e. volunteer) and has one-year renewable terms. Is this acceptable?	Yes
Please specify how you found out about this position?	The Board List
<p><i>Why are you interested in being considered for Committee Member position as part of the Executive Compensation Committee at El Camino Health?</i></p> <p>First and foremost, I am looking for an opportunity to help the local community. Before immigrating to the United States in 2016, I was very active in supporting gender equity causes through the Avon Foundation for Women in Brazil (my home country) and I miss it. For the past years I have been focused on settling in the country (new job, finishing my Ph.D., serving on my first board as an independent director, getting married) and now that I have these milestones behind me, I want to invest some of my time in service of others. In addition, I have made a few cross-industry career moves from CPG to Financial Services, Automotive, and Technology and I am very intrigued with the opportunity to learn more about healthcare.</p>	
<p><i>Please describe a specific instance in which you were instrumental in developing an executive compensation strategy for an organization. What factors did you consider in determining the elements of the strategy? What obstacles did you encounter in gaining consensus on the strategy? How did you deal with them? What was the outcome?</i></p> <p>Developing and evolving the executive compensation strategy for an organization is part of my accountabilities on an ongoing basis. I will highlight two instances that were particularly critical. Philips Electronics acquired a public company in the US, and I worked together with two colleagues on creating and implementing a multi-year transition plan that harmonized the executive total rewards strategy and practices across the two organizations. Given the myriad of differences between the two companies (national and organization cultures, business strategies and models, pay philosophies, operational capabilities) and the competitive market dynamics, it was not only critical to stay focused on shareholder value creation to guide our recommendations, but also to have an intentional change management & communication strategy not to risk top talent retention.</p> <p>The second example was about ensuring that executive compensation remained strongly linked to the most pressing priorities for the business in the short-term without impacting long-term priorities and the plan design at HPE during the COVID-19 pandemic. Typical business performance indicators could not be relied upon as metrics for short and long-term incentives and priorities such as the health and safety of the employees as well as customer orders fulfillment became the new business imperatives in 2020. It was important for the Compensation committee to be agile and decisive so that new KPIs and targets were re-defined as early as possible in the year. On the other hand, the committee did not compromise on design features that ultimately the shareholders would not support.</p> <p>In summary, context matters tremendously, and one needs to remain flexible whilst developing an executive compensation strategy that is fit for purpose in the specific situation but does not compromise governance requirements. The thought process I tend to use considers the internal congruency between strategy-culture</p>	

Candidate Questionnaire

El Camino Hospital Board of Directors || Executive Compensation Committee Member

(Is the company a growth or value organization? Individual or team accountability? Is ESG as important as EVA?)-key business metrics-SMART targets-right incentive (base pay, bonus, LTI, perks) and leverages **external validity** (executive total rewards market practices, labor and talent market dynamics, corporate governance requirements/ISS). Lastly, equally important to developing the strategy is advising management on how it will be managed year-round so that the pay for performance as a philosophy is truly systematized and executives see it visibly and constantly.

Please describe a specific instance in which you had to make recommendations of cost and reasonableness of severance and benefits for executives.

Ideally the governance around what the organization “does not do” in terms of severance is clearly articulated away before severance situations occur. Moreover, especially in the rare cases in which employment contracts are in place, it is very important for the general counsel and the CHRO to work very closely with the chair of the board and the human capital/compensation committee on all clauses, including parameters for change in control. I have had to set severance policies and employment contracts in past experiences and, when done well, they proved to protect the organization as well as properly manage expectations by the executive involved.

Making benefits recommendations not only for executives but for large employee populations has been part of my job in years now.

Please describe a specific instance in which you had to provide input into the CEO and executive team’s annual performance goals to execute a strategic plan, and then recommending these goals for approval by the Board.

Both at HPE and at Pure Storage, working with the CEO and CFO have been a core part of my areas of accountability. I was particularly successful not only in aligned individual goals to payouts but also to ensure that there is cross-functional alignment at the executive committee level to avoid siloed optimization of results.

This is not directly linked to the question, but my Ph.D. dissertation is about how CEOs can create superior performance for their firms and many of the findings where related to linking vision to strategy and goals, and embedding them in the company’s operating model to accelerate execution.

Please describe a specific situation in which you were asked to develop an executive development and succession planning process. How did you advise the organization as to which elements to evaluate for suitability for advancement? How did you recommend those elements be assessed in individual executives? How were those elements woven into individual development plans?

I held two global Talent Management roles in large organizations. Before becoming the CHRO of Pure Storage, I was HPE’s Chief Talent Officer for 3 years (60,000 employees - \$29Billion in annual revenues). I was also the Global Head of Talent Management for Philips Electronics’ Lighting Division based in the Netherlands (45,000 – EUR7Billion in annual revenues). My roles ranged from shaping and executing talent strategies and working with the board of directors in CEO and c-suite succession planning to coaching senior executives and successors in their own growth journey.

Firstly, it is important to understand which are the key organizational capabilities that are crucial for the company to win in the marketplace. Once the organizational capabilities are identified, competency profiles – both leadership but also knowledge and skills – need to be clearly articulated ideally in various levels of complexity so that everyone in the organization receives direction related to which behaviors, experiences, knowledge, skills they should possess to perform well, and develop to further progress in their career. It is important to hardwire individual development plans (ideally based on the 70-20-10 learning model for adults) in the annual

Candidate Questionnaire

El Camino Hospital Board of Directors || Executive Compensation Committee Member

performance and development management process, in which performance and development goals are set, and leaders and employees check-in frequently to discuss progress. I believe that stronger succession plans are attained if the entire organization is part of this structured learning ecosystem. Specifically on the succession planning aspect of the question, using the competency profiles to project who the best bets are to hold the most senior roles in the future is very important to minimize subjectivity. It is also important by design to promote internal mobility at the top layers of the structure so that top talent does not get discouraged by the lack of future opportunities. Lastly, I have created and implemented succession planning approaches for large enterprises for many years now and, in addition to thoughtful design components, it is crucial that leaders role model and are held accountable for driving the process and own talent mobility.

Do you have experience serving on committees and boards in the human resources or executive compensation advisory capacity?

As part of senior management in the CHRO capacity, I work extremely closely with the Human Resources & Compensation Committee at Pure Storage. I worked closely with HPE's compensation committee in all aspects of the committee's charter, spanning from executive compensation to board and C-suite succession, ESG/DEI, culture & employee engagement, technical and business skills of the future. I am an independent board member of a Talent Cloud company called iCIMS (a Vista Equity Partners company pre-IPO, \$350M in annual revenue, ~40%CAGR) and I serve on the audit committee.

Are there any other aspects of the position description that you have experience with that are not specifically called out above? If so, please describe that experience.

I consider myself very experienced with leading organization design transformation to support evolving business strategies that require business model shifts. For ~2,5 years I left HR and ran Strategy and Business Excellence (Lean Six-Sigma/Agile) for Philips Lighting in Latin America. That experience taught me how to engage the workforce in a mindset of continuous improvement that enhances services for customers and enables productivity gains through streamlined simple processes.

Estrella Parker

Email: [REDACTED]

SUMMARY

Strategic human capital executive and business partner with demonstrated strengths in leadership and team development, culture and business transformation, strategic planning, organization development, change management, talent management, executive coaching, total rewards, operations and shared service management, systems development and large scale program management. Ability to engage with top leadership on business issues involving strategic alignment, growth, revenue enhancement, operations improvement, and restructuring.

ACCOMPLISHMENT AND EXPERIENCE OVERVIEW

CUPERTINO ELECTRIC INC.

July 2021 - Present

Chief People Officer. Reporting to the CEO, chief executive responsible for building upon and improving the existing HR and marketing infrastructure at CEI. Charged to develop and implement innovative people programs that can be scaled to support growth and business expansion. Working closely with the CEI executive team to establish the people and brand strategy including culture, DEI, talent management, organizational development, performance management, total rewards, HR operations, marketing/PR and community affairs.

SATELLITE HEALTHCARE

2015 - 2021

Chief Human Resources Officer. Reporting to the CEO, chief executive responsible for providing strategic leadership and direction to maximize employee engagement and contribution, while driving workforce excellence and productivity. Provides leadership and oversight for all human resources functions and programs including Total Rewards, Talent Acquisition and Management, Employee Relations, Organization Development, Training, and Workforce Planning.

Plays an active role in ensuring that Satellite Healthcare's senior leaders work as a cohesive and collaborative executive team.

Successfully completed the reinvention of the human resources organization and people practices to ensure that Satellite Healthcare has a pulse on the future direction of the healthcare industry and its workforce while supporting the organization's aggressive growth plans. Results include a successful rollout of leadership development programs, a talent management strategy and transformation of performance management, ramp up of talent acquisition programs, revamped total rewards strategy and programs, increased employee engagement, improved employment brand, enhancement of culture resulting in the organization topping industry quality standards and double digit growth. Was actively involved in furthering the strategic impact of people and culture strategies for a reinvigorated vision and industry disruptive strategy for the expansion of the company's mission in a highly dynamic healthcare industry landscape.

THE CLOROX COMPANY

2005 - 2015

Leading member of HR Executive Team overseeing all aspects of HR Function Leadership supporting Clorox Strategies and Operations including Enterprise Strategic Alignment, Capability Development and HR Transformation.

Sr. Director, HR Global Solutions & Specialty Division Business Partner (2009-2015). Led global programs, projects, and business process management to implement Clorox HR Strategic and Business Imperatives. Oversaw roadmap for ongoing HR Transformation efforts. HR Solution Practice Areas include Total Rewards (compensation, benefits and recognition), Talent Management (talent acquisition, learning and development, capability development, succession planning, employee relations, and Workforce Planning), Diversity, Compliance/Risk Management, HR Communications and HR Analytics and Technology.

- Developed consulting and project management practice methodologies and governance that enabled strategic alignment of programs and projects and increased success of projects
- Co-led award winning total rewards (compensation and benefits) portfolio redesign including the rollout of a wellness program
- Upgraded multiple talent programs including global leadership programs, succession planning, performance management, strength of diversity and inclusion, employee engagement, talent acquisition
- Developed HRIT Strategy and oversaw ongoing implementation of roadmap including 2 HRIS implementations
- Developed strategic HR/People Communications Programs
- Led multiple mergers & acquisition/integration (HR/People/Organization segment)

- Program Lead for Culture (Change Roadmap): ongoing work with C-level executives in developing strategies and aligning efforts for culture change
- Strategic HR Business Partner to and expanding \$3BB Business Unit with multiple brands in various categories

Sr. Director, Global HR Business Partnership. (2012-2013). Strategic People and Organization Consulting. Oversaw the application of people and culture related programs, projects, and processes to create strategic business impact. Led team of global HR business partners in working directly with senior business leaders to ensure the alignment of human capital strategies and capability development with business strategies. Strategic Business Partner to Executive/Business Leadership Teams.

Sr. Director, HR Workforce Services (2008-2009). Led all aspects of HR end to end operations including payroll, compensation, benefits, global mobility, total rewards programs, employee relations, talent acquisition, performance management, learning and development, HRIS, HR Portal/Customer Support, and vendor management of outsourced services.

- Led transformation of HR Operations from Center of Expertise Operations to an HR Shared Service Environment.
- Implemented Process Management, Vendor Management, Knowledge Management, Case Management, HR Operations Metrics and various Operational Improvement Initiatives.
- Led HR SAP Functional Enhancement and Expansion.
- Executive talent acquisition.
- Participated in Business Acquisition and integration projects leading HR and organization strategy segments.

Director, HR Operations and Technology/HR MegaProcess Leader (2005-2008). Oversight of HR Technology Initiatives including ERP/HR SAP implementation and HR Operations Turnaround and Process Improvement. Led HR Strategic Planning and Business Process Integration. Provided HR Business Partnership for Europe and Middle East Business/Regions.

KAISER PERMANENTE

1997 - 2003

Vice President, Human Resources & HR Transformation Program Integration (2002-2003). Led development of business case and implementation plan for the enterprise-wide transformation of the HR function for Kaiser's 120,000+ employee organization. Scope included HRIS Implementation (PeopleSoft), consolidation of HR administration, policy development and compliance, redesign of staffing and learning processes, compensation, labor relations, and other HR professional support services. Defined annual saving of \$35MM, means to increase HR strategic impact, and improve workforce development and labor partnership.

Vice President, Human Resources for Enterprise Information Technology (2000-2002). Member of executive leadership for enterprise IT business unit, a \$1B+ function with 5,000+ professionals; led development of comprehensive workforce plans supporting overall IT business strategies; oversaw performance against business goals related to human capital and performance; managed a function of 50+ professionals and a budget of \$20MM+; participated in executive leadership of enterprise HR.

- Developed and implemented aggressive staffing programs, global sourcing, and workforce planning & development programs that generated above industry performance in hiring/staffing, improved talent management and retention, reduced reliance on contractors, reduced labor costs by over \$40M, and enhanced productivity
- Developed and implemented compensation/benefits program, centralized service center, and HRIS
- Developed and implemented a comprehensive process for Restructuring and Workforce Alignment
- Revamped training & development for IT workforce resulting in enhanced training & development usage (20-50% over 3 years), increased employee satisfaction, and reduced training costs by 10-20%
- Enhanced HR consulting capability and managed employee relations issues using a systemic approach that reduced organizational risk exposure
- Developed and implemented Organizational Restructuring and Workforce Reduction programs reducing legal liability and increasing successful employee transitions

Program Director, IT Capabilities Initiative (1999-2000). Led the development and implementation of restructuring initiatives in enterprise IT. Developed a stronger IT linkage to business priorities and focused organization around critical competencies. Improved IT throughput/investment ratio by 20-30% through implementation of enterprise-based business processes, and enhanced workforce capabilities.

Director, Human Resources for Information Technology (1997-1999). Chief HR strategist and functional leader of merger and consolidation of 14 separate IT divisions into an enterprise-based unit; created and managed a function of 30+ professionals and a budget of \$10MM+. Implemented and developed common HR policies, a comprehensive

performance-based market-driven compensation program, streamlined job families and development paths, a performance management system, and training & development services.

THE PRUDENTIAL INSURANCE CO.

1993 - 1997

National Director, Strategic Change (1996-1997). Initiated and developed change management programs associated with business transformation and performance turnaround efforts for Prudential HealthCare, an \$11B business unit of The Prudential; managed a nationally dispersed professional staff of 30+ professionals. Led organizational effectiveness programs and functions including organizational development, training and development, performance consulting, and internal communications. Provided change management, communications, training & development support for the consolidation and reengineering program that achieved 20% cost reductions and increased member satisfaction.

Director, Human Resources and Organizational Effectiveness, Western Group BU (1993-1996).

Managed human resources, management consulting, and training and development functions for Prudential HealthCare's Western Operations, a \$1B business unit. Promoted from Manager, Organizational Effectiveness within 1 year. Managed a staff of 30+ and a budget of \$8MM+.

- Directed business process reengineering of claims and member services, resulting in 5-20% reduced operational costs, higher customer satisfaction, and enhanced sales/marketing capabilities.
- Managed strategy development process for integrated business planning of aggressive market expansion and revenue enhancement targets.
- Implemented a strategic management process, management development program, and a Total Quality Management program.
- Reengineered human resources function, resulting in higher levels of support and alignment of HR initiatives and services with business needs, increased productivity, and higher customer satisfaction.
- Implemented a fully automated market-based performance driven compensation program

GEMINI CONSULTING CO./UNITED RESEARCH CO.

1990 - 1993

Senior Consultant. Started as consultant, merited progressively greater responsibilities in consulting assignments focused on business transformation efforts. Projects included:

- **International Petroleum Company, subsidiary of a multinational chemical company.** Managed redesign of Finance business processes; generating 40% budget reduction; reengineering of Accounts Payable and Travel Reimbursement processes.
- **International Petroleum Company, North America Exploration and Production Division.** Developed a strategic organizational blueprint; focused leasing and bidding processes generating \$140MM sourcing differential with competitors; created a diagnostic program for trending against key competitors; developed organizational effectiveness diagnostics including span of control, culture assessment, and functional decomposition.
- **Leading Tobacco Company - \$28.8B division of a multinational holding company.** Addressed opportunities for increased profitability via business integration; developed tools to optimize purchasing of \$200MM in direct materials with identified \$67MM.
- **Multinational Chemicals and Plastics Co., a \$7.6B subsidiary of an international holding company.** Participated in a major business transformation effort; identified \$75M in savings opportunities, developed project measurement tracking methodologies and Quality Assessment package.

EDUCATION

MBA, Anderson Graduate School of Management at UCLA
BS, Computer Science, cum laude, University of the Philippines

Professional Coaching Certification, New Ventures West

Clorox Executive Leadership Program, Wharton School of Business Executive Education

Kaiser Permanente Advanced Leadership Program, University of North Carolina Executive Education

OTHER LEADERSHIP and ADVISORY

Board of Trustee, The Oakland Museum of California (2015-present)

Curriculum Advisor and Consultant, Human Resources at College of St. Benilde (2017-present)

Executive Advisor, National Kidney Foundation Northern California (2016-2020)

Consultant/Professor, Strategic Human Resources College of St. Benilde (2018)

Candidate Questionnaire

El Camino Hospital Board of Directors || Executive Compensation Committee Member

Name:	Estrella Parker
Email Address:	[REDACTED]
City of Residence:	[REDACTED]
Do you feel you have adequate flexibility in your schedule for this commitment? (4 ECC meetings & 2 Board Education Sessions annually from 530-730p)	yes
Are there any civil, employment-related or criminal incidents in your background that we may uncover in a reference or background check? Have you ever been involved in a government investigating for business related issues (e.g. SEC)? (Note: Disclosure of a civil, employment-related, criminal incident(s) or government investigation will not necessarily disqualify you from appointment. The nature and timeframe will be taken into consideration.)	no
Would this position create a conflict of interest with any of your other commitments?	no
The El Camino Health Executive Compensation Committee Member position is a non-compensated (i.e. volunteer) and has one-year renewable terms. Is this acceptable?	yes
Please specify how you found out about this position?	Via Jason Layney
<p><i>Why are you interested in being considered for Committee Member position as part of the Executive Compensation Committee at El Camino Health?</i></p> <p>I personally believe in the core importance of health care in creating a vibrant community. Recently, I transitioned to working in a different industry (from healthcare) so this is a way for me stay involved in healthcare. In addition, I feel it is important to serve in organizations such as ECH that are non-profit, mission-based, and community oriented. Lastly, it helps someone in my role and position to be involved in other related endeavors to reinforce a broader perspective in applying HR capabilities/knowledge.</p>	
<p><i>Please describe a specific instance in which you were instrumental in developing an executive compensation strategy for an organization. What factors did you consider in determining the elements of the strategy? What obstacles did you encounter in gaining consensus on the strategy? How did you deal with them? What was the outcome?</i></p> <p>In my last organization, I was the CHRO. As the organization was implementing a new business strategy, I worked with the CEO and the board to develop new elements in the executive compensation programs such as the LTI and annual bonus incentives. In addition, we reviewed the perq's and benefits to ensure we had an understanding of how we stacked against the market. Several factors were considered: how we scope out our market for talent and for the business (market reference) and our current organization's practices. These were considerations in determining how we applied our compensation philosophy. Eventually a compensation committee was established and I worked as management team lead staff for that committee. We first developed a philosophy and used market data and information to determine our baseline relative to the market and relative to our intended application of the philosophy elements. We developed a "system" or cadence for review and adjustment. Some obstacles we encountered pertained to the volatility of the healthcare industry and how difficult it was to have line of sight to long term goals especially when the strategy called for expansion and entry into new areas of services. We eventually realized that because this was an industry dynamic, about 50% of the market transitioned out of the use of LTI and used other mechanisms to ensure the long term line of sight in decision making and rewards. We decided to eliminate the LTI and created board review processes to ensure our goal setting processes were related to multi year strategic plan. In addition, we created more incentives for longer tenure with the use of our executive retirement programs. There were more complexities that we addressed but this example should give you a sense of how I worked with the board. I am happy to discuss further.</p>	

Candidate Questionnaire

El Camino Hospital Board of Directors || Executive Compensation Committee Member

Please describe a specific instance in which you had to make recommendations of cost and reasonableness of severance and benefits for executives.
I would prefer to describe this in a live discussion. In general, I track organization practices (history), check on market practices and do financial projections/analyses, and handle each situation as its own case with historical and other contextual perspective.

Please describe a specific instance in which you had to provide input into the CEO and executive team's annual performance goals to execute a strategic plan, and then recommending these goals for approval by the Board.
I actually led the executive team at Satellite to determine annual goals that align to our overall strategic roadmap, under the guidance and direction of the CEO. I worked with each executive owning each pillar of our strategy to help them with goal setting and we reviewed the goals as a team with the CEO finalizing for recommendation to the board. We would typically bring in the executive subject matter expert for certain goals that may be different from what could be expected but majority of the years it was mostly the CEO and me presenting with occasional support from the CMO (Chief Medical Officer) and CFO.

Please describe a specific situation in which you were asked to develop an executive development and succession planning process. How did you advise the organization as to which elements to evaluate for suitability for advancement? How did you recommend those elements be assessed in individual executives? How were those elements woven into individual development plans?
I actually initiated the succession planning process at Satellite. I worked with the CEO, the board chair who was also eventually the comp committee chair, and the management team to identify key requirements in succession for each role. Over a 3 year period, the team got better at discerning qualities not only as they understood their role currently but also in consideration of the future as defined by our strategy and the industry competitive landscape. We evaluated the status of readiness of internal successors and build development plans to improve their readiness.

Do you have experience serving on committees and boards in the human resources or executive compensation advisory capacity?
I informally advise and participate in matters related to executive compensation for the OMCA in which I currently am on the board of trustees and the governance committee.

Are there any other aspects of the position description that you have experience with that are not specifically called out above? If so, please describe that experience.
My entire career has been shaped by an interest in organization growth and transformation, with a strong affiliation towards organizations that have a strong value for integrity and stakeholder responsibility (not just shareholders but the community, employees, customers, and regarding sustainability). These career

Candidate Questionnaire

El Camino Hospital Board of Directors || Executive Compensation Committee Member

experiences, along with my own personal development interests have provided me with the type of personal characteristics you seek and describe in the position description: high integrity, collaboration, communication, high energy/drive, innovative/creative, mission-driven, change hearty.

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

To: El Camino Hospital Board of Directors
From: Apurva Marfatia, MD, Enterprise Chief of Staff
Michael Kan, MD Chief of Staff Los Gatos
Date: December 8, 2021
Subject: Medical Staff Report – Open Session

Recommendation:

To approve the Medical Staff Report.

Summary:

1. Situation: The Medical Executive Committee met on November 18, 2021
2. Background: MEC received the following informational reports.
 - a) Quality Council – The Quality Council met on November 3, 2021. Reports and performance dashboards were reviewed and approved from the following ECH Departments/Service Lines:
 1. Annual PI Report MCH
 2. MCH KPI Quality Council FY 21-22
 3. Annual PI Report Oncology Quality Council 2021
 4. Cancer Dashboard
 5. Annual PI Report Human Resources
 6. Human Resources Quality Council Dashboard
 7. Annual PI Report
 8. PI Dashboard FY22
 - b) Leadership Council – The Leadership Council met on November 9, 2021 and discussed the following:
 1. Informed Consent
 2. Dues Refund Process
 3. Physician Orientation
 4. CME Software Request
 5. Medical Staff Bylaws
 6. High Reliability Organization (HRO) Presentation
 - c) The CEO Report was provided
 - d) The CMO Report was provided
 - e) The CNO Report was provided

List of Attachments: None

Suggested Board Discussion Questions: None

OPEN SESSION CEO Report
December 2021
Dan Woods, Chief Executive Officer

Human Resources

Human Resources and Nursing Administration has engaged representatives from our Nursing Union, Professional Resource for Nurses (PRN), in discussions to create an additional level to our Nursing Career Ladder that firmly establishes criteria to recognize the professional nature of our nursing staff. We are also engaging representatives for Service Employees International Union (SEIU) in initial discussions regarding establishing Career Ladders for a number of classifications in the SEIU unit.

Human Resources also completed the hiring of a Diversity Manager who will start December 30, 2021 and is currently conducting an exploration into potential internships for under represented high school and/or college student is underway.

Finance

Net operating margin for the month ending October 31st was \$15.1 million which is \$7.4 million favorable to budget. Favorable operating performance was the result of strong patient activity, a one-time recognition of \$4.2 million associated with a payor claims settlement / I/T distribution and initiatives in place to manage variable expenses such as purchased services. Higher than budgeted patient volumes and the on-going labor shortage are driving higher utilization of OT / premium pay. We expect continued labor shortages and other inflation pressures to drive higher than budgeted expenses per unit in Q3 / Q4, but we have initiatives in place which we anticipate will mitigate the financial impact. A rebound in the capital markets in October contributed to favorable performance of non-operating income.

Information Services

El Camino Health has achieved 'Gold Stars Level' which measures adoption of features and best practices within the Epic system. Only 10% of Epic organizations have achieved this level of feature utilization and adoption.

El Camino Health received the designation of 'Most Preferred Level' for Acute Care again this year and additionally also received the same designation for Ambulatory Care. Most Preferred identifies, recognizes and certifies the adoption, implementation and use of information technology by healthcare provider organizations. Level 1 designees are considered leaders in healthcare technology who actively push the industry forward by leveraging technologies in innovative ways. Less than 100 healthcare organizations have received this designation.

Philanthropy

El Camino Health Foundation held the 25th anniversary El Camino Heritage Golf Tournament on October 25 at Sharon Heights Golf & Country Club. The benefit for the Cardiopulmonary Wellness Center was sold out with 124 golfers participating and another 25 guests joining for the celebration dinner. All guests, volunteers, and staff were required to provide proof of vaccination or a negative PCR test within three days of the tournament before being allowed, fully masked, to enter the club. Norma Melchor Heart & Vascular Institute Medical Director and Foundation Board Member Dr. Fred St. Clair spoke to the enormous benefit the unique and comprehensive cardiopulmonary wellness program provides and conducted the fund-in-need appeal, which raised \$77,000. Since its inception the El Camino Heritage Golf Tournament has raised more than \$7.5 million for a variety of hospital programs.

Corporate & Community Health Services

The Chinese Health Initiative partnered with Santa Clara County Public Health to provide an overview on COVID-19 updates, vaccines and resources in Mandarin by the County communication officer. CHI



outreached to 13 isolated seniors to help them access the webinar. November is Diabetes Awareness month. CHI established a new partnership with the Los Altos Library and provided a bilingual webinar by a registered dietitian about diabetes prevention.

The South Asian Heart Center engaged 147 new participants in the AIM to Prevent and STOP-D programs, and completed 100 consultations, workshops, and health coaching appointments. The Center also hosted three education events. The Center became a CDPH affiliate for the Sweet Success gestational diabetes program in collaboration with the Prenatal Diagnostic Center.

Concern completed an upgrade of our digital platform that included mobile first design, simplified access to our virtual counseling services and improved algorithms to match clients to providers.

Concern created and distributed engaging and upbeat videos to promote our services to employees, managers and HR leaders. The videos have been extremely well received.

Auxiliary

The Auxiliary donated 2,003 volunteer hours for the month of October.