AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, June 12, 2024 – 5:30 pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 986 0722 3492# No participant code. Just press #.**

To watch the meeting, please visit: ECH Board Meeting Link

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.

NOTE: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

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

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 pm**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
4	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Bob Rebitzer, Board Chair	Information	**5:30 pm**
5	**MEDICAL STAFF VERBAL REPORT**	Prithvi Legha, MD MV Chief of Staff	Information	**5:31 – 5:36**
6	**RECEIVE QUALITY COMMITTEE REPORT**	Carol Somersille, MD Quality Committee Chair Shreyas Mallur, MD Associate Chief Medical Officer	Information	**5:36 – 5:45**
7	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	Motion Required	**5:45 – 5:46**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
8	*Health and Safety Code Section 32106(b) Report on health facility trade secrets regarding new services or programs*: **ENTERPRISE RISK MANAGEMENT**	Carlos Bohorquez, Chief Financial Officer Diane Wigglesworth, Compliance & Privacy Officer	Discussion	**5:46 – 5:56**
9	*Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets:* **FY25 OPERATING AND CAPITAL BUDGET**	Carlos Bohorquez, Chief Financial Officer	Discussion	**5:56 – 6:16**
10	*Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets:* **LOS GATOS CAMPUS DEVELOPMENT**	Dan Woods, CEO Omar Chughtai, Chief Growth Officer	Discussion	**6:16 – 6:26**
11	*Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets and Gov't Code Section 54957 and 54957.6 for a report and discussion on personnel matters:* **FY25 ORGANIZATIONAL STRATEGIC MILESTONES**	Dan Woods, CEO A.J. Reall, VP, Strategy	Discussion	**6:26 – 6:50**
12	*Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters*: **APPROVE CREDENTIALING AND PRIVILEGING REPORT**	Mark Adams, MD, CMO	Motion Required	**6:50 – 6:55**
13	*Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets:* **FINANCE COMMITTEE ITEMS:** - Respiratory Care Services Medical Director Renewal Agreement as Reviewed and Recommended for Approval by the Finance Committee - Call Panel Renewal Agreements as Reviewed and Recommended for Approval by the Finance Committee	Bob Rebitzer, Board Chair	Discussion	**6:55 – 7:00**
14	*Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets and Gov't Code Section 54957 and 54957.6 for a report and discussion on personnel matters:* **EXECUTIVE COMPENSATION COMMITTEE ITEMS:** - FY25 Organizational Performance Incentive Goals as Reviewed and Recommended for Approval by the Executive Compensation Committee - Receive FY25 Executive Individual Incentive Goals as Approved by the Executive Compensation Committee	Bob Rebitzer, Board Chair	Discussion	**7:00 – 7:05**
15	*Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management:* **EXECUTIVE SESSION**	Bob Rebitzer, Board Chair	Discussion	**7:05 – 7:10**
16	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	Motion Required	**7:10 – 7:11**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
17	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Bob Rebitzer, Board Chair	Information	**7:12 – 7:13**
18	**CONSENT CALENDAR ITEMS:** *Items removed from the Consent Calendar will be considered at the end of the regular agenda.* a. Approve Hospital Board Open Session Minutes (05/08/2024) b. Approve Minutes of the Closed Session of the Hospital Board (05/08/2024) c. Approve Adding VP-Chief Marketing and Communications Officer to Executive Group as Reviewed and Recommended for Approval by the Executive Compensation Committee d. Approve Resolution 2024-04 (ECC Delegation of Authority) as Reviewed and Recommended for Approval by the Executive Compensation Committee e. Approve FY25 Performance Incentive Goals as Reviewed and Recommended for Approval by the Executive Compensation Committee f. Approve Signature Authority Policy as Reviewed and Recommended for Approval by the Finance Committee g. Approve FY25 Implementation Strategy Report and Community Benefit Plan as Reviewed and Recommended for Approval by the Finance Committee h. Approve Respiratory Care Services Medical Director Renewal Agreement as Reviewed and Recommended for Approval by the Finance Committee i. Approve Call Panel Renewal Agreements as Reviewed and Recommended for Approval by the Finance Committee j. Approve FY25 Master Calendar as Reviewed and Recommended for Approval by the Governance Committee k. Approve FY25 Committee Goals as Reviewed and Recommended for Approval by the Governance Committee l. Approve FY25 Committee Pacing Plans as Reviewed and Recommended for Approval by the Governance Committee m. Approve FY25 Committee and Liaisons Appointments as Reviewed and Recommended for Approval by the Chairperson and Governance Committee n. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee o. Approve QAPI as Reviewed and Recommended for Approval by the Quality Committee	Bob Rebitzer, Board Chair	Motion Required	**7:14 – 7:20**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
	p. Approve FY25 Operating and Capital Budget q. Receive Period 10 Financials			
19	**CEO REPORT**	Dan Woods, Chief Executive Officer	Information	**7:21 – 7:25**
20	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:25 – 7:30**
21	**ADJOURNMENT** **APPENDIX** **POLICIES APPENDIX**	Bob Rebitzer, Board Chair	Motion Required	**7:30**

El Camino Health Board of Directors
Quality, Patient Care, and Patient Experience Committee Memo

To: El Camino Hospital Board of Directors
From: Carol Somersille, MD, Committee Chair, Shreyas Mallur, MD, Interim Chief Quality Officer.
Date: June 12, 2024
Subject: ECH Quality, Patient Care and Patient Experience Committee Meeting (Quality Committee) Report

Purpose and Authority:
The governing board of El Camino Hospital is responsible for oversight of the quality and safety of the care provided to our patients. The Quality Committee has the delegated authority to oversee the Quality, Experience, and Safety programs through a review of the quality of care we deliver and the implementation of specific improvement activities and projects on an ongoing basis for all services provided by the hospital, while considering the scope and complexity of those services and the patient populations we serve.

Summary of Meeting:

The Quality Committee met on June 3, 2024, to deliberate on various critical matters and provide updates:

The Consent Calendar, encompassing the approval of minutes from the 5/6/2024 meeting, the FY24 Enterprise Quality Dashboard, progress notes on FY24 Committee Goals, and Leapfrog update, garnered unanimous approval. Discussion centered around the minutes, the dashboard, Leapfrog measures and anticipated changes in Leapfrog reporting.

Melora Simon, Vice Chair of the Quality Committee, shared information on equitable health. Discussion included aspects of the CalAIM program and how El Camino Health could leverage those resources to help MediCal patients in our health system. This would help reduce readmissions as well as decrease length of stay by getting patients the resources they need outside the hospital.

Shreyas Mallur, MD, Associate Chief Medical Officer and Interim Chief Quality Officer delivered a comprehensive update on health care equity focusing on Social Determinants of Health Screening requirements. CMS has a new SDOH screening requirement that facilities are required to comply with. El Camino Health has already been screening per the new requirements and will monitor this on an ongoing basis.

Dr. Mallur presented proposed changes to the STEEEP dashboard for FY 25. Discussion ensued on the proposed changes and the rationale behind decision making on the proposed changes. Changes to the STEEEP dashboard were made with the intent of aligning metrics on the dashboard to the metrics that El Camino will be measured and benchmarked against by CMS, Leapfrog and other National rating agencies. The Committee unanimously voted to recommend approval of the proposed changes.

El Camino Health

DRAFT VERSION – BEING UPDATED BY DEANNA DUDLEY AND ED BRAXTON

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING COVER MEMO

To: **El Camino Hospital Board of Directors**
From: Dan Woods, CEO
Date: June 12, 2024
Subject: Job Classification for VP-Chief Marketing & Communications Officer

Recommendation(s):

Approve recommendation to add new position – VP-Chief Marketing and Communications Officer – to the executive group.

Summary:

As we continue our recruitment efforts for the open Marketing position, it has become evident through discussions with potential candidates that the current job level is not fully aligned with the responsibilities and expectations outlined in the job description. To better support our strategic goals and growth objectives, we propose that this position be reclassified as part of the executive group.

Rationale:

Strategic Alignment:
The responsibilities of the open Marketing position are critical to the strategic direction and success of our organization. The role involves high-level decision-making, strategic planning, and significant influence over our brand and market positioning, all of which are integral to achieving our growth objectives.

Market Competitiveness:
In our discussions with candidates, it has become clear that individuals with the requisite skills and experience for this role expect a job classification that reflects its strategic importance. Reclassifying this position as an executive role will help us attract and retain top-tier talent who can drive our marketing initiatives forward.

Organizational Impact:
Elevating this position to executive status will empower the incumbent to work more effectively with other senior leaders, ensuring cohesive and aligned strategic initiatives across departments. This collaboration at the executive level is crucial for integrated marketing strategies that support overall business goals.

Growth and Innovation:
A marketing leader at the executive level will bring a fresh perspective and innovative ideas, fostering a culture of growth and adaptability. This is essential as we navigate an increasingly competitive market and seek to expand our market share.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: June 12, 2024
Subject: Updated Signature Authority Policy

Purpose:

The Finance Committee is recommending that the Board approve the updated Signature Authority Policy.

Summary:

1. Situation: Given the increase in size / scope of the organization and value of contracts due to inflation / complexity, the signature authorities for the CEO, CFO, COO and other leaders have been updated. This is intended to ensure management's ability to implement timely operational or strategic initiatives which might be limited by timing of the Finance Committee. Please note that ECH & ECHD Board approval thresholds have not been modified.

Below are the updated signature authority limits by level:

Position / Committee / Board	Signature Authority
Manager	$10,000
Director	$25,000
Senior Director/Executive Director	$50,000
Division Executive (Chief, President, or VP)	$250,000
Chief Operating Officer	$500,000
Chief Financial Officer	$750,000
Chief Executive Officer	$2,000,000
Finance Committee	$2,000,000.01 to $5,000,000
Hospital Board	> $5M - 5% of assets
ECHD Board	> 5% assets or $25M

The updated policy includes new language which authorizes the CEO to approve the expenditure of funds in an Emergency. An emergency is defined as a sudden, generally unexpected circumstance that demands immediate action, the absence of which would undermine essential ECH services or cause a significant economic loss to ECH.

The updated policy also includes new language which strengthens internal controls by requiring the construction department to submit all contracts to ECH's centralized contracts database (Conga) or provide access to finance, legal and internal audit to an alternative database.

Recommendation:

Recommend that the Board approve the updated Signature Authority Policy.

List of Attachments:

1. Signature Authority Policy –Redline version is in the appendix.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
COMMITTEE MEETING MEMO

To: El Camino Hospital Board of Directors
From: Jon Cowan, Executive Director, Government Relations & Community Partnerships
Date: June 12, 2024
Subject: FY2025 El Camino Health Implementation Strategy Report and Community Benefit Plan

Recommendation:

To approve the FY2025 El Camino Health Implementation Strategy Report and Community Benefit Plan (Plan). To approve authority for Jon Cowan, Executive Director of Government Relations & Community Partnerships, to execute all grant agreements specified in the Plan.

Summary:

1. Situation: The Plan reflects a total request of $3,410,000 and includes funding recommendations for grants, sponsorships, and placeholder.

- The Plan outlines strategies to address the top unmet health needs identified in the 2022 ECH Community Health Needs Assessment (CHNA)
- Grant proposals in the Plan set metrics aimed at reducing these unmet health needs
- Sponsorships and placeholder funds are separate from grants and approved in aggregate amounts

2. Authority: Per the Community Benefit Grants Policy approved by the ECH Board of Directors, the Finance Committee is to review and recommend approval of the annual Plan.

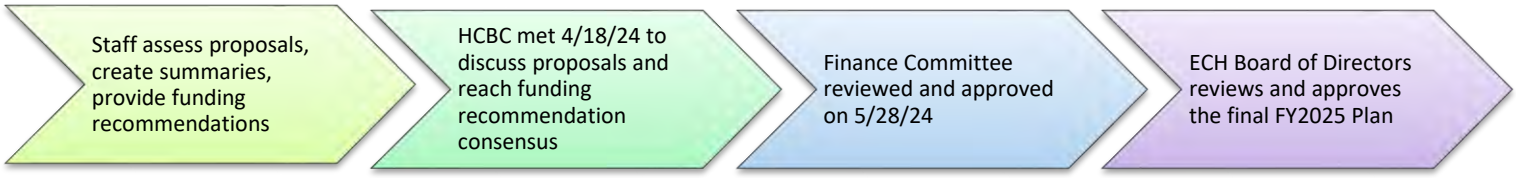
3. Background:

Plan

- Plan includes grant proposals, sponsorships, and placeholder.

Grant proposals review process:

- December 2023: Community Benefit (CB) FY2025 Application and Grant Guide released online with announcement to community and current grantees.
- February 23, 2024: Submission deadline



- Funding overview:

  Grant Proposals: 45 recommended at $3,310,000

  - Total Proposals: 76 (7% increase over prior year)
  - Total Requested: $5,996,392 (5% decrease over prior year)
  - Total Funded: $3,310,000 (0% increase over prior year)
    - Total Unfunded: $2,686,392 (11% decrease over prior year)

Sponsorships: Recommended = $85,000

Placeholder: Recommended = $15,000

- **Placeholder process:** Designated funds to be used in accordance with the ECH Community Benefit Grants Policy/Placeholder

FY2025 ECH Total Plan Request: $3,410,000

4. Assessment: N/A

5. Other Reviews: Hospital Community Benefit Committee (HCBC) and Finance Committee reviewed proposals and provided funding recommendations.

6. Outcomes: ECH Board of Directors votes to fund original Plan or Plan with approved amendments.

7. List of Attachments:

1. FY2025 ECH Implementation Strategy Report and Community Benefit Plan

Suggested Committee Discussion Questions: N/A

FY25 ECHD and ECH Board & Committee Master Calendar

*Federal / Religious Holiday & School Dates

JULY 2024

S	M	T	W	T	F	S
	1	2	3	4 Indep. Day	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3

AUGUST 2024

S	M	T	W	T	F	S
28	29	30	31	1	2	3
4	5 QC	6	7 ECHB	8	9	10
11	12 IC	13	14 ECHMN	15	16	17
18	19	20 ECHD	21	22	23	24
25	26 FC	27	28	29	30	31

SEPTEMBER 2024

S	M	T	W	T	F	S
1	2 Labor Day	3 QC	4	5	6	7
8	9	10	11 ECHB	12	13	14
15	16	17 GC	18	19	20	21
22	23	24	25 CAC	26 ECC	27	28
29	30	1	2	3	4	5

OCTOBER 2024

S	M	T	W	T	F	S
30	31	1	2 Rosh Hashanah	3	4	5
6	7	8	9 ECHB	10	11 Yom Kippur	12
13	14 FC Columbus Day	15 ECHD	16	17	18	19
20	21	22	23	24	25 ECHD SV	26
27	28	29	30	31	1	2

NOVEMBER 2024

S	M	T	W	T	F	S
27	28	29	30	1	1	2
3	4 QC	5	6	7	8	9
10	11 Veterans Day	12	13 CAC	14 ECC	15	16
17	18	19	20 ECHB	21 ECHMN	22	23
24	25	26	27	28 Thanksgiving	29	30

DECEMBER 2024

S	M	T	W	T	F	S
1	2 QC	3 GC	4 ECHD (Election Results)	5 FC	6	7
8	9 IC	10	11 ECHB	12	13 ECHD SV	14
15	16	17	18	19	20	21
22	23	24 Xmas Eve	25 Xmas / Hanukkah Begins	26	27	28
29	30	31 NYE	1	2	3	4

JANUARY 2025

S	M	T	W	T	F	S
29	30	31	1 NYD	2 Hanukkah Ends	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20 MLK	21	22	23	24	25
26	27 FC	28	29 Chinese New Year	30	31	1

FEBRUARY 2025

S	M	T	W	T	F	S
26	27	28	29	30	31	1
2	3 QC	4	5 ECHB	6	7	8
9	10 IC	11 ECHD	12	13 ECHMN	14 ECHD SV	15
16 Ski Week	17 Pres. Day	18	19	20	21	22
23	24 FC | IC	25	26 CAC	27	28 Ramadan Begins	1

MARCH 2025

S	M	T	W	T	F	S
23	24	25	26	27	28	1
2	3 QC	4	5	6	7	8
9	10	11	12 ECHB	13 ECHMN	14	15
16	17	18 ECHD	19	20 ECC	21	22
23/30	24/31 FC	25 GC	26	27	28 ECHD SV	29 Ramadan Ends

APRIL 2025

S	M	T	W	T	F	S
30	31	1	2	3	4	5
6	7 Spring Break	8	9	10	11	12 Passover
13	14 Holy Monday	15	16 ECHB	17	18	19
20 Easter/ Passover	21	22	23 CAC	24	25	26
27	28	29 Passover End	30 Eid al-Fitr	1	2	3

MAY 2025

**all Committees must meet and approve FY2026 goals before ECC and GC*

S	M	T	W	T	F	S
27	28	29	30	1	2	3
4	5 QC	6	7	8	9	10
11	12 IC	13	14 ECHB	15 ECHMN	16	17
18	19 FC	20 ECHD	21	22	23	24
25	26 Mem. Day	27	28	29	30	31

JUNE 2025

S	M	T	W	T	F	S
1	2 QC	3 GC	4	5 ECC	6	7
8	9	10	11	12	13	14
15	16	17 ECHD	18 ECHB	19	20	21
22	23	24	25 CAC	26	27	28
29	30	1	2	3	4	5

District Board | ECHD	Hospital Board | ECHB	Executive Comp | ECC	Finance | FC	Quality | QC	Compliance | CAC	Governance | GC	Investment | IC	ECHMN
7x per year (Year 2)	10x per year	4x per year	6x per year	8x per year	5x per year	4x per year	4x per year	6x per year

Updated 06/05/2024. Pending Review and Approval.

El Camino Health

FY25 El Camino Hospital Board of Directors
Advisory Committee & Liaison Appointments

COMMITTEE APPOINTMENTS						
COMMITTEE	COMPLIANCE & AUDIT	EXEC COMPENSATION	FINANCE	GOVERNANCE	INVESTMENT	QUALITY
CHAIR	Lica Hartman	Bob Miller*	Don Watters	Lanhee J. Chen	Brooks Nelson	Carol Somersille, MD
VICE CHAIR	Julia E. Miller	Wayne Doiguchi	Bill Hooper	Christina Lai	John Zoglin	Melora Simon
BOARD MEMBERS	Jack Po, MD	Carol Somersille, MD	Wayne Doiguchi	Don Watters	Peter C. Fung, MD	Jack Po, MD
		George O. Ting, MD	Peter C. Fung, MD	Julia E. Miller		John Zoglin
COMMUNITY MEMBERS	Sylvia Fong	Tom Asmar	Cynthia Stewart	Ken Alvares	Nicola Boone	Krutica Sharma
	Sharon Anolik Shakked	Mary Hassett	RECRUIT	Mike Kasperzak	John Conover	Pancho Chang
	Christine Sublett	Estrella Parker			Robin Driscoll	RECRUIT
		Todd Shaw			Ken Frier	
MEDICAL STAFF OFFICERS & MEDICAL NETWORK BOARD MEMBERS						Prithvi Legha, MD
						Philip Ho, MD
						Steve Xanthopoulos, MD *Alternate*
						Shahram Gholami, MD *Alternate*

LIAISON APPOINTMENTS		LEGEND: *Hospital Board Members *District Board Members *Community & Staff Members	
COMMUNITY BENEFIT ADVISORY COUNCIL (CBAC) (Liaison)*	Carol Somersille, MD	ECH FOUNDATION BOARD OF DIRECTORS (Liaison)	Julia E. Miller

*Develop transition plan for Bob Miller

*CBAC Liaison is appointed by ECHD.

To Be Approved by Hospital Board of Directors: 06/12/2024

Proposed by Bob Rebitzer and Jack Po: 05/06/2024

El Camino Health

BOARD OF DIRECTORS
Policies for Review
June 12, 2024

Department	Document Name	Revised?	Doc Type	Notes	Committee Approvals
New Business					
HR	AB18k1. Leadership Policy	None	Policy	1. None	• ePolicy > Board > Publish
Women's Hospital	AB18k2. Certified Nurse Midwives Scope of Service	Revised	Scope of Svc	1. Updated Sections: Types and Ages of Clients Served; Appropriateness, Necessity and Timeliness of Services; Standard of Practice	• IDPC • MCH Exec • ePolicy • MEC > Board > Publish
Information Security	AB18k3. Generative Artificial Intelligence Policy	New	Policy	1. None	• CISO | CIO • ePolicy • MEC > Board > Publish
Clinical Engineering	AB18k4. Environment of Care Medical Equipment Management Plan	Revised	Plan	1. Updated Sections: Program Objectives, Intent and Core Values; Scope and Application; Program Organization and Responsibilities; Risk Assessment; Program Implementation and Processes of Performance; Performance Measure; Program Effectiveness; Annual Program Evaluation	• Central Safety • PESC • ePolicy • MEC > Board. Publish
Patient Experience	AB18k5. Interpreting Services AB18k6. Administrative: Visitors Policy	None Revised	Policy Policy	1. None 2. Updated Sections: Purpose, Definitions, Procedure,	• ePolicy • MEC > Board > Publish
MCH	AB18k7. Child Passenger Safety Seat Requirements	Revised	Policy	1. Updated Sections: References, Procedure	• MV | LG Manager • UPC | Staff Meeting • Peds Dept • MCH Exec • ePolicy • MEC > Board > Publish
Pharmacy	AB18k8. Pharmacy: Tech-Check-Tech Program	New	Policy	1. None	• P&T • ePolicy • MEC > Board > Publish

HR	AB18k9. Fair and Just Culture	New	Policy	1. None	• HRO • ePolicy • MEC > Board > Publish
HVI	AB18k10. Heart and Vascular Institute (HVI): Echo & ECG Per Diem Staff Requirements	New	Policy	1. None	• HVI Leadership • HR Business Partner • ePolicy • MEC > Board > Publish
Supply Chain	AB18k11. Supply Chain – Departmental Access Policy	New	Policy	1. None	• ePolicy > Board > Publish
Acute Rehab Unit	AB18k12. Acute Rehab – Utilization Review Plan	None	Plan	1. None	• Acute Rehab Leadership • Med Dept Exec • ePolicy • MEC > Board > Publish
HIMS	AB18k13. MyCare Access	Revised	Policy	1. Updated Sections: Reference, Procedure	• HIM Leadership • ePolicy • MEC > Board > Publish
NICU	AB18k14. Medication Administration in the Neonatal Intensive Care Unit (NICU) AB18k15. Neonatal Screening for Critical Congenital Heart Disease (CCHD) Using Pulse Oximetry	None Revised	Policy Policy	1. None 2. Updated Coverage section; formatting corrections	• UPC | Staff Meeting • Peds Dept • MCH Exec • P&T • ePolicy • MEC > Board > Publish
Respiratory Care	AB18k16. Mountain View and Los Gatos Arterial Blood Gas Laboratory Director Responsibilities and Delegations AB18k17. Individualized Quality Control Plan Respiratory Care Blood Gas Laboratories	New None	Policy Plan	1. None 2. None	• Med Dir • ePolicy • MEC > Board > Publish
Foundation	AB18k18. Donor Gift Acceptance Policy AB18k19. Restricted Fund Policy AB18k20. Tribute Gifts Policy	All New	All Policy	All None	#1-2: • Finance Cmte • Executive Cmte

					• Foundation Board • ePolicy > Board > Publish #3: • ePolicy > Board > Publish
Medical Staff	AB18k21. Medical Staff Services – Credentialing Quality Process Improvement AB18k22. Medical Staff Services – Protecting Credentialing Information and System Controls AB18k23. Medical Staff Services – Ongoing Monitoring and Interventions AB18k24. Medical Staff Services – Electronic Signatures	Revised Revised None New	Plan Policy Policy Policy	1. Updated Credentialing Quality Improvement Program Strcuture section D 2. Updated Procedure section C 3. None 4. None	• IDPC • Credentialing Cmte • ePolicy • MEC > Board > Publish

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: June 12, 2024
Subject: FY2025 Operating and Capital Budget

Purpose:

The Finance Committee is recommending that the Board approve the FY2025 Operating and Capital Budget.

Executive Summary:

- The FY2025 Budget balances the need to maintain financial stability while at the same time funding priority operating and strategic initiatives
- We anticipate expect workforce shortage and inflation to linger into FY2025
- Despite the anticipated headwinds, the proposed FY2025 budget achieves continued growth and targets

FY2025 Budget vs. Target

- Total Operating Revenue: $1.65 billion (budget) vs. $1.60 billion (target)
- Operating Margin: 8.0% (budget) vs. 7.4% (target)
- Operating EBIDA: $233 million (budget) vs. $226 million (target)
- Operating EBIDA Margin: 14.1% (budget) vs. 14.1% (target)
- Capital Expenditures: $169 million (budget) vs. $159 million (target)

- Management has prepared a budget that reflects short-term tactics as well as long-term strategic investments to ensure we meet the 2027 Strategic Plan

List of Attachments:

- FY2025 Operating and Capital Budget - Presentation

Recommendation:

Approval of the Fiscal Year 2025 operating and capital budget as recommended by the Finance Committee and Management

El Camino Health

FY2025 Operating / Capital Budget
Open Session

Dan Woods, Chief Executive Officer
Carlos Bohorquez, Chief Financial Officer

June 12, 2024

Table of Contents

The purpose of this presentation is to provide the Board an overview of the FY2025 operating & capital budget:

1. Volume, Revenue, Expense Categories and Consolidated Operating Budget
2. Routine, Strategic and Facilities Capital
3. Proposed Motion

1. Volume, Revenue, Expense Categories and Consolidated Operating Budget

Inpatient & Outpatient Volume Statistics (Hospital)

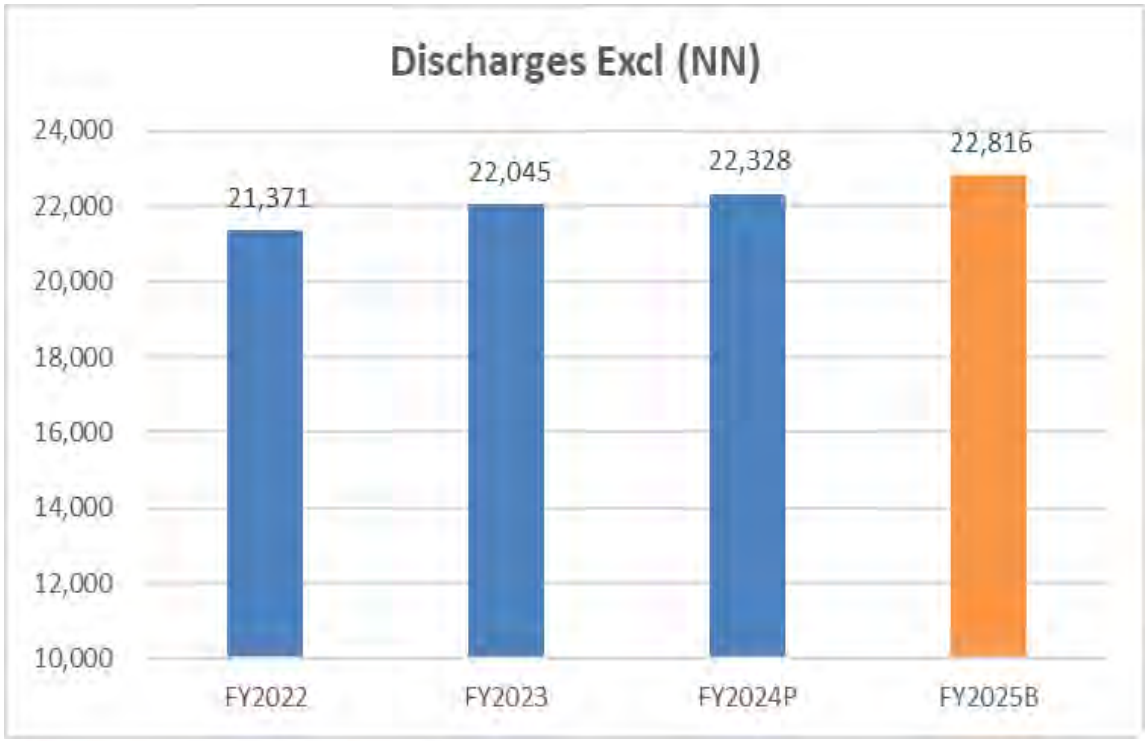
Key Statistical Indicators

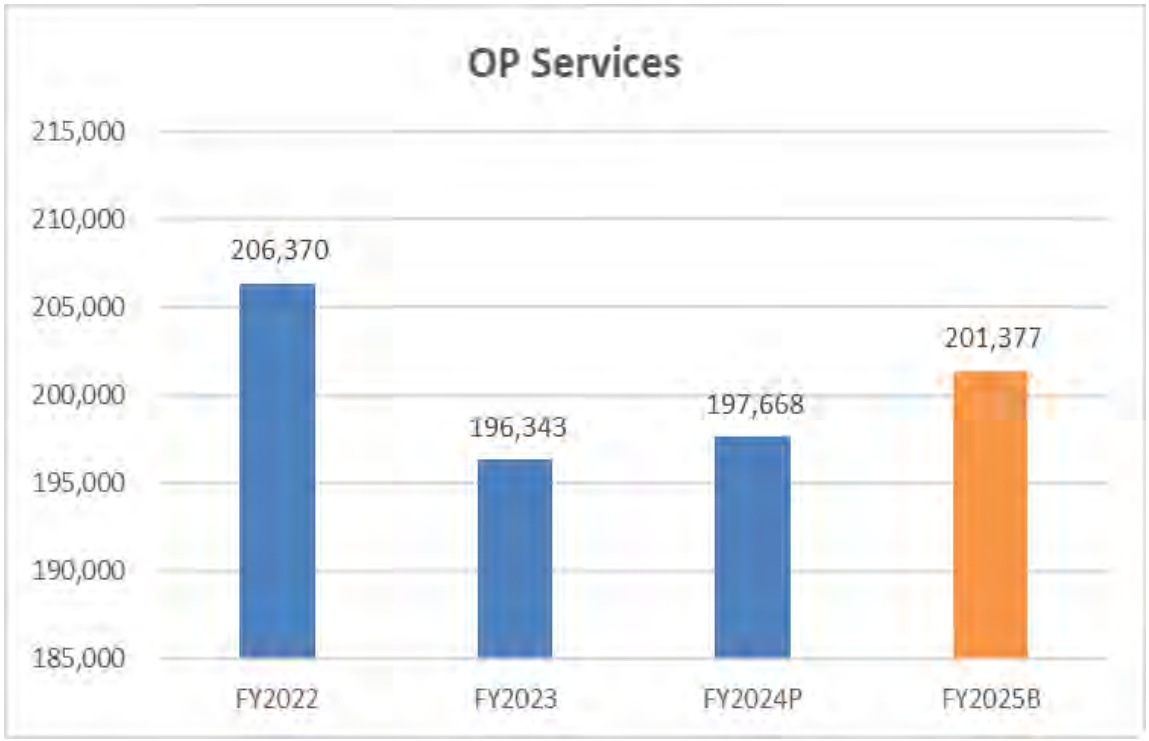
Inpatient Discharges (Excl. Newborn)

- Solid growth in FY2024 carried over into FY2025 Budget with budgeted increase of 488 / 2.2%
- FY2024 Growth in General Medicine cases leveling off for FY2025
- Heart & Vascular cases projected to increase

Outpatient Services

- Excluding laboratory services, outpatient volume is budgeted to increase YOY by 2.3%, primarily driven by sustained Emergency volumes and Oncology services, specifically in Los Gatos



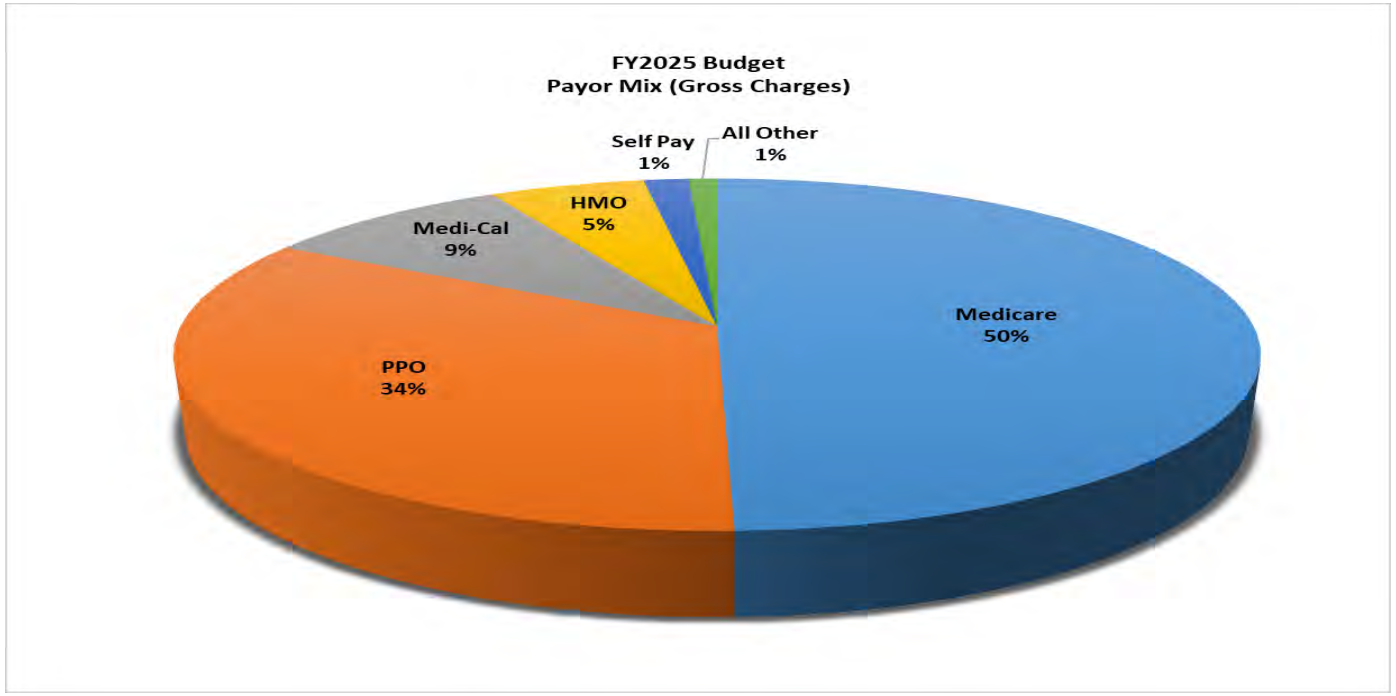


El Camino Health

FY2025 Budget: Gross Revenue by Payor Type

Key Revenue Considerations

Payor Category ($000's)	Total Gross Charges	Payor Mix
Medicare	$3,451,142	49.6%
PPO	$2,345,957	33.7%
Medi-Cal	$612,699	8.8%
HMO	$376,131	5.4%
Self Pay	$108,345	1.6%
All Other	$68,891	1.0%
Total	**$6,963,164**	**100.0%**



- Payor Mix
  - Government: 58.4%
  - Private: 39.1%

El Camino Health

FY2025 Budget: Labor Analysis (E)

Labor Analysis | Salaries, Wages & Benefits

- FY2025 total Salaries, Wages, Contract Labor, and Benefits are increasing by $86.8M, or 11.0%. Excluding increases tied to volume and programmatic changes, SWBs are budgeted to increase at a rate of 4.5%.
- Salary and benefit increases include additional resources to support workforce stability and support the growth in ECHMN activity.

El Camino Health

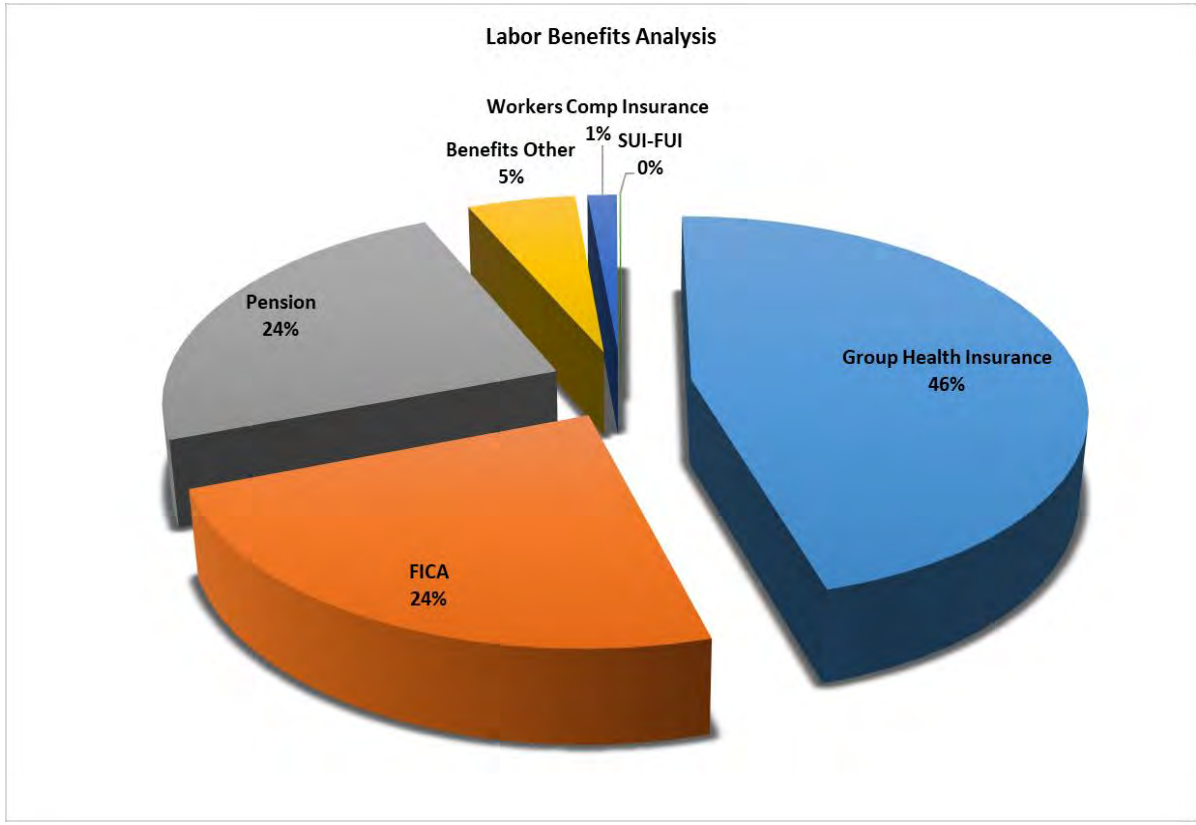
FY2025 Budget: Labor Analysis – Benefits Excl. PTO (E)

Labor Analysis | Benefits (excl. PTO)

Type of Benefit	% of Total Benefit
Group Health Insurance	45.6%
FICA	23.7%
Pension	24.1%
Benefits Other	5.2%
Workers Comp Insurance	1.4%
SUI-FUI	0.1%
Total Benefit Spend ($000's)	**$188,231**

Significant Impacts

- Projected Group Health Insurance increase
- FICA, Pension, and Worker's Compensation are all increasing in proportion with salaries

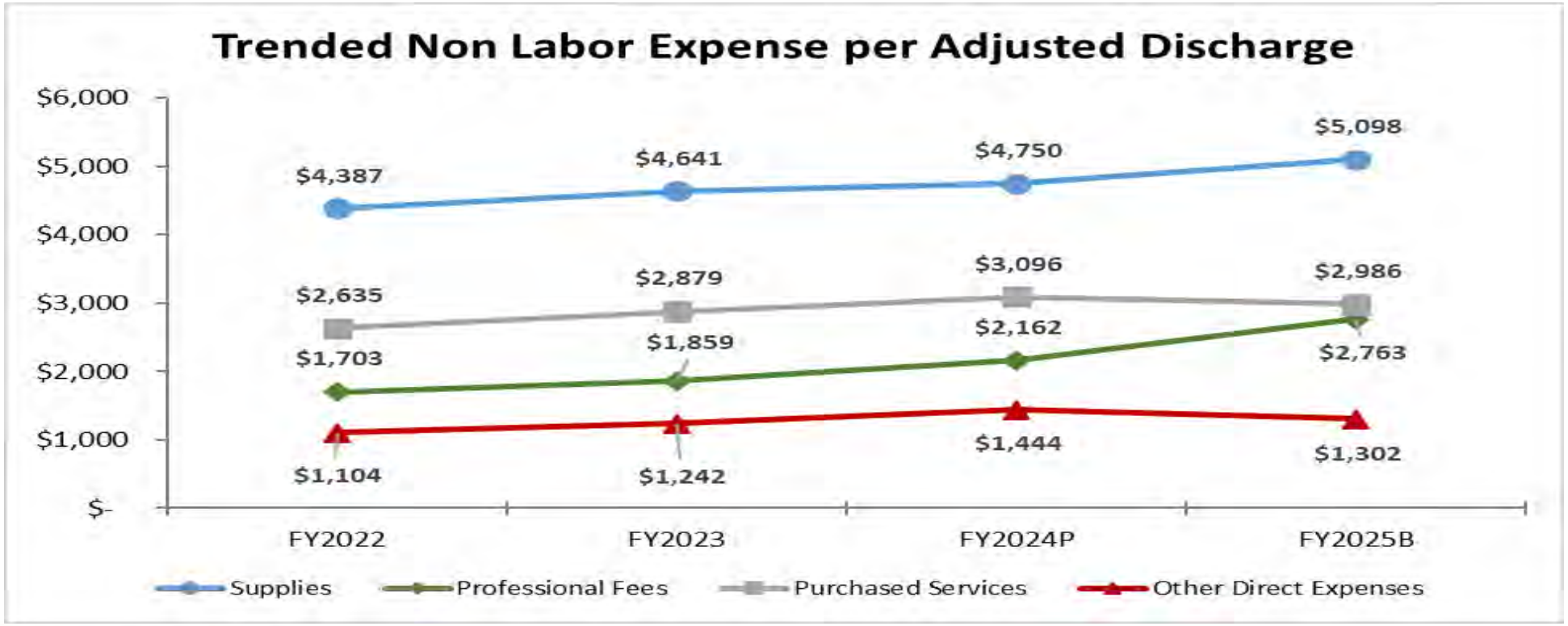


El Camino Health

FY2025 Budget: Non Labor Analysis (E)

Non-Labor Analysis | Summary

- FY2025 Non-Labor expense is increasing $47.0M, or 9.4%
- Primarily driven by:
  - Drug and Supply inflation
  - New Physician Contracts (Anesthesia, PAMF APC support)
  - Physician Fee contract changes (Hospitalist, Call agreements)



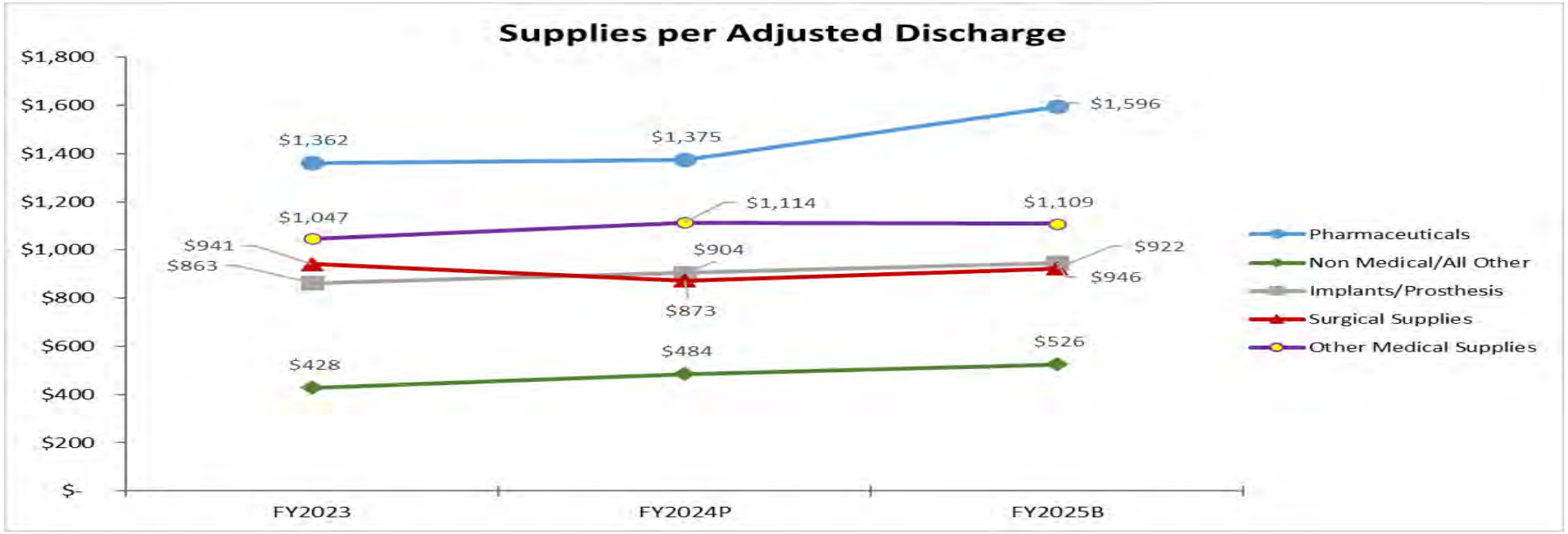
El Camino Health

FY2025 Budget: Non Labor Analysis (E)

Non Labor Analysis | Supplies

- Pharmaceutical increase driven primarily by:
  - Infusion services at Los Gatos campus
  - New services in ECHMN
  - Pharmaceutical supply inflation

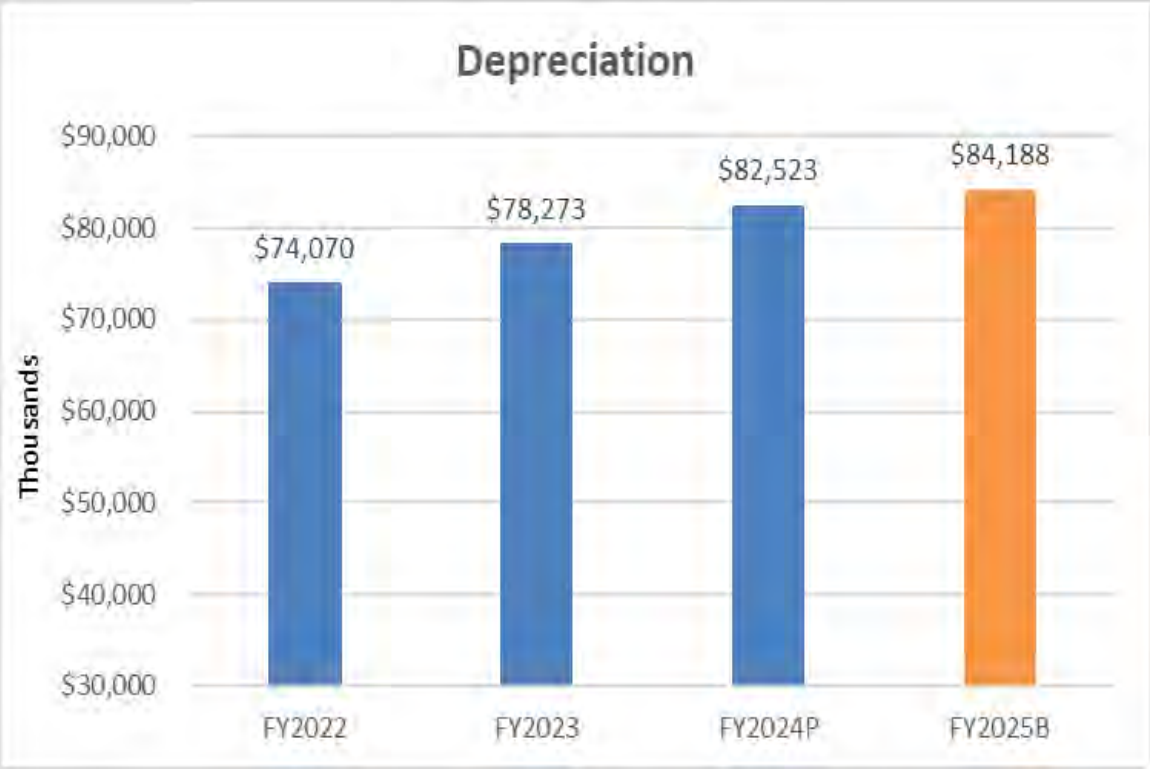
FY2025 Supply Roll Forward	Expense ($000's)
FY2024 Projected Supply Expense	**207,010**
Increase due to Volume and Utilization	6,970
Inflationary Increases	11,032
New Urology Business (Drugs)	4,159
FY2025 Budgeted Supply Expense	**229,170**



FY2025 Budget: Non-Operating Expenses (E)

Depreciation and Interest Expense

- Increase in depreciation for FY2025 is associated with Women's Hospital renovation and Imaging Equipment replacement projects coming online



El Camino Health

Consolidated: Trajectory FY2020 – Budget FY2025

(Hospital Division, Medical Network, CONCERN and Foundation)

	Actual				Projected	Budget	
	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	Pct Change
Charges	3,648,323,525	4,309,256,613	5,122,894,747	5,757,132,705	6,250,302,133	6,963,164,231	11.4%
Deductions	2,665,627,360	3,201,345,516	3,813,743,003	4,379,083,205	4,782,682,247	5,378,831,224	12.5%
Net Patient Revenue	982,696,164	1,107,911,098	1,309,151,743	1,378,049,500	1,467,619,886	1,584,333,007	8.0%
Other Operating Revenue	55,792,398	48,431,083	44,367,400	61,301,318	75,062,514	67,438,096	-10.2%
Total Revenue	**1,038,488,562**	**1,156,342,181**	**1,353,519,143**	**1,439,350,817**	**1,542,682,400**	**1,651,771,103**	**7.1%**
Yield	26.9%	25.7%	25.6%	23.9%	23.5%	22.8%	-3.1%
Salaries, Wages & Benefits	542,418,226	588,470,319	655,924,794	732,843,860	786,065,405	872,844,210	11.0%
Supplies & Drugs	152,490,256	171,714,469	183,688,685	198,184,194	207,010,295	229,170,432	10.7%
All Other Expenses	223,132,621	225,467,420	227,861,863	255,343,683	303,041,291	316,912,415	4.6%
Depreciation	53,981,527	66,486,173	74,069,927	78,273,313	82,522,521	84,187,808	2.0%
Interest Expense	9,449,117	16,959,584	16,887,469	17,626,013	17,727,051	16,256,912	-8.3%
Total Operating Expense	**981,471,747**	**1,069,097,965**	**1,158,432,737**	**1,282,271,062**	**1,396,366,564**	**1,519,371,777**	**8.8%**
Operating Margin	**57,016,815**	**87,244,216**	**195,086,406**	**157,079,756**	**146,315,836**	**132,399,326**	**-9.5%**
Operating Margin %	**5.5%**	**7.5%**	**14.4%**	**10.9%**	**9.5%**	**8.0%**	**-15.5%**
Operating EBIDA	**120,447,459**	**170,689,973**	**286,043,801**	**252,979,081**	**246,565,408**	**232,844,046**	**-5.6%**
Operating EBIDA %	**11.6%**	**14.8%**	**21.1%**	**17.6%**	**16.0%**	**14.1%**	**-11.8%**

El Camino Health

2. FY2025 Budget: Routine, Strategic and Facilities Capital

FY2025 Budget – Routine, Strategic and Facilities Capital ($000s)

Projects / Capital	Committed FY2025 Capital
Routine Capital / Equipment	$ 17,500
Women's Hospital Expansion Project	24,000
Imaging Replacement Project	15,000
IR / Cath Lab Equipment Replacement	8,500
MV Main Pharmacy USP 797 & 800 Upgrades	3,000
LG Pharmacy USP 797 & 800 & Pathology Upgrades	2,500
Nurse Call System Replacement	2,400
Other Projects	3,500
Total - Committed FY2025 Capital	**$ 76,400**

Projects Pending Approval (Facility and Strategic)	Pending FC / Board Approval
Total - Pending Approval FY2025 Capital	**$ 92,900**

FY2025 CAPITAL BUDGET	**$ 169,300**

El Camino Health

3. Proposed Motion

Proposed Motion

- The FY2025 budget includes the following expenditures across the enterprise:
  - Total Operating Expenses: $1,419.4 million
  - ECHMN Funding Support: $41.8 million
  - Capital Expenditures: $169.3 million

Proposed Motion

- Approval of the Fiscal Year 2025 operating and capital budget as recommended by the Finance Committee and Management

Q & A

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: June 12, 2024
Subject: Financial Report: Period 10 & YTD FY2024 (as of 4/30/2024) – Consent Calendar

Purpose:

The Finance Committee is recommending that the Board approve the financial results for Period 10 and YTD FY2024.

Executive Summary – Period 10 (April 2024):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 302 which is 15 / 4.6% unfavorable to budget and 12 / 3.9% lower than the same period last year.
- **Adjusted Discharges:** 3,700 which are 47 / 1.3% favorable to budget and 286 / 8.4% higher than the same period last year.
- **Emergency Room Visits:** 6,047 which are 556 / 8.4% unfavorable to budget and 32 / 0.5% lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 12,111 which are 121 / 1.0% favorable to budget and 2,052 / 20.4% higher than the same period last fiscal year.

Financial performance for Period 10 was unfavorable to budget and lower than the same period last fiscal year mainly attributed to lower than budgeted ED visits.

Total Operating Revenue ($):	$132.6M is favorable to budget by $2.1M / 1.6% and $12.0M / 9.9% higher than the same period last fiscal year.
Operating EBIDA ($):	$18.9M is unfavorable to budget by $0.8M / 3.9% and $0.5M / 2.7% lower than the same period last fiscal year.
Net Income ($):	($1.2M) is unfavorable to budget by $15.5M / 108.5% and $21.3M / 106.1% lower than the same period last fiscal year. Unfavorable net income is attributed unrealized losses on investment portfolio.
Operating Margin (%):	7.8% (actual) vs. 9.0% (budget)
Operating EBIDA Margin (%):	14.2% (actual) vs. 15.0% (budget)
Net Days in A/R (days):	52.5 days are favorable to budget by 1.5 days / 2.7% and 2.1 days / 3.9% better than the same period last year.

Financial Report: Period 10 & YTD FY2024 (as of 4/30/2024)
June 12, 2024

Executive Summary – YTD FY2024 (as of 4/30/2024):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 308 which is 10 / 3.4% favorable to budget and 3 / 0.9% higher than the same period last year.
- **Adjusted Discharges:** 36,488 which are 708 / 2.0% favorable to budget and 1,138 / 3.2% higher than the same period last year.
- **Emergency Room Visits:** 67,257 which are 2,518 / 3.9% favorable to budget and 3,908 / 6.2% higher than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 114,521 which are 7,077 / 5.8% unfavorable to budget and 1,234 / 1.1% higher than the same period last fiscal year.

YTD FY2024 financial performance is consistent with budget and better versus the same period last fiscal year. Stable financial results are attributed to strong ED volumes, significant reductions in premium pay / contract labor, revenue improvement initiatives and a one-time claims settlement.

Total Operating Revenue ($):	$1,294M is favorable to budget by $8.1M / 0.6% and $102.7M / 8.6% higher than the same period last fiscal year.
Operating EBIDA ($):	$205.9M is favorable to budget by $11.9M / 6.1% and $13.8M / 7.2% higher than the same period last fiscal year.
Net Income ($):	$235.1M is favorable to budget by $95.1M / 67.9% and $36.9M / 18.6% higher than the same period last fiscal year. Favorable net income is attributed unrealized gains on investment portfolio.
Operating Margin (%):	9.4% (actual) vs. 8.8% (budget)
Operating EBIDA Margin (%):	15.9% (actual) vs. 15.1% (budget)

Recommendation:

Recommend the Board approve Period 10 & YTD FY2024 financials.

List of Attachments:

1. Period 10 & YTD FY2024 financial report.

Suggested Board Discussion Questions: None.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I JUNE 12, 2024

FINANCE:

- Period 10 – April 2024
  - Total Operating Revenue: $132.5M ($2.1M / 1.6% vs. budget)
    - $12.0M / 9.9% higher than the same period last year
  - Operating EBIDA: $18.9M
    - ($0.8M) / (3.9%) vs. budget
  - Net Income: ($1.2M)
    - ($15.5M) / (108.5%) vs. budget
- FY24 YTD (As of 4/30/24)
  - Total Operating Revenue: $1,294M ($8.1M / 0.6% vs. budget)
    - $102.7M / 8.6% higher than the same period last year
  - Operating EBIDA: $205.9M ($11.9M / 6.1% vs. budget)
    - $13.8M / 7.2% higher than the same period last year
  - Net Income: $235.1M ($95.0M / 67.9% vs. budget)

GROWTH:

- Women's Health: Newsweek recognized ECH as one of the 2024 Best Maternity Hospitals
- Imaging: MV's state-of-the-art CT scanner, provides high quality 4D images and precision at half the dose
- Oncology: National Cancer Survivorship Day is June 1st and Dr. Shane Dormady and his patients have been interviewed by NBC, FOX TV in Oakland and KGO-TV ABC – San Jose stations
- Spine/Neuro/Ortho/Robotics: The Stroke Center completed its participation in the annual Pacific Stroke Association education conference and in a nationwide acute stroke research study.

NURSING: Our first Annual Evidence Based Practice Showcase featured presentations from 10 of our nurses and 16 poster presentations with topics ranging from early recovery after C-section and nurse-driven testing improvements for C.diff.

MEDICAL STAFF: El Camino Health sponsored the annual Mountain View Public Safety Foundation seminar on first responder mental health.

HUMAN RESOURCES: The first few SEIU negotiations have been productive, with agreements reached on 3 non-economic issues. Our next bargaining session is scheduled for June 4th and 5th.

INFORMATION SERVICES: "Find a Doctor" feature now includes Press Ganey survey star ratings. PACS, radiology imaging modality system, includes features specifically dedicated for ophthalmology and glaucoma patients.

FOUNDATION: Through period 10, The Foundation has raised over $8.7M, which is 87% of the FY24 fundraising goal. Santa Clara Sporting Club donated $50K to Lurie Women's Imaging Center's Free Mammogram Program.

CORPORATE HEALTH: Meru Health, an app-based counseling service, provides best in class digital therapeutics. The Chinese Health Initiative and The South Asian Heart Center continue to to expand their reach and engagement through outreach events and lifestyle workshops.

AUXILIARY: The month of April recorded 3,561 volunteer hours. This brings our combined hours for FY24 to 38,148.

A12b. CP Report 05.15.2024 v.5 - MEC BOD Initialized

El Camino Health

CONFIDENTIAL For Submission to the Board of Directors

Credentials Committee Recommendations: 05/15/2024
Medical Staff Executive Committee Recommendations: 05/23/2024
Quality Committee: 06/03/2024
Board of Directors: 06/12/2024
Report Date: 6/5/2024

Initial Appointment Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
1	VGD	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		MD Applicant	Provisional	Requesting waiver of activity requirement for Core Obstetrics privileges. Start date 7/15/2024 per COI. The Committee recommended initial appointment with waiver acceptance of activity requirement for Core Obstetrics privileges and additional FPPE.
2	CLH	Mountain View	Medicine	Diagnostic Radiology		MD Applicant	Telemedicine - Provisional	One closed claim in 2020 for $125,000.00. The Committee recommended initial appointment with FPPE.
3	SMN	Mountain View	Medicine	Psychiatry		MD Applicant	Affiliate	Peer reference flagged. The Committee recommended initial appointment.

Initial Appointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
4	MMM	Los Gatos	Maternal/Child Health	Pediatrics		MD Applicant	Provisional	The Committee recommended initial appointment with FPPE.
5	EDV	Mountain View	Maternal/Child Health	Pediatrics		MD Applicant	Provisional	The Committee recommended initial appointment with FPPE.

*Confidentiality Reminder (Committee Members)
Conducting peer review activities is a critical aspect of the medical staff's oversight of physicians and others providing care. As important as these requirements are, health care providers and organizations participating in these activities need to remember that the practitioners who are subjected to these requirements also enjoy confidentiality, due process and other legal protections, which can create significant liability when violated. Consequently, health care organizations, physicians and members of management, and other staff and participants should use care to follow the proper procedures to ensure that physician rights to confidentiality, due process and other protections are honored as these activities are conducted.

*Nondiscrimination Acknowledgement Statement
ECH credentialing and recredentialing process acts in compliance with all federal, state and local laws and regulations governing discrimination. The ECH Medical Staff Bylaws 3.4 defines the commitment of the ECH Medical Staff to maintaining a discrimination-free credentialing and recredentialing process. The ECH credentialing and recredentialing process does not make credentialing decisions based on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The credentialing and recredentialing application and verification process does not include the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The date of birth and sex is obtained for primary source verification purposes only, e.g. NPDB. The credentialing and recredentialing review and approval process does not include the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The information presented to the Interdiscipinary Practice Committee, Credentials Committee, and Medical Staff Executive Committee is not inclusive of this information.

Initial Appointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
6	SRH	Mountain View	Medicine	Diagnostic Radiology		MD Applicant	Telemedicine - Provisional	The Committee recommended initial appointment with FPPE.
7	JTH	Mountain View	Medicine	Diagnostic Radiology		MD Applicant	Telemedicine - Provisional	The Committee recommended initial appointment with FPPE.
8	SHM	Los Gatos	Medicine	Internal Medicine		MD Applicant	Affiliate	The Committee recommended initial appointment.
9	CCS	Mountain View	Medicine	Clinical Cardiac Electrophysiology		Temporary Privileges	Provisional	Temporary privileges granted 04/17/2024. The Committee recommended initial appointment with FPPE.
10	SWW	Los Gatos	Medicine	Internal Medicine		Temporary Privileges	Provisional	Temporary privileges granted 04/05/2024. The Committee recommended initial appointment with FPPE.
11	HA	Mountain View	Surgery	General Surgery		Temporary Privileges	Provisional	Temporary privileges granted 04/23/2024. The Committee recommended initial appointment with FPPE.
12	TBH	Mountain View	Surgery	General Surgery		Temporary Privileges	Provisional	Temporary privileges granted 05/08/2024. The Committee recommended initial appointment with FPPE.

Reappointment Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
13	NSJ	Mountain View	Maternal/Child Health	Pediatrics		Active	Active	Requesting waiver of internal activity requirement for Core Pediatric privileges. Provider is on the ED call panel. The Committee recommended reappointment with waiver acceptance of internal activity requirement for Core Pediatric privileges.

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Conducting peer review activities is a critical aspect of the medical staff's oversight of physicians and others providing care. As important as these requirements are, health care providers and organizations participating in these activities need to remember that the practitioners who are subjected to these requirements also enjoy confidentiality, due process and other legal protections, which can create significant liability when violated. Consequently, health care organizations, physicians and members of management, and other staff and participants should use care to follow the proper procedures to ensure that physician rights to confidentiality, due process and other protections are honored as these activities are conducted.

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Reappointment Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
14	EA	Mountain View	Medicine	Internal Medicine		Active	Active	Requesting Board Certification Waiver. Relinquishing privileges within Core Internal Medicine privileges. The Committee recommended reappointment with waiver acceptance of board certification pending results in October 2024.
15	YEA	Mountain View	Medicine	Internal Medicine		Affiliate	Affiliate	Practitioner entered chart notes into patients EMR on 04/01/2022. The Committee recommended reappointment.
16	CR	Mountain View	Medicine	Interventional Cardiology		Active	Active	Requesting retrospective FPPE on ECMO & requesting waiver on CMEs for renewal of ECMO. The Committee recommended reappointment with one retrospective FPPE for ECMO and waiver acceptance of CME for renewal of ECMO.
17	ASY	Mountain View	Medicine	Gastroenterology		Consultant	Consultant	Requesting waiver of current activity requirement for Core Gastroenterology and Moderate Sedation privileges and waiver of hospital affiliation requirement for Consultant staff status. The Committee recommended reappointment with a one-time waiver acceptance of current activity requirement for Core Gastroenterology and Moderate Sedation privileges, The Committee also recommended waiver acceptance of hospital affiliation requirement for Consultant staff status.

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Conducting peer review activities is a critical aspect of the medical staff's oversight of physicians and others providing care. As important as these requirements are, health care providers and organizations participating in these activities need to remember that the practitioners who are subjected to these requirements also enjoy confidentiality, due process and other legal protections, which can create significant liability when violated. Consequently, health care organizations, physicians and members of management, and other staff and participants should use care to follow the proper procedures to ensure that physician rights to confidentiality, due process and other protections are honored as these activities are conducted.

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Reappointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
18	SPA	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Active	The Committee recommended reappointment.
19	DAB	Mountain View	Maternal/Child Health	Pediatrics		Active	Active	The Committee recommended reappointment.
20	SCB	Mountain View	Maternal/Child Health	Surgical Assist		Consultant	Consultant	The Committee recommended reappointment.
21	PPC	Mountain View	Maternal/Child Health	Pediatrics		Active	Active	The Committee recommended reappointment with relinquishment of non-core Circumcision privilege.
22	CAC	Mountain View	Maternal/Child Health	Pediatrics		Affiliate	Affiliate	The Committee recommended reappointment.
23	JAC	Mountain View	Maternal/Child Health	Pediatric Allergy and Immunology		Affiliate	Affiliate	The Committee recommended reappointment.
24	ALH	Mountain View	Maternal/Child Health	Pediatric Cardiology		Active	Active	The Committee recommended reappointment.
25	SH	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Active	The Committee recommended reappointment.
26	MP	Los Gatos	Maternal/Child Health	Pediatrics		Active	Active	The Committee recommended reappointment.
27	MMS	Mountain View	Maternal/Child Health	Maternal - Fetal Medicine		Active	Active	The Committee recommended reappointment.
28	TPT	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Active	The Committee recommended reappointment.
29	CLV	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Active	The Committee recommended reappointment.
30	MEW	Mountain View	Maternal/Child Health	Pediatrics		Active	Active	The Committee recommended reappointment.
31	AEW	Mountain View	Maternal/Child Health	Maternal - Fetal Medicine		Active	Active	The Committee recommended reappointment.

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Reappointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
32	SA	Mountain View	Medicine	Endocrinology Diabetes & Metabolism		Affiliate	Affiliate	The Committee recommended reappointment.
33	AGB	Los Gatos	Medicine	Critical Care Medicine		Affiliate	Affiliate	The Committee recommended reappointment.
34	MDD	Los Gatos	Medicine	Family Medicine		Active	Active	The Committee recommended reappointment.
35	ETF	Los Gatos	Medicine	Internal Medicine		Active	Active	The Committee recommended reappointment.
36	TGM	Los Gatos	Medicine	Family Medicine		Affiliate	Affiliate	The Committee recommended reappointment.
37	SAK	Mountain View	Medicine	Neurology		Telemedicine	Telemedicine	The Committee recommended reappointment.
38	SK	Mountain View	Medicine	Internal Medicine		Affiliate	Affiliate	The Committee recommended reappointment.
39	GK	Mountain View	Medicine	Neurology		Active	Active	The Committee recommended reappointment.
40	SMK	Mountain View	Medicine	Radiation Oncology		Active	Active	The Committee recommended reappointment.
41	SM	Mountain View	Medicine	Neurology		Telemedicine	Telemedicine	FPPE for Neurophysiological Monitoring in process. The Committee recommended reappointment.
42	KHN	Mountain View	Medicine	Hematology/Medical Oncology		Active	Active	The Committee recommended reappointment.
43	GKP	Mountain View	Medicine	Family Medicine		Affiliate	Affiliate	The Committee recommended reappointment.
44	RSP	Mountain View	Medicine	Family Medicine		Affiliate	Affiliate	The Committee recommended reappointment.
45	AS	Mountain View	Medicine	Internal Medicine		Affiliate	Affiliate	The Committee recommended reappointment.

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Reappointment

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46	SLS	Mountain View	Medicine	Endocrinology Diabetes & Metabolism		Affiliate	Affiliate	The Committee recommended reappointment.
47	WT	Los Gatos	Medicine	Pulmonary Disease		Active	Active	The Committee recommended reappointment with relinquishment of Cricothyrotomy tube placement and Transtracheal catheterization within Core Critical Care privileges.
48	DDV	Mountain View	Medicine	Emergency Medicine		Active	Active	The Committee recommended reappointment.
49	WW	Los Gatos	Medicine	Neurology		Affiliate	Affiliate	The Committee recommended reappointment.
50	AMY	Mountain View	Medicine	Emergency Medicine		Active	Active	The Committee recommended reappointment.
51	SCB	Mountain View	Surgery	Oral & Maxillofacial Surgery		Affiliate	Affiliate	The Committee recommended reappointment.
52	WDB	Mountain View	Surgery	Urology		Active	Active	The Committee recommended reappointment with relinquishment of laser surgery privileges.
53	AYF	Mountain View	Surgery	Anesthesiology		Active	Active	FPPE complete for Cardiothoracic Anesthesia. The Committee recommended reappointment.
54	GLH	Mountain View	Surgery	Gynecologic Oncology		Active	Active	The Committee recommended reappointment.
55	MRK	Los Gatos	Surgery	General Surgery		Consultant	Consultant	The Committee recommended reappointment.
56	JSK	Mountain View	Surgery	Oral & Maxillofacial Surgery		Affiliate	Affiliate	The Committee recommended reappointment.

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Reappointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
57	RJK	Mountain View	Surgery	Otolaryngology/Head and Neck Surgery - General		Affiliate	Affiliate	The Committee recommended reappointment.
58	TL	Mountain View	Surgery	Anesthesiology		Active	Active	The Committee recommended reappointment.
59	JM	Mountain View	Surgery	Anesthesiology		Active	Active	The Committee recommended reappointment.
60	AHN	Los Gatos	Surgery	Pain Medicine		Affiliate	Affiliate	The Committee recommended reappointment.
61	MWN	Los Gatos	Surgery	Urology		Active	Active	The Committee recommended reappointment.
62	RTP	Los Gatos	Surgery	Ophthalmology		Consultant	Consultant	The Committee recommended reappointment.
63	NNW	Mountain View	Surgery	Urology		Active	Active	The Committee recommended reappointment.
64	PYY	Los Gatos	Surgery	General Surgery		Active	Active	Relinquishing Moderate Sedation. The Committee recommended reappointment with relinquishment of moderate sedation.

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
65	NCR	Mountain View	Medicine	Neurology		Active	Active	The Committee recommended reappointment with addition of perform history and physical exam within Neurology Core privileges.

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Reappointment w/ Advancement Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
66	AAT	Mountain View	Maternal/Child Health	Gynecology		Consultant	Active	Advance to Active status due to increase in internal volume. Proctoring complete for Da Vinci privilege. The Committee recommended reappointment with waiver acceptance of minimum activity requirement for Da Vinci Robot privileges.

Reappointment w/ Advancement

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
67	KS	Mountain View	Maternal/Child Health	Maternal - Fetal Medicine		Consultant	Active	Advance to Active status due to increase volume. The Committee recommended reappointment with advancement to Active staff status.
68	BPG	Mountain View	Surgery	Orthopaedic Surgery		Consultant	Active	Advance to Active status due to increase in volume. The Committee recommended reappointment with advancement to Active staff status.
69	JJH	Los Gatos	Surgery	Podiatry		Provisional	Consultant	Proctoring complete for Core Type II Podiatric privileges. Relinquishing Core Type I Podiatric privileges due to incomplete proctoring. The Committee recommended reappointment with relinquishment of Core Type I Podiatric privilege. The Committee also recommended advancement to Consultant staff status.

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Reappointment w/ Transfer

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
70	TLR	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Leave of absence	Requesting Leave of Absence fom 4/1/2024 through 3/31/2025. The Committee recommended reappointment with relinquishment of Core Obstetric privileges. The Committee also recommended LOA through 03/31/2025.
71	AWD	Los Gatos	Medicine	Neurology		Consultant	Active	Advancement due to increased volume; The Committee recommended reappointment to Active staff status with relinquishment of lumbar puncture, EMG and Nerve Conduction Studies.
72	BMS	Mountain View	Surgery	Thoracic and Cardiac Surgery		Consultant	Affiliate	Transfer due to no clinical activity within the past 24 months. The Committee recommended reappointment with transfer to Affiliate.

Modification of Privilege

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
73	HCC	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Provisional	Active	Advance from Provisional to Active status due to internal volume. FPPE complete for Obstetrics. Pending FPPE completion for Gynecology granted 02/15/2023 Requesting non-core Da Vinci privilege. The Committee recommended advancement to Active staff status due to increased internal volume and FPPE completion for Obstetrics. The Committee also recommended addition of non-core Da Vinci privilege.

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Modification of Privilege

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
74	AA	Mountain View	Medicine	Internal Medicine		Active	Active	Adding Preliminary Interpretation of EKGs, Use of CPAP (continuous positive airway pressure) and Ventilator Management up to 36 hours. BIPAP (bi-level positive airway pressure) within Core Internal Medicine. The Committee recommended addition of Preliminary Interpretation of EKGs, Use of CPAP, Ventilator Management up to 36 hours within Core Internal Medicine.
75	SPM	Mountain View	Medicine	Diagnostic Radiology		Affiliate	Telemedicine - Provisional	Adding Core Teleradiology. The Committee recommended addition of Core Teleradiology with FPPE.
76	DAR	Mountain View	Medicine	Internal Medicine		Active	Active	Adding Preliminary Interpretation of EKGs, Use of CPAP (continuous positive airway pressure) and Ventilator Management up to 36 hours.BIPAP (bi-level positive airway pressure) within Core Internal Medicine privileges. The Committee recommended addition of Preliminary Interpretation of EKGs, Use of CPAP, Ventilator Management up to 36 hours within Core Internal Medicine.
77	FNY	Los Gatos	Medicine	Cardiovascular Disease		Active	Active	Adding Cardiovascular Computed Tomography (CCT) privilege. The Committee recommended addition of Cardiovascular Computed Tomography (CCT) privilege with FPPE.

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Advancement

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
78	OEF	Mountain View	Maternal/Child Health	Pediatrics		Provisional	Active	FPPE complete. The Committee recommended advancement.
79	CG	Mountain View	Maternal/Child Health	Pediatrics		Provisional	Active	FPPE complete. Advance to Active due to being on the ER call panel. The Committee recommended advancement.
80	ACP	Mountain View	Maternal/Child Health	Pediatrics		Provisional	Active	FPPE complete. The Committee recommended advancement with relinquishment of non-core Frenotomy and Circumcision privilege.
81	SES	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Provisional	Active	FPPE complete. The Committee recommended advancement.
82	KY	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Provisional	Active	Advancement to Active due to increase in volume. FPPE complete for Obstetrics privileges on 4/17/2023. The Committee recommended advancement.
83	DB	Mountain View	Medicine	Diagnostic Radiology		Provisional	Telemedicine	FPPE Complete. The Committee recommended advancement with relinquishment of Core Diagnostic Radiology.
84	JSC	Mountain View	Medicine	Neurology		Telemedicine - Provisional	Telemedicine	FPPE Complete. The Committee recommended advancement.
85	JKFV	Los Gatos	Medicine	Clinical Neurophysiology		Telemedicine - Provisional	Telemedicine	FPPE Complete. The Committee recommended advancement.
86	YSL	Mountain View	Medicine	Diagnostic Radiology		Telemedicine - Provisional	Telemedicine - Provisional	FPPE Complete. The Committee recommended advancement.
87	GS	Mountain View	Medicine	Hospice and Palliative Medicine		Provisional	Active	FPPE Complete. The Committee recommended advancement.
88	AYY	Mountain View	Medicine	Diagnostic Radiology		Telemedicine - Provisional	Telemedicine	FPPE Complete. The Committee recommended advancement.

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Advancement

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
89	MM	Mountain View	Surgery	Otolaryngology		Provisional	Consultant	FPPE complete. The Committee recommended advancement.

Transfer

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
90	JSZ	Mountain View	Maternal/Child Health	Urogynecology		Active	Active	Temporary privileges granted for LOA return 5/8/2024. The Committee recommended return from LOA.
91	MGS	Mountain View	Surgery	Vascular Surgery		Provisional	Affiliate	Transfer due to incomplete proctoring. The Committee recommended transfer to Affiliate.

Other Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
92	FSL	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Provisional	Provisional	Requesting FPPE Extension through 12/14/2024. The Committee recommended FPPE extension.
93	CTP	Mountain View	Maternal/Child Health	Gynecology		Provisional	Provisional	Requesting FPPE extension through 12/14/2024. The Committee recommended FPPE extension.
94	FMW	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Provisional	Provisional	Requesting FPPE extension through 12/14/2024. The Committee recommended FPPE extension.
95	AAM	Los Gatos	Medicine	Family Medicine		Provisional	Provisional	Requesting FPPE extension through 10/20/2024. The Committee recommended FPPE extension.

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Other

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
96	ATK	Los Gatos	Medicine	Interventional Cardiology		Active	Active	Relinquishing Implantable Heart Failure Monitoring Devices privilege due to incomplete FPPE. The Committee recommended relinquishment of Implantable Heart Failure Monitoring Devices.

Resignation

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
97	SB	Mountain View	Medicine	Neurology		Telemedicine - Provisional	Resigned	The Committee recommended resignation to the Medical Staff.
98	SB	Mountain View	Medicine	Neurology		Telemedicine	Resigned	The Committee recommended resignation to the Medical Staff.
99	OFS	Mountain View	Medicine	Internal Medicine		Provisional	Resigned	The Committee recommended resignation to the Medical Staff.
100	KMB	Mountain View	Surgery	Otolaryngology		Resigned	Resigned	The Committee recommended resignation to the Medical Staff.

LOA

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
101	EB	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Leave of absence	The Committee recommended LOA from June 28, 2024 through August 18, 2025. The Committee also recommended proctoring completion for proctoscopy.

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LOA

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
102	RSB	Mountain View	Maternal/Child Health	Obstetrics and Gynecology		Active	Leave of absence	The Committee recommended LOA from January 25, 2024 – August 1, 2024.

Ongoing Monitoring Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
103	SK	Mountain View	Maternal/Child Health	Urogynecology		Active	Active	One closed case on 3/18/2024 for $20,000.00. No quality of care concern. The Committee recommended no action at this time.

Training Rotation

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
104	CJM	Mountain View	Maternal/Child Health	Resident	Pediatrics	Resigned	Resident	Training Rotation dates 04/08/2024 - 04/28/2024
105	KMS	Mountain View	Maternal/Child Health	Resident	Pediatrics	Resident	Resident	Resident Rotation Date 05/13/2024 - 06/24/2024
106	NSZ	Mountain View	Maternal/Child Health	Resident	Pediatrics	Resident	Resident	Training Rotation dates 04/29/2024 - 05/26/2024
107	BAG	Mountain View	Medicine	Medical Students	Psychiatry	Medical Student	Medical Student	Training Rotation Dates 04/29/2024 - 05/23/2024

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Allied Health Professionals - Initial Appointment Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
108	MAK	Los Gatos	Surgery	Nurse Practitioner	General Surgery	AHP Applicant	Allied Health/FPPE	The Committee recommended initial application with FPPE and acceptance of waiver of Current Activity Requirement in Core Surgical NP privileges, Waiver of 3 Peer References, and Waiver of Furnishing License.

Allied Health Professionals - Initial Appointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
109	HLD	Mountain View	Surgery	Physician Assistant	Gynecologic Oncology	AHP Applicant	Allied Health/FPPE	The Committee recommended initial appointment with FPPE.
110	ARD	Los Gatos	Surgery	Physician Assistant	Orthopedics	AHP Applicant	Allied Health/FPPE	The Committee recommended initial appointment with FPPE pending malpractice insurance certificate.

Allied Health Professionals - Reappointment Category 2

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
111	HW	Los Gatos	Surgery	Orthopaedic Technician	Orthopedics	Allied Health	Allied Health	Requesting Waiver of Inpatient Activity. The Committee recommended reappointment with waiver acceptance of inpatient activity.

*Confidentiality Reminder (Committee Members)
Conducting peer review activities is a critical aspect of the medical staff's oversight of physicians and others providing care. As important as these requirements are, health care providers and organizations participating in these activities need to remember that the practitioners who are subjected to these requirements also enjoy confidentiality, due process and other legal protections, which can create significant liability when violated. Consequently, health care organizations, physicians and members of management, and other staff and participants should use care to follow the proper procedures to ensure that physician rights to confidentiality, due process and other protections are honored as these activities are conducted.

*Nondiscrimination Acknowledgement Statement
ECH credentialing and recredentialing process acts in compliance with all federal, state and local laws and regulations governing discrimination. The ECH Medical Staff Bylaws 3.4 defines the commitment of the ECH Medical Staff to maintaining a discrimination-free credentialing and recredentialing process. The ECH credentialing and recredentialing process does not make credentialing decisions based on the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The credentialing and recredentialing application and verification process does not include the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The date of birth and sex is obtained for primary source verification purposes only, e.g. NPDB. The credentialing and recredentialing review and approval process does not include the applicant's race, ethnic/national identity, gender, age, sexual orientation, or patient type. The information presented to the Interdiscipinary Practice Committee, Credentials Committee, and Medical Staff Executive Committee is not inclusive of this information.

Allied Health Professionals - Reappointment

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
112	SMC	Mountain View	Medicine	Physician Assistant	Emergency Medicine	Allied Health	Allied Health	The Committee recommended reappointment.
113	CAS	Mountain View	Medicine	Physician Assistant	Emergency Medicine	Allied Health	Allied Health	The Committee recommended reappointment.
114	MVG	Mountain View	Surgery	Perfusionist	Cardiology	Allied Health	Allied Health	The Committee recommended reappointment.
115	SP	Los Gatos	Surgery	Physician Assistant	Orthopedics	Allied Health	Allied Health	The Committee recommended reappointment.
116	KR	Mountain View	Surgery	Physician Assistant	General Surgery	Allied Health	Allied Health	Adding Davinci Robotic Privilege. The Committee recommended reappointment with addition of Davinci Robotic privilege. FPPE plan is not required.
117	SBS	Mountain View	Surgery	Perfusionist	Cardiology	Allied Health	Allied Health	The Committee recommended reappointment.
118	PES	Mountain View	Surgery	Perfusionist	Cardiology	Allied Health	Allied Health	The Committee recommended reappointment.

Allied Health Professionals - Other

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
119	DMND	Mountain View	Medicine	Nurse Practitioner	Psychiatry	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.
120	ASJ	Mountain View	Medicine	Nurse Practitioner	Psychiatry	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.
121	HBN	Mountain View	Medicine	Physician Assistant	Gastroenterology	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.
122	DY	Mountain View	Medicine	Physician Assistant	Emergency Medicine	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.

*Confidentiality Reminder (Committee Members)
Conducting peer review activities is a critical aspect of the medical staff's oversight of physicians and others providing care. As important as these requirements are, health care providers and organizations participating in these activities need to remember that the practitioners who are subjected to these requirements also enjoy confidentiality, due process and other legal protections, which can create significant liability when violated. Consequently, health care organizations, physicians and members of management, and other staff and participants should use care to follow the proper procedures to ensure that physician rights to confidentiality, due process and other protections are honored as these activities are conducted.

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Allied Health Professionals - Other

PID	Practitioner	Main Campus	Department	Specialty	Practice Area	Current Status	Status Recommended	Comments
123	YSK	Mountain View	Surgery	Physician Assistant	Otolaryngology	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.
124	CMT	Mountain View	Surgery	Physician Assistant	Urology	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.
125	KLT	Mountain View	Surgery	Physician Assistant	Orthopedics	Allied Health/FPPE	Allied Health	FPPE Completion. The Committee recommended proctoring completion.
126	RCV	Mountain View	Surgery	RN First Assistant	Surgical Assist	Allied Health/FPPE	Allied Health/FPPE	Requesting FPPE Extension. The Committee recommended proctoring completion.

*Confidentiality Reminder (Committee Members)
Conducting peer review activities is a critical aspect of the medical staff's oversight of physicians and others providing care. As important as these requirements are, health care providers and organizations participating in these activities need to remember that the practitioners who are subjected to these requirements also enjoy confidentiality, due process and other legal protections, which can create significant liability when violated. Consequently, health care organizations, physicians and members of management, and other staff and participants should use care to follow the proper procedures to ensure that physician rights to confidentiality, due process and other protections are honored as these activities are conducted.

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a. Approve Hospital Board Open Session Minutes (05/08/2024)

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, May 8, 2024

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

Board Members Present
Bob Rebitzer, Chair
Julia E. Miller, Secretary/Treasurer
Lanhee Chen, JD, PhD *(at 5:33pm)*
Wayne Doiguchi
Peter Fung, MD
Carol A. Somersille, MD *(at 6:04 pm)*
George O. Ting, MD
Don Watters
John Zoglin

Board Members Absent
Jack Po, MD, Ph.D., Vice-Chair

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO **
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO
Theresa Fuentes, CLO
Omar Chughtai, Chief Growth Officer **
Deb Muro, CIO **

***via teleconference*

Others Present (cont.)
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology
Bob Miller, Executive Compensation Committee Chair
Teri Eyre, Executive Compensation Committee Member
Mike Ichikawa, Photographer
Joshua Entrekin, Member of the Public

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:32 p.m. by Chair Bob Rebitzer. Chair Rebitzer reviewed the logistics for the meeting. Directors Doiguchi, Fung, Miller, Po, Rebitzer, Ting, Watters, and Zoglin were present constituting a quorum. Directors Chen and Somersille were absent at roll call.	**The meeting was called to order at *5:32 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	No AB-2449 requests were received by the members of the Board.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board if any member had a conflict of interest with any items on the agenda. None were reported.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. Mr. Joshua Entrekin spoke regarding SEIU contract negotiations. Mr. Entrekin shared the perspective of some of the Medical Assistants at SVMD regarding the current contract negotiations. No other members of the public shared comments.	

5. ECHB SPOTLIGHT RECOGNITION – Teri Eyre	The Board recognized Teri Eyre for her twelve years of service on the Executive Compensation Committee. ECC Chair Bob Miller expressed great gratitude for the expertise and professionalism that Ms. Eyre provided to the enterprise over the course of her service. Ms. Eyre thanked the Board for their service and for the opportunity to serve the community with the organization. Ms. Eyre shared her future plans and great appreciation for all of the opportunities from El Camino Health. **Motion:** To adopt resolution 2024-02. **Movant**: Miller **Second**: Watters **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po, Somersille **Recused**: None	
6. QUALITY FOCUSED REVIEW	Dr. Mallur shared the Quality Focused Review with the Board of Directors. The Board inquired regarding outcome effectiveness of the STEEEP dashboard. The Board continued with inquiries regarding metrics regarding mortality. Dr. Mallur assured that developments in implementation of a new inpatient hospice program should assist with the overall mortality rates for the hospital.	**Actions:** *Staff to provide a detailed report on the overall mortality index to understand root causes of the rates.*
7. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 6:08 pm. **Movant**: Ting **Second**: Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None	***Recessed to closed session at 6:08 p.m.***
8. AGENDA ITEM 12: CLOSED SESSION REPORT OUT	The open session was reconvened at **7:04 p.m.** by Chair Rebitzer. Agenda Items 8-11 were addressed in closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report was approved by a unanimous vote of all Directors present (Directors Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin).	***Reconvened Open Session at 7:04 p.m.***
9. AGENDA ITEM 13: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Item f) Approve QAPI as Reviewed and Recommended for Approval by the Quality Committee, was removed. Ms.	***Consent Calendar item F was removed for approval at a future Board***

	Fuentes advised that item F was not included on the agenda posted 72 hours prior to the beginning of the meeting and should not be included as a part of the meeting's consent calendar. **Motion:** To approve the consent calendar items with the removal of Item f. **Movant:** Chen **Second:** Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None	***meeting.*** ***Consent Calendar (minus item F) Approved***
10. AGENDA ITEM 14: BOARD OFFICER ELECTIONS	Chair Rebitzer outlined the logistics and procedures for the Board Officer Elections. **Board Chair:** Chair Rebitzer outlined his proposed goals as the Chair of the Hospital Board. Chair Rebitzer's proposed goals encompassed execution of the organizational strategy, strengthen committee structures, encouragement of diversity within the organization, and continuing to improve the function of the Board as a whole. **Motion:** To elect Bob Rebitzer as the El Camino Hospital Board Chair for a two year term. **Movant:** Miller **Second:** Watters **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None **Vice Chair:** Vice Chair Po was absent for the meeting. Chair Rebitzer took the allotted time to discuss and exemplify Director Po's contributions as Vice Chair and his gratitude to have served with him in the previous term. **Motion:** To elect Jack Po as the El Camino Hospital Board Vice Chair for a two year term.	***Director Bob Rebitzer elected as El Camino Hospital Board of Directors Board Chair.*** ***Director Jack Po elected as El Camino Hospital Board of Directors Vice Chair*** ***Director John Zoglin elected as El Camino Hospital Board if Directors Secretary / Treasurer*** ***Resolution 2024-03 Approved***

Movant: Watters
Second: Somersille
Ayes: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin
Noes: None
Abstentions: None
Absent: Po
Recused: None

Secretary / Treasurer:

Director Miller focused her candidate statement on her service and developments as the current Secretary / Treasurer for the El Camino Hospital Board. Director Miller highlighted the processes and procedures she currently is a part of and helped develop as the Secretary / Treasurer.

Director Zoglin focused on continuing an effective workflow between hospital staff and the Board. Director Zoglin commented on the benefits of competency and egalitarian rotation of leadership positions within the Governance structure of the enterprise.

Ballot Voting for Secretary/ Treasurer:

A paper ballot was distributed to the Board of Directors per the established voting procedures to vote for a candidate for the office of Secretary / Treasurer. Director Julia Miller received three (3) votes. Director John Zoglin received six (6) votes.

Motion: To elect John Zoglin as the El Camino Hospital Board Secretary/ Treasurer for a two year term.

Movant: Watters
Second: Fung
Ayes: Chen, Doiguchi, Fung, Rebitzer, Somersille, Ting, Watters, Zoglin
Noes: None
Abstentions: Miller
Absent: Po
Recused: None

Adoption of Resolution 2024-03:

Motion: To adopt resolution 2024-03

Movant: Ting
Second: Doiguchi
Ayes: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille,

	Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None	
11. AGENDA ITEM 15: CEO REPORT	Mr. Woods provided a CEO report acknowledging Nurse's Week and recognizing Cheryl Reinking, the organization's Chief Nursing Officer. Mr. Woods continued to highlight recognition from the Santa Clara County Department of Public Health for El Camino Health's Women's program's advancements in perinatal equity. Additionally, Mr. Woods recognized the auxiliary staff, who donated 3,829 volunteer hours for the month of March.	
12. AGENDA ITEM 16: BOARD ANNOUNCEMENTS	Director Miller highlighted the recognition of Deb Muro at the YWCA Tribute to Women awards.	
13. AGENDA ITEM 17: ADJOURNMENT	**Motion:** To adjourn at 7:38 pm **Movant:** Doiguchi **Second:** Fung **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None	***Meeting adjourned at 7:38 p.m.***

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

_____

Julia Miller, Secretary/Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: 05/29/2024 – Tracy Fowler, Director, Governance Services
Reviewed by Legal: 05/29/2024 – Theresa Fuentes, Chief Legal Officer

A18b. DRAFT 2024-05-08 ECHB Minutes (Closed) - Final

El Camino Health

CONFIDENTIAL

Minutes of the Closed Session of the
El Camino Hospital Board of Directors
Wednesday, May 8, 2024

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

Board Members Present
Bob Rebitzer, Chair
Julia E. Miller, Secretary/Treasurer
Lanhee Chen, JD, PhD
Wayne Doiguchi
Peter Fung, MD
Carol A. Somersille, MD
George O. Ting, MD
Don Watters
John Zoglin

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO **
Andreu Reall, VP of Strategy
Cheryl Reinking, CNO
Theresa Fuentes, CLO
Omar Chughtai, Chief Growth Officer **
Deb Muro, CIO **

***via teleconference*

Others Present (cont.)
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology

Board Members Absent
Jack Po, MD, Ph.D., Vice-Chair

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER	Chair Rebitzer called the closed-session meeting of the El Camino Hospital Board of Directors to order at 6:08 p.m. A quorum was present.	***Called to order at 6:08 pm.***
2. AGENDA ITEM 8: QUARTERLY FINANCE AND STRATEGIC MARKET SHARE UPDATE	Mr. Bohorquez provided the Quarterly Finance and Strategic Market Share Update to the Board. Mr. Bohorquez reviewed metrics from the update that were attributed to timing, as well as strategic initiatives being set forth by the organization. Mr. Bohorquez shared that overall financial performance is favorable to budget and better than last fiscal year. Mr. Bohorquez continued to outline patient activity and volume and which areas of the organization are reporting strong results.	***Actions:** Staff to provide a list of strategic challenges and plans to address them.*
3. AGENDA ITEM 9: APPROVE CREDENTIALING AND PRIVILEGING REPORT	**Motion:** To approve the Credentialing and Privileging report **Movant:** Miller **Second:** Fung **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None	***Credentialing and Privileging Report Approved***
4. AGENDA ITEM 10: EXECUTIVE SESSION	The Board of Directors went into Executive Session at 6:50 p.m. Staff, excluding Mr. Woods, left the room. The staff returned at 7:03	

	p.m.	
5. AGENDA ITEM 11: RECONVENE TO OPEN SESSION	**Motion:** To reconvene to open session at 7:04 pm. **Movant:** Miller **Second:** Doiguchi **Ayes**: Chen, Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Po **Recused**: None	***Reconvened to Open Session at 7:04 pm***

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

_____
Julia Miller, Secretary/ Treasurer

Prepared by: Gabriel Fernandez, Governance Services Coordinator
Reviewed by Governance: 05/29/2024 – Tracy Fowler, Director, Governance Services
Reviewed by Legal: 05/29/2024 – Theresa Fuentes, Chief Legal Officer

d. Approve Resolution 2024-04 (ECC Delegation of Authority) as Reviewed and Recommended for Approval by the Executive Compensation Committee

DRAFT FOR RECOMMENDATION TO ECHB

AMENDED AND RESTATED RESOLUTION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS REGARDING DELEGATION TO EXECUTIVE COMPENSATION COMMITTEE

ORIGINALLY ADOPTED APRIL 18, 2018, RESOLUTION 2018-05

AS AMENDED AND RESTATED June 12, 2024

RESOLUTION 2024 - 04

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL DELEGATING CERTAIN AUTHORITY TO THE EXECUTIVE COMPENSATION COMMITTEE ("ECC") REGARDING EXECUTIVE COMPENSATION, ADOPTING PROCEDURES FOR THE ECC TO FOLLOW IN CONNECTION WITH THE EXERCISE OF SUCH DELEGATED AUTHORITY AND PROVIDING INDEMNIFICATION.

WHEREAS, the Board of Directors ("Board") of El Camino Hospital ("Hospital") has previously created the ECC as an advisory committee of the Board which includes experts in executive compensation among its members;

WHEREAS, the Hospital has previously taken and continues to take all steps needed to meet the requirements of the Internal Revenue Service in order to obtain the presumption of the reasonableness of executive compensation;

WHEREAS, the ECC has advised the Board on general and specific matters relating to executive compensation, recommending policies and procedures, as well as activities related to individual executive's compensation and the reasonableness thereof;

WHEREAS, on April 17, 2018, the Board previously adopted Resolution 2018-05 delegating certain authority to the ECC;

WHEREAS, on November 8, 2023, by unanimous vote with all directors present, the Board authorized the CEO to approve executive base salaries for executives reporting to the CEO as long as the salary remains within the reasonable compensation range set by the Board and the ECC and that do not exceed the median as recommended by the ECC;

WHEREAS, in order to streamline the executive hiring process and permit quicker reaction in a competitive market, the Board desires to authorize the CEO, after consulting with the ECC Chair, or with the Hospital Board Chair if the ECC Chair is unavailable within the time frame needed to make the offer, to approve total renumeration offers to individuals in positions designated by the Board to be in the Executive Group as long as the total renumeration remains within the reasonable compensation range set by the Board and the ECC and is consistent with the policies and procedures listed on Exhibit A, and to report the details of the offer at the next regularly scheduled ECC;

WHEREAS, the Board has determined to exercise its authority under Section 5210 of the California Nonprofit Corporation Law to delegate certain authority over executive compensation to the ECC; now, therefore, be it

RESOLVED, the Board hereby delegates to the ECC the authority to determine the base salary to be paid to executives who are included in Policy entitled "Executive Compensation Philosophy," except the Chief Executive Officer ("Executives"); be it further

RESOLVED, that the ECC will also establish the individual incentive goals and determine the relative achievement of such goals by each of the Executives; be it further

RESOLVED, that the Board confirms the authority of the ECC to set salary ranges for individuals in positions designated by the Board to be in the Executive Group and to retain, supervise and work with a compensation consultant with respect to compensation determinations that the ECC makes as to the individuals in positions designated to be in the Executive Group and, with respect to the Chief Executive Officer ("CEO") salary range and compensation recommendations the ECC makes to the Board; be it further

RESOLVED, that the ECC shall take steps to confirm that the approved base salary and all other compensation and benefits payable to the Executives and the CEO (as to the CEO, as recommended to the Board) is reasonable compensation; be it further

RESOLVED, in all its actions pursuant to the authority delegated in this Resolution, the ECC shall follow the Board-approved applicable policies and procedures including the procedures attached as Exhibit A, as amended from time to time, which are hereby approved; be it further

RESOLVED, that the ECC charter and the policies and procedures listed on Exhibit A are hereby amended to read as provided in the attached version of the ECC charter and the policies and any amendments to such policies shall be approved by the Board; be it further

RESOLVED, that the CEO is authorized, after consulting with the ECC Chair, or with the Hospital Board Chair if the ECC Chair is unavailable within the time frame needed to make the offer, to approve total renumeration offers to individuals in positions designated to be in the Executive Group as long as the total renumeration remains within the reasonable compensation range set by the Board and the ECC and is consistent with the policies and procedures listed on Exhibit A, and to report the details of the offer at the next regularly scheduled ECC;

RESOLVED, that the ECC will comply with the Brown Act with respect to the exercise of its delegated authority; be it further

RESOLVED, that in exercising the authority delegated by the Board in this Resolution, each member of the ECC shall be deemed to be an agent of the Hospital for purposes of indemnification pursuant to state law and the Hospital's bylaws; be it further

RESOLVED, that any authority not expressly delegated to the ECC hereunder is retained by the Board; decisions of the ECC within the delegated authority do not require Board approval; be it further

RESOLVED, that this Resolution grants no contract or other rights to any individual and this Resolution may be amended, repealed or replaced by the Board at any time.

Duly passed and adopted at a regular meeting held on this ____ day of _____, 2024, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
Secretary/Treasurer, El Camino Hospital Board of Directors

EXHIBIT A

Amended Policies and Procedures

1. Procedures to Be Followed by the El Camino Hospital Compensation Committee When Approving Compensation Pursuant to a Delegation of Authority Under California Nonprofit Corporation Law
2. Policy 3.01. Executive Compensation Philosophy.
3. Policy 3.02. Executive Base Salary Administration.
4. Policy 3.03. Executive Benefits Plan.
5. Policy 3.04. Executive Performance Incentive Plan.

A18f2. ECHB Meeting - June 2024 - Signature Authority Policy - REDLINE - Final 05.30.2024

Current Status: *Active* PolicyStat ID: *6943001*

El Camino Health

Origination:	*01/1990*
Effective:	*01/2019*
Last Approved:	*01/2019*
Last Revised:	*02/2024*
Next Review:	*02/2026*
Owner:	*Carlos Bohorquez, CFO*
Area:	*Finance*
Document Types:	*Procedure*

Signature Authority

SIGNATURE AUTHORITY

I. COVERAGE:

All El Camino Health Staff and Affiliates

II. PURPOSE:

The purpose of this policy is to establish the level of authority required to approve operating and capital expenditures and to establish the signature authority to execute resulting contracts and related documents on behalf of El Camino Health. Authorization per the following guidelines must be obtained **prior** to the expenditure of funds.

Expenditure contracts and amendments, legal agreements, settlements, operating and capital purchases, professional services, consulting, construction, and other commitments requiring expenditures by El Camino Health (collectively referred to as "contracts") may only be authorized and executed by individuals with authority per this policy and the governing documents of the Board of Directors. If this policy conflicts with the governing documents of the Board of Directors, the governing documents control. Review and approval of contracts must adhere to the approved Contract Review Procedure (Policy Stat #11635115).

To ensure a centralized contract database, all contracts must be submitted to ECH's contracts management system (Conga, or if approved by the CFO, CLO, and Compliance Officer, an alternative system that can be accessed and audited as directed by the CFO, CLO, and Compliance Officer) regardless of whether or not the contract requires legal review, including if it has been reviewed by outside counsel.

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~~V.~~ III. CHIEF EXECUTIVE OFFICER AUTHORITY:

As delegated by the Board of Directors, the following authority is granted to the Chief Executive Officer.

Unbudgeted Expenditures

The Chief Executive Officer (CEO) has authority, without Board approval, to approve and execute all contracts necessary for unbudgeted capital and operating expenses that do not exceed $2 million dollars. Contracts for the same or similar scopes of work with a single contractor **may not** be separated into multiple contracts or amendments solely to meet the signature authority requirements.

For contracts exceeding $2 million dollars, including amendments, the following approvals are necessary before the CEO can execute the contract:

- Finance Committee approval required for expenditures that exceed $2 million dollars but are not in excess of $5 million dollars.
- Hospital Board approval required for expenditures that exceed $5 million dollars but are not in excess of $25 million dollars.
- District Board approval required for expenditures that exceed $25 million dollars in a single transaction or any expenditures or transfers in a single transaction or a series of related transactions in excess of 5% of assets of the Hospital.

Budgeted Expenditures

The CEO has the authority to execute all budgeted operating contracts. However, capital / construction expenditures require the following approvals:

- Finance Committee approval required for expenditures that exceed $2 million dollars but are not in excess of $5 million dollars.
- Hospital Board approval required for expenditures that exceed $5 million dollars but are not in excess of $25 million dollars.
- District Board approval required for expenditures that exceed $25 million dollars in a single transaction or any expenditures or transfers in a single transaction or a series of related transactions in excess of 5% of assets of the Hospital.

Physician Contracts

Authority with respect to contracts with physicians are subject to this policy as well as the requirements of the approved Physician Financial Arrangements policy (Policy Stat

#13978288) and Physician Recruitment Program policy (Policy Stat #6942749).

Emergency Need

An emergency is defined as a sudden, generally unexpected circumstance that demands immediate action, the absence of which would undermine essential ECH services or cause a significant economic loss to ECH. When an emergency occurs and funds must be expended or obligated without the required approvals or authority per this policy, CEO may authorize a short-term expenditure as needed to address the emergency. The action shall be brought to the next Board meeting for ratification.

Construction Contracts

Construction contracts may be executed only within the authority of this policy. Construction contract expenditures are subject to review by the CLO, CFO, and Compliance Officer, or their designees.

~~VI.~~IV. MANAGEMENT AUTHORITY:

GENERAL AUTHORITY

The CEO may delegate signature authority to certain managers for contracts **that are within the manager's approved operating and capital budget,** as determined by the Chief Financial Officer (CFO) or the CFO's designee in the Finance Department. All budget determinations for contracts exceeding $200,000 must be made by the CFO and for contracts below $200,000 CFO will assign individuals in the finance department to determine and delegate Individuals in the finance department for contracts less than $200,000 Finance Department

There is no authority for individuals other than the CEO to execute contracts for items that are not within the approved operating and capital budget. The CEO may delegate signature authority for unbudgeted contracts to the CFO or other Chief Executive in the CEO's absence.

Signature authority for budgeted contracts is based on the total expenditure for the term of the contract without regard to termination language or other provisions. Amendments to contracts that extend the term or add a new scope are considered new contracts for purposes of signature authority, as long as they are within the approved operating and capital budget, as determined by the CFO or designee. Contracts for the same or similar scopes of work with a single contractor **may not** be separated into multiple contracts or amendments solely to meet the signature authority requirements.

Contract Approval Levels for Budgeted Contracts

Position	Signature Authority

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Manager	$10,000
Director~~/~~	$25,000
Senior Director/Executive Director ~~Executive Director~~	$50,000
Division Executive (Chief, President, or VP)	$250,000
COO	$500,000
CFO	$750,000
CEO	$2,000,000 ~~$1,000,000~~
Finance Committee~~CEO~~	$2,000,000.01 - $5,000,000~~$1,000,000~~
Hospital Board ~~Finance Committee~~[2]	> $5M - 5% of assets~~$1m - $5M~~
ECHD ~~Hospital Board~~[3]	> 5% assets or $25M~~> $5M - 5% of assets~~
~~ECHD~~[4]	~~> 5% assets or $25M~~

~~Notes:~~

~~[1] Executives can authorize items, up to their signature authority, which are in the approved operating and capital budget~~

~~[2] Per El Camino Hospital Board of Directors Finance Committee Charter, Finance Committee shall approve unbudgeted capital expenditures exceeding the CEO's signature authority but not in excess of $5 million. CEO shall have signature authority upon approval.~~

~~[3] See El Camino Hospital Bylaws. CEO shall have signature authority upon approval.~~

~~[4] See ECHD Bylaws. CEO shall have signature authority upon approval.~~

~~1.~~ ~~**Emergency Exception**~~

~~When an emergency occurs and funds must be expended or obligated without an appropriate signature, the appropriate signatures shall be obtained the following working day by the originator or if Board approval is required at the next upcoming Board meeting.~~

ADDITIONAL AUTHORITY/INFORMATION

~~2.~~ **Physician Contracts and Recruitment**

See Physician Financiale Arrangements Policy (Policy Stat #13978288).

See Physician Recruitment Program Policy (Policy Stat #6942749).

~~3.~~ **Business, Education, and Travel Expenses**

See Reimbursement of Business, Education, and Travel Expenses policy (Policy Stat #6942719). ~~Procedure.~~

~~5.~~ ~~**Accounting Firms**~~ **Independent Financial Auditors**

The selection of a certified public accounting firm must be approved by the District Board of Directors as recommended by the CFO. ~~. All invoices for audit fees and accounting services must be approved by the Chief Financial Officer and/or Controller~~

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of the Hospital.

6. **Building Leases**

Medical Office Space/Building Leases – Hospital is the Landlord

All building lease agreements (including space needs within a department) entered into with tenants of Hospital owned buildings shall be executed by the Chief Administrative Services Officer (CASO) and shall be at current fair market value.

Sublease of Non-Medical Office Building Hospital Properties - The Hospital shall not sublease any of its non-medical office building properties without the approval of the El Camino Healthcare District Board of Directors (per ground lease between El Camino Hospital District and El Camino Healthcare System [El Camino Hospital] of December 17, 1992 – Article 5.6 (d).

See Community Benefits Grants Policy (Policy Stat #9462743).

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Per El Camino Hospital Bylaws, the Hospital Board of Directors hires, with approval of the District Board, and negotiates the salary, benefits, and incentive compensation of the Hospital's CEO. The CEO hires or delegates to appropriate management the hiring of all other employees. Incentive pay for executive management staff requires the approval of the Board or Committee. Incentive pay for middle management requires the approval of the CEO.

9. **Outside Legal Firms**

All retainer and engagement agreements for outside legal counsel must be approved signed by the Chief Legal Officer (CLO). All requests to use invoices for outside legal counsel (from any) department e.g. Human Resources, Medical Staff), regardless of the amount must be approved are to be approved in advance by the CLOhief Legal Officer or CEO.

10. **Payor Agreements – Commercial, Medicare Advantage and Medi- Cal Managed Care and other PPO/HMO Contracts**

a. Single (individual patient) case agreements, regardless of amount, are approved by the VP of Payor Relations / Managed Care. .
b. All contracts with third party payors, regardless of amount, to provide medical care are to be approved by the CFO or CEO.

[illegible] or VP). See below for approval authority for agreements without monetary value. These non-monetary contracts must be reviewed by Legal (and IT for data use) and approved as per the Contract Review Procedure. Contracts that include sharing of confidential information data such as payor mix, contract rates, conversion percent of gross charges to net patient revenue, surgical volumes by service line and/or provider, must be approved by CFO.

A18g. FY2025 ECH Implementation Strategy Report & CB Plan

Implementation Strategy Report and Community Benefit Plan, FY2025

June 2024



El Camino Health

I. GENERAL INFORMATION

Contact Person:	Jon Cowan
Years the Plan Refers to:	Fiscal year 2025
Date Written Plan Was Adopted by Authorized Governing Body:	June 12, 2024
Authorized Governing Body that Adopted the Written Plan:	El Camino Hospital Board of Directors
Name and EIN of Hospital Organization Operating Hospital Facility:	El Camino Hospital EIN 94-3167314
Address of Hospital Organization:	El Camino Hospital 2500 Grant Road Mountain View, CA 94040-4302

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II. ABOUT EL CAMINO HEALTH

El Camino Health[1] includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and urgent care, multi-specialty care and primary care locations across Santa Clara County. Key medical specialties of El Camino Health include cancer, heart and vascular, men's health, mental health and addictions, pulmonary, mother-baby, neurology, orthopedic and spine, and urology. Affiliated partners include El Camino Health Medical Network, El Camino Health Foundation and Concern.

MISSION

It is the mission of El Camino Health to heal, relieve suffering and advance wellness as the community's publicly accountable health partner.

COMMUNITY BENEFIT PROGRAM

For more than 55 years, El Camino Health has provided healthcare services beyond its walls — crossing barriers of age, education and income level — to serve the people of its region, because a healthier community benefits everyone.

Building a healthier community requires a combined effort. It has been the privilege of El Camino Health to collaborate with community members who have expertise in understanding health disparities in local cities, as well as organizations with similar missions. Working together has vastly multiplied El Camino Health's ability to make a difference.

El Camino Health, in partnership with El Camino Healthcare District, provides funding through the Community Benefit Program in the form of grants and sponsorships to organizations that demonstrate an ability to impact the health needs of vulnerable, underserved and at-risk community members.

Every year, El Camino Health publishes the Community Benefit Annual Report to inform the community about Community Benefit Program financials, the grant programs and how these funded services improve the health of vulnerable populations both through direct services and prevention initiatives.[2]

III. EL CAMINO HEALTH'S SERVICE AREA

El Camino Health is located in Santa Clara County, and its community encompasses most of the cities in that county, including Santa Clara, San José, Sunnyvale, Mountain View, and Los Gatos. Santa Clara County comprises 18 cities and large areas of unincorporated rural land. In 2020, approximately 1.93 million people lived here, making it the sixth largest county in California by population. San José is its largest city, with over 1.01 million people (52% of the total). The population of the county is substantially more dense than the state, with 9,115 people per square mile compared to 8,486 per square mile in California.

The median age in Santa Clara County is 38.1 years old. More than 22% of the county's residents are under the age of 18, and over 13% are 65 years or older. Among the population aged 75 and older, nearly half (48%) are living with a disability. Santa Clara County is also very diverse, with sizable proportions of Asian, Latinx, and white populations. Nearly four in ten (39%) people in Santa Clara County were born outside the United States. This percentage is higher than the foreign-born populations statewide (27%) and nationwide (14%).

Our communities earn some of the highest annual median incomes in the U.S., but they also bear some of the highest costs of living. The median household income in Santa Clara County is $124,055, far higher than California's median of $75,325.[3] Yet the California Self-Sufficiency Standard,[4] set by the Insight Center for Community Economic Development, suggests that many households in Santa Clara County are unable to meet their basic needs.[5] (The Standard in 2021 for a family with two children was $144,135.) Housing costs are high: In 2021, the median home price was $1.4 million[6] and the median rent was $2,374.[7] A total of 26% of children are eligible for free or reduced-price lunch and close to one quarter (23%) of children live in single-parent households. About 4% of people in our community are uninsured.

The minimum wage in Santa Clara County[8] was $15.45–$16.30 per hour in 2021, where self-sufficiency requires an estimated $34–$39 per hour. California Self-Sufficiency Standard data show a 27% increase in the cost of living in Santa Clara County between 2018 and 2021, while the U.S. Bureau of Labor Statistics reports only a 5.4% per year average increase in wages in the San Jose-Sunnyvale-Santa Clara metropolitan area between 2018 and 2020.

Judging by the Neighborhood Deprivation Index, a composite of 13 measures of social determinants of health such as poverty/wealth, education, employment, and housing conditions, the county's population overall is healthier than the national average.[9] Although the county is quite diverse and has substantial resources (see our CHNA 2022 report, Attachment 3), there is significant inequality in the population's social determinants of health and health outcomes. For example, the Gini Index, a measure of income inequality, is higher in certain zip codes compared to others.[10] Certain areas also have poorer access to high-speed internet (e.g., zip codes 95013, 95140), or to walkable neighborhoods (e.g., zip codes 95002, 95141), or jobs (e.g., zip codes 95020, 95130). In our assessment of the health needs in our community, we focused particularly on disparities and inequities within our community rather than simply in comparison to California or the nation as a whole.

IV. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

Per state and federal law, a Community Health Needs Assessment (CHNA) must be conducted every three years by nonprofit hospitals. In 2022, El Camino Health Community Benefit staff conducted a Community Health Needs Assessment in collaboration with the Santa Clara County Community Benefit Coalition. This assessment resulted in the identification of community health needs. The 2022 CHNA serves as a tool for guiding policy and program planning efforts and is available to the public. For information about El Camino Health's 2022 CHNA process and for a copy of the 2022 CHNA report, please visit https://www.elcaminohospital.org/about-us/community-benefit.

IRS regulations mandate that all nonprofit hospitals develop and adopt an implementation strategy to address community needs every three years. Section 1.501(r)(3)(c) of the IRS regulations pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will address and a description of the health needs that the hospital will not address.

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Health's planned response to the needs identified through the 2022 CHNA process. Per IRS requirements, the following descriptions of the actions (strategies) El Camino Health intends to take include the anticipated impact of the strategies, the resources the hospital facility plans to commit to address the health needs, and any planned collaboration between the hospital facility and other facilities or organizations in addressing the health needs.

This 2025 IS Report and CB Plan is based on the 2022 CHNA and outlines El Camino Health's funding for fiscal year 2025. It will be updated annually and the update will be based on the most recently conducted CHNA.

Financial Summary

FY2025 El Camino Health Community Benefit Plan:

- 45 Grants: $3,310,000
    - Requested Grant Funding: $5,996,392
- Sponsorships: $85,000
- Placeholder: $15,000
- Plan Total: $3,410,000

V. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2022 CHNA

The 2022 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide averages and rates.

To be considered a health need for the purposes of the 2022 CHNA, the need had to fit a standard definition, be present in at least two data sources, and either prioritized by key informants or focus groups, or suggested by direct statistical indicators that fail benchmarks or exhibit documented inequities by race.[11] A total of 12 health needs were identified in the 2022 CHNA. The health need selection process is described in Section VI of this report.

2022 Community Health Needs List

1. Economic Stability
2. Behavioral Health
3. Housing & Homelessness
4. Health Care Access & Delivery
5. Diabetes & Obesity
6. Cancer
7. Maternal & Infant Health
8. Oral/Dental Health
9. Climate/Natural Environment
10. Unintended Injuries/Accidents
11. Community Safety
12. Sexually Transmitted Infections

VI. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) & COMMUNITY BENEFIT PLAN DEVELOPMENT

El Camino Health selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health initiative. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VII. HEALTH NEEDS THAT EL CAMINO HEALTH PLANS TO ADDRESS

PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In October 2021, the Hospital Community Benefit Committee met to review the information collected for the 2022 CHNA. The purpose of the meeting was to help select the needs El Camino Health would address, which would form the basis for its community benefit plan and implementation strategies. El Camino Health, by consensus, selected the following needs to address:

- Health Care Access & Delivery (including oral health)
- Behavioral Health (including domestic violence and trauma)
- Diabetes & Obesity
- Other Chronic Conditions (other than Diabetes & Obesity)
- Economic Stability (including food insecurity, housing, and homelessness)

DESCRIPTION OF HEALTH NEEDS EL CAMINO HEALTH PLANS TO ADDRESS

Health Care Access & Delivery (including oral health)

Health care access and delivery, which affects various other community health needs, was identified as a top health need by more than half the CHNA's focus groups and nearly one-third of key informants. Experts and county residents felt there was a lack of access to primary and specialty care (oral health and mental health were specifically named), especially for middle- and low-income community members. Healthcare access may be especially problematic for youth in the community: In Santa Clara County's schools, the ratio of students to each school nurse (2,992:1) exceeds the state ratio (2,410:1) by nearly 25%.[12] Further, the county's ratio of students to school speech, language, and hearing specialists (1,126:1) is larger than the state's (1,093:1).[12] In addition, Black and Latinx Santa Clara County residents experience significantly worse health compared to county residents of other races; for example, preventable hospital stays (4,942 per 100,000 Black Medicare enrollees [adults aged 65 and over and persons with disabilities] and 3,969 per 100,000 Latinx Medicare enrollees in the county versus 3,358 per 100,000 Medicare enrollees statewide[13]) may be a sign of inequitable access to high-quality care. Certainly in East San José, one of the geographic areas where health disparities are concentrated, there is a higher percentage of individuals enrolled in Medicaid or other public health insurance (42%) compared to the state average (38%).[14] Conversely, in Sunnyvale (zip code 94085), another area of concentrated health disparities, a much lower proportion of individuals are enrolled in Medicaid/public health insurance (21%)[14], but a slightly higher proportion of individuals are uninsured (8%) compared to the state overall (7.5%).[14]

Many key informants and focus group participants connected healthcare access with economic instability. For example, some mentioned that low-income residents may be required to prioritize rent and food over healthcare. Others noted that individuals who are not provided with sick time must choose to go unpaid in order to visit the doctor for themselves and/or family members,

stating that expanded service hours on weekends and evenings are still needed. It was stated that low-income and undocumented county residents especially have difficulty accessing insurance. Affordability, both of insurance premiums and of healthcare itself, especially preventive care, was a particular concern; in our 2019 CHNA report, Latinx county residents were significantly less likely to have health insurance than others. Additionally, CHNA participants identified the lack of information for patients about healthcare costs as a barrier to accessing care.

Experts indicated that they had mixed experiences with telehealth, which rose substantially during the pandemic. While telehealth can overcome transportation barriers, experts worried about the digital divide as well as patients' lack of privacy. There was also concern expressed by providers about the lower reimbursement rate for telephone appointments (i.e., without video).

The need for healthcare workforce training in order to deliver care in a sensitive manner was a common theme among key informants and focus group participants. Training areas that were identified included LGBTQ+ sensitivity and education about issues specific to the population, trauma-informed care, and greater respect/efforts for patients who have mental health issues, are low-income, lack digital and/or English literacy, or are monolingual non-English speakers. Other delivery issues included education of healthcare workers around public charge issues, and the need for greater language capacity. More than one in ten (11%) Santa Clara County residents speak limited English, compared to less than 10% in California overall.[14] However, there are even more-glaring geographic disparities: in Sunnyvale (zip code 94085) more than one in seven (14%), and in the East San José area more than two in ten (22%) residents speak limited English.[14] Limited English proficiency can restrict healthcare access.

Systemic issues such as low Medi-Cal reimbursement rates and the annual requirement for Medi-Cal patients to re-verify their eligibility in order to retain coverage were called out as specific concerns. Experts expressed concern about the use of the emergency department for non-emergent issues among immigrants, the unhoused population, and individuals who lack insurance, which speaks to the inequity in access to healthcare among these groups.

Behavioral Health (including domestic violence and trauma)

Behavioral health, which includes mental health and trauma as well as consequences such as substance use, ranked high as a health need, being prioritized by all focus groups and more than half of key informants.

The pandemic's negative effect on mental health was one of the strongest themes from the qualitative data. Many experts spoke of depression, anxiety, trauma, and grief among all populations and reported an increased demand for services; however, children and adolescents were of particular concern. Statistics from prior to the pandemic's advent suggest that youth mental health is an issue: Students in Santa Clara County have lower access to psychologists at school (1,199:1) compared to students statewide (1,041:1, a 15% difference).[15] Perhaps in part due to these access issues, the county's youth self-harm injury hospitalization rate (32.7

per 100,000 age 0-17) is significantly higher than the state's rate (22.4 per 100,000).[16] Experts noted the lack of mental health providers (348.0 per 100,000 people in the county vs. 352.3 per 100,000 at the state level)[17] and addiction services overall, especially in non-English languages.

Key informants and focus group attendees, all of whom participated in the CHNA after the pandemic began, described youth isolation and lack of interaction with peers as preventing normal adolescent development. They also suggested that many students were anxious about returning to school, in part because of the chance of infection. While data prior to the pandemic already indicated that youth behavioral health was a concern, experts described an increase in youth suicide attempts, especially by overdose with prescription medications, that seemed to occur beginning about three months into the pandemic.

Statistics suggest that there are disparities associated with behavioral health. For example, drug overdose deaths among Santa Clara County's Black population occur at nearly twice the rate (25.0 per 100,000 people) as for all Californians (14.0 per 100,000).[18] Self-harm injury hospitalizations are much higher for the county's white youth (66.3 per 100,000 age 0-17) and Latinx youth (31.9 per 100,000) than for all California youth (22.4 per 100,000).[19] The county's white suicide rate for all ages (13 per 100,000 people) remains persistently higher than the state rate (11 per 100,000 people).[20] Experts, however, note that "racial and ethnic minorities have less access to mental health services than do whites, are less likely to receive needed care and are more likely to receive poor quality care when treated."[21] An expert on the historical context of such disparities suggests that "racism and discrimination," as well as "fear and mistrust of treatment" pose barriers to community members who are Black, Indigenous, or other people of color (BIPOC) seeking help for behavioral health issues. The expert also notes that overrepresentation in the criminal justice system "suggests that rather than receiving treatment for mental illness, BIPOC end up incarcerated because of their symptoms."[22] Among the statistical data available for this CHNA, juvenile felony arrests (for ages 10-17) were substantially higher for Black (23.0 per 1,000) and Latinx (9.3) Santa Clara County youth than for California youth overall (4.1 per 1,000).[23]

Community members made clear connections between COVID-related economic insecurity causing stress and anxiety, especially for those who lost jobs or saw their incomes affected. African immigrants were one group singled out by experts as experiencing behavioral health issues at a high rate, in part due to job losses during the pandemic. Experts also said that youth worried about the economic hardships of their families and sought employment themselves to reduce the burden on their families.

Experts spoke to the fact that the mental health and addiction services systems have historically been siloed, which has resulted in a lack of coordinated, comprehensive treatment. Further, some noted that many hospitals no longer provide mental health services and there are very few inpatient psychiatric beds for acute/high needs.[24] It was stated that services for people without health insurance can be expensive and difficult to access.

Diabetes & Obesity

Approximately one-third of key informants and focus groups identified diabetes and obesity as a top health need. Two experts in Santa Clara County specifically called out diabetes as a rising problem in the community, while the trend for adult obesity remains flat. Currently, 8.4% of Santa Clara County community members have diabetes, compared to 9.9% of all Californians.[25] Key informants and focus group participants identified the need for nutrition education, particularly from a young age, and some key informants further noted the cost of healthy food as a barrier to good nutrition. SNAP enrollment, an indicator of food insecurity, in the East San José area is substantially higher (14%) compared to the state average (10%).[26]

The lack of physical activity was cited as a driver of obesity by multiple key informants, mostly in the context of the pandemic's interference with regular activities. Associated with this concern, the county's walkability index (9.9) is worse than the state's (11.2), while the walkability index for East San José (0.8) and the 94040 zip code of Mountain View (1.5), another area of concentrated health disparities, are substantially worse than either.[27] The county's Pacific Islander and Latinx middle- and high-schoolers are much less likely to meet healthy body composition and fitness standards than middle- and high-school students statewide; Black middle-schoolers in Santa Clara County generally meet body composition standards but not fitness standards.

Community members expressed dissatisfaction with the quality of the food supply, especially for those reliant on food from food pantries or institutions such as schools. Data show that, among the venues from which community members can obtain food, there are substantially fewer supercenters and club stores, which sell fresh produce, in Santa Clara County (22.2 per 1,000 people) compared to the state rate (48.1 per 1,000).[28] Further, and perhaps related to the lack of produce access, a smaller proportion of children ages 2-11 in the county eat adequate amounts of fruits and vegetables daily (31%) compared to children statewide (35%).[29] Multiple residents made the connection between unhealthy eating and mental health—what's going on "in their head and their heart."

Our 2019 CHNA report identified disparities in diabetes and obesity, with local Black and Latinx populations experiencing obesity at higher rates compared to the state, and the county's Black population also experiencing higher rates of diabetes. Although key informants and focus group participants did not connect diabetes and obesity with health disparities or inequities, experts writing on behalf of the American Diabetes Association describe placing "socioeconomic disparities and the other [social determinants of health] downstream from racism—which we posit is a root cause for disparities in diabetes outcomes in marginalized and minoritized populations."[30]

Other Chronic Conditions (other than Diabetes & Obesity)

Santa Clara County generally fares well with respect to chronic conditions other than diabetes and obesity: Mortality rates for heart disease, stroke, cancer, chronic liver disease/cirrhosis, and Alzheimer's disease and other dementias are all better than state benchmarks.

However, health conditions such as cardiovascular disease, cancer, and respiratory problems are among the top 10 causes of death in the county. With regard to cancer, the rate of cancer incidence among children ages 0-19 is slightly higher in the county (19.0 per 100,000) than the state (18.2 per 100,000).[31] Mammography screening levels, an early cancer detection measure, are lower for the county's Black women (33%), Latinas (29%), and Native American women (33%) than California women overall (36%).[32] Our previous (2019) CHNA report indicated that Black county residents have a higher incidence of breast cancer, lung cancer, prostate cancer, and a higher prevalence of cancer of all sites combined, while Latina residents have a substantially higher incidence of cervical cancer. With regard to respiratory problems, the level of asthma prevalence for people of all ages is higher for Santa Clara County (10%) than the state (9%).[33] One key informant noted that asthma rates have been worsening.

An expert in chronic disease mentioned a rise in dementia-related issues. Additionally, two health experts mentioned the issue of hypertension, one in conjunction with poor mental health, and the other as a condition that is often unmanaged among unhoused patients.

There are also racial/ethnic disparities and inequities with respect to chronic conditions: Heart disease and stroke were identified as two of the chronic conditions that are often seen in data on ethnic health disparities. An expert in Black health cautioned about high rates of asthma in areas with poor air quality. There are also persistent disparities in cancer incidence rates and other cancer statistics. The rate of cancer incidence among children ages 0-19 is highest among Santa Clara County's white children (21.2 per 100,000) and Asian/Pacific Islander children (20.2 per 100,000).[31] The National Cancer Institute acknowledges socioeconomic and racial/ethnic disparities in cancer detection, treatment, and outcomes. It attributes these to a variety of factors, including institutional racism and conscious or unconscious bias among care providers, as well as barriers such as low income, low health literacy, lack of insurance, and lack of transportation. It also acknowledges the role of neighborhoods in cancer risks (e.g., when a neighborhood has poor access to affordable healthy food, residents are more likely to be obese, which is a cancer risk factor). The Institute states, "Reducing or eliminating some cancer disparities in the pursuit of health equity will require policy changes to overcome systemic social, racial, and/or institutional inequalities."[34]

Economic Stability (including food insecurity, housing, and homelessness)

Nearly all focus groups and almost three-quarters of key informants identified economic stability, including education and food insecurity, as a top community priority. According to the U.S. Office of Disease Prevention and Health Promotion, "many people can't afford things like healthy foods, health care, and housing. …People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or [chronic] conditions… may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy."[35]

The cost of living in Santa Clara County is extremely high, and income inequality in Silicon Valley is 1.5 times higher than at the state level.[36] More specifically, the 94040 and 94043 zip

code areas of Mountain View have a higher level of income inequality (both 0.5 on the Gini index) than either the county or the state overall (both 0.4 on the Gini index).[37] In addition, the East San José area experiences higher levels of Neighborhood Deprivation[38] (0.6) compared to the rest of the county (-0.8) and California as a whole (0.0).[37] Further, while the index that maps geographic access to job opportunities for the county (50, on a scale of 0 to 100) is similar to California overall (48), jobs proximity index metrics for East San Jose (2) and the 94040 zip code in Mountain View (10) are much worse.[39] The median household income in East San José ($79,602) is also lower than even the state median ($82,053), let alone the county median household income ($129,210).[37]

Education generally correlates with income; therefore, educational statistics that differ by race/ethnicity are particularly concerning. Smaller proportions of Santa Clara County Black (45%), Pacific Islander (38%), and Latinx (46%) 11th-graders met or exceeded grade-level English-language arts standards compared to California 11th-graders overall (57%).[40] Also, a smaller percentage of local Latinx 11th graders met or exceeded math standards (28%) versus California's 11th-graders (32%).[40] Related to these statistics, much smaller proportions of the county's Black (32%), Pacific Islander (34%), and Latinx (38%) high school graduates completed college-preparatory courses compared to high school graduates statewide (47%).[41] In our 2019 CHNA report, we described similar inequities in educational attainment. In some county sub-geographies in particular, the proportion of adults who do not have at least a high school diploma is much higher (East San José, 31%; 94040 in Mountain View, approximately 28%) than the state average (18%).[37] Educational inequities, often related to neighborhood segregation[42], lead to educational disparities that begin at an early age: the elementary school proficiency index, which measures the academic performance of 4th-graders, is significantly lower in both East San José (4.2) and the 94040 zip code of Mountain View (12.4) than the county (69.7) or the state (49.4).[43]

Data available on economically precarious households shows that while 50% of California households in which the most educated adult has only a high school diploma or GED struggle economically statewide, this proportion rises to 58% among Santa Clara County households.[44] Fully 30% of Silicon Valley households are not meeting economic self-sufficiency standards.[44] Furthermore, in seven out of 50 school districts in Silicon Valley, more than 50% of students are eligible for free- or reduced-price meals (a proxy for poverty).[36] In our 2019 CHNA report, poverty and food insecurity statistics illustrated inequities by race/ethnicity. Economic precariousness can force people to choose between paying rent and accessing healthcare; it can also lead to homelessness and the many barriers to health that unhoused individuals face.

Qualitative data showed that COVID created more economic insecurity for those who lost work and specifically impacted low-income essential workers, many of whom were Latinx and/or undocumented. Key informants and focus group participants mentioned that county residents often lost childcare during the pandemic, which affected their ability to work; according to the Public Policy Institute of California, this affected women significantly more than men. Women were also "overrepresented in both frontline and hardest-hit sectors" of the economy.[45] Prior to the pandemic, the cost of childcare may also have been a limiting factor; infant child care (age

0-2) cost $20,746 per year in Santa Clara County, compared to $17,384 on average statewide. Similarly, pre-K child care (age 3-5) cost $15,315 in Santa Clara County versus $12,168 on average in California overall.[46] Economic insecurity affects single-parent households more than dual-parent households[47]; in East San José specifically, there are a higher proportion of children in single-parent households (39%) than in California overall (32%).[37]

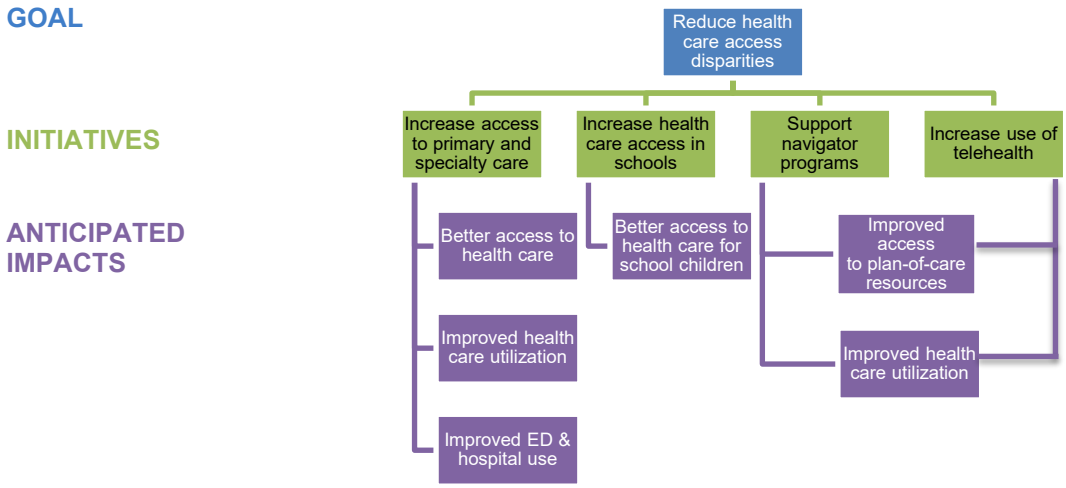
VIII. EL CAMINO HEALTH'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

El Camino Health's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, our community health investment for FY2025 will be directed to improve health care access & delivery (including oral health), behavioral health (including domestic violence and trauma), economic security (including food insecurity, housing, and homelessness), diabetes and obesity, and other chronic conditions (other than diabetes & obesity) through community and hospital-based programs and partnerships.

This plan represents the revamping of a multi-year strategic investment in community health. El Camino Health believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2022 CHNA process.

HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

El Camino Health views efforts to ensure equitable access to high-quality health care and respectful, compassionate, culturally competent delivery of health care services as a top priority for its community benefit investments. Given the community's strong focus on issues of health care access and delivery during the 2022 CHNA, El Camino Health chose goals that support initiatives to reduce disparities in access to and delivery of primary and specialty care for community members in its service area. The goals also include improvements in access to and delivery of oral health care and maternal/infant health care, based on statistical data and information provided by experts interviewed during the CHNA. The hospital expects to make a positive impact by improving health care access and utilization, reducing unnecessary emergency department visits and hospitalizations, and reducing disparities in health outcomes.

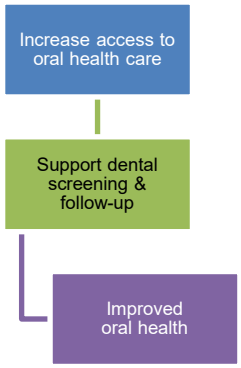


Goal	Initiative	Anticipated Impact
1. Reduce disparities in access to high-quality care	A. Support increased access to primary care and specialty care services for vulnerable individuals[48, 49, 50, 51, 52, 53, 54, 55, 56, 57]	(i) Individuals experience better access to health care (ii) Improved health care utilization (iii) Reduced unnecessary ED visits and hospitalizations
	B. Support greater access to healthcare in schools[58]	(i) Improved access to health care for school-aged children and youth
	C. Support clinical and community health navigator programs[59, 60, 61]	(i) Community members access clinical and community resources that support their plan of care
	D. Support increased use of telehealth and other technology solutions[62, 63, 64]	

GOAL

INITIATIVE

ANTICIPATED IMPACT

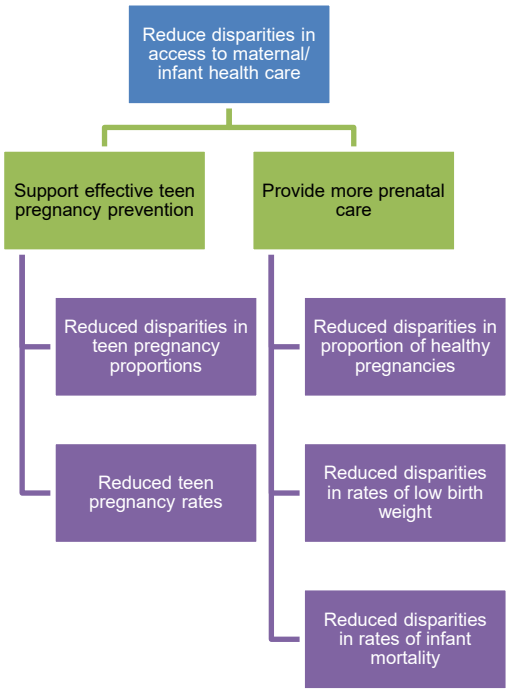


Goal	Initiative	Anticipated Impact
2. Increase access to oral health care for underserved community members	A. Support school- and community-based programs that offer dental screenings and care, including tele-dentistry[65, 66, 67, 68]	(i) Improved oral health among community members

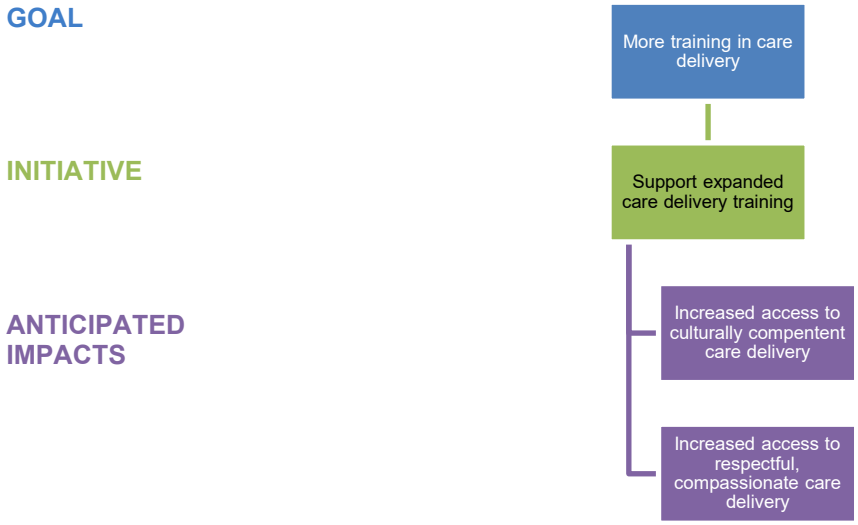
GOAL

INITIATIVES

ANTICIPATED IMPACTS



Goal	Initiative	Anticipated Impact
3. Reduce disparities and inequitable access to maternal/ infant health care for community members	A. Support effective teen pregnancy prevention programs[69, 70, 71]	(i) Reduced disparities in the proportion of teens who are pregnant (ii) Reduced proportions of teens who are pregnant
	B. Increase access to and utilization of adequate prenatal care[72, 73, 74, 75, 76]	Reduced disparities in: (i) Proportions of women with healthy pregnancies (ii) Rates of low birth weight (iii) Rates of infant mortality



Goal	Initiative	Anticipated Impact
4. Provide/ expand workforce training in cultural competence, and compassionate and respectful care delivery	A. Support workforce training in cultural competence, and compassionate and respectful care delivery[77, 78, 79, 80]	(i) Increased access to culturally competent health care services among underserved community members, including LGBTQ+ and community members with limited English proficiency (ii) Increased access to compassionate and respectful health care among underserved community members, including LGBTQ+ and community members with limited English proficiency

HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH) PROPOSAL RECOMMENDATIONS

Agency	New	DNF	Dual Request	Requested	FY2024 Approved (if applicable)	HCBC Rec.
Asian Americans for Community Involvement				$120,000	$120,000	$120,000
Cambrian School District				$250,000	$135,000	$135,000
Campbell Union School District				$240,000	$235,000	$235,000
Cupertino Union School District			X	$122,000	$110,000	$110,000
Via Services	X			$31,730	N/A	$30,000
Health Connected	X	X		$30,000	N/A	$ -
Healthier Kids Foundation				$70,000	$70,000	$70,000
Heart of the Valley, Services for Seniors, Inc. (HOV)	X	X		$25,000	N/A	$ -
Mt. Pleasant School District				$130,000	$126,000	$126,000
Pacific Hearing Connection	X	X		$25,000	N/A	$ -
Santa Clara County Public Health				$100,000	$80,000	$85,000
Vista Center for the Blind and Visually Impaired				$68,028	$40,000	$45,000
Bay Area Community Health	X	X		$75,000	N/A	$ -
Catholic Charities of Santa Clara County	X	X		$50,000	N/A	$ -
Chinese American Coalition for Compassionate Care	X	X		$25,000	N/A	$ -
Civic Ventures dba CoGenerate	X	X		$30,000	N/A	$ -
Fogarty Innovation	X	X		$500,000	N/A	$ -
Health Mobile	X		X	$150,000	N/A	$50,000

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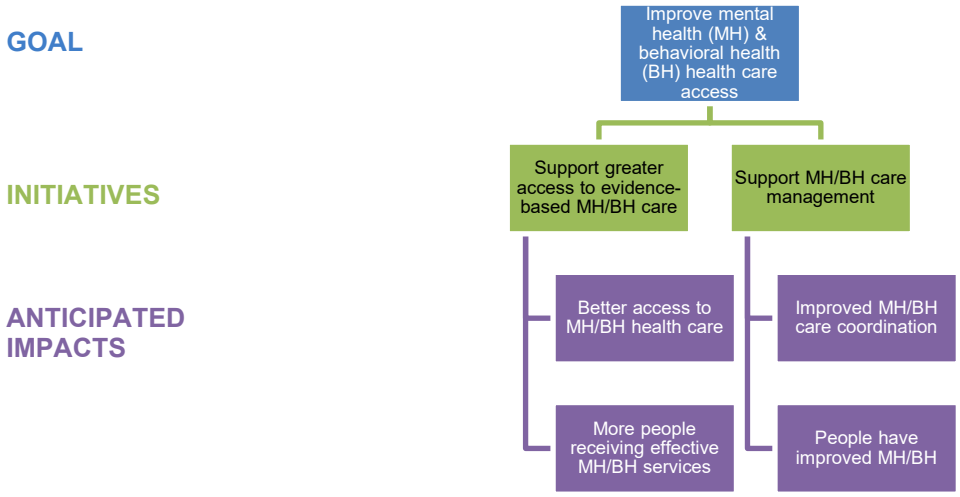
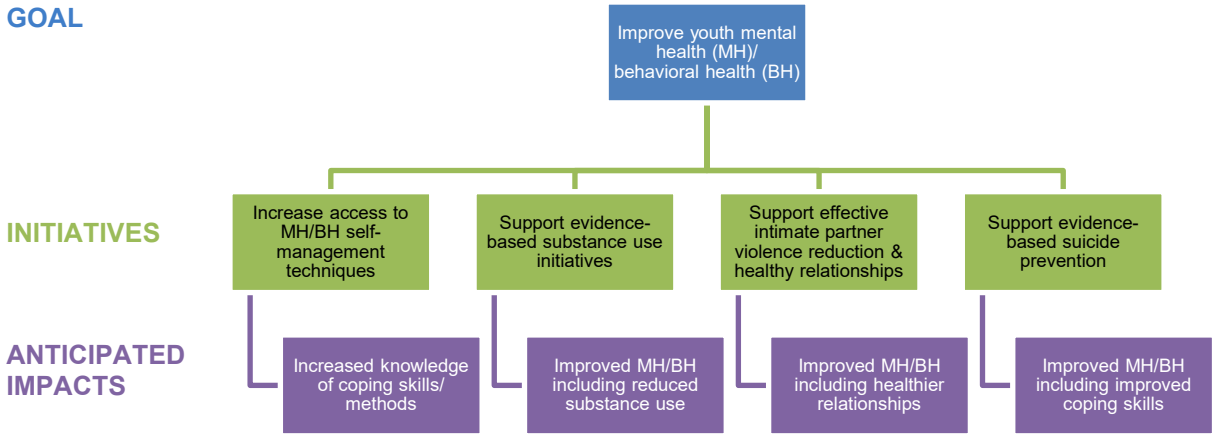
BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

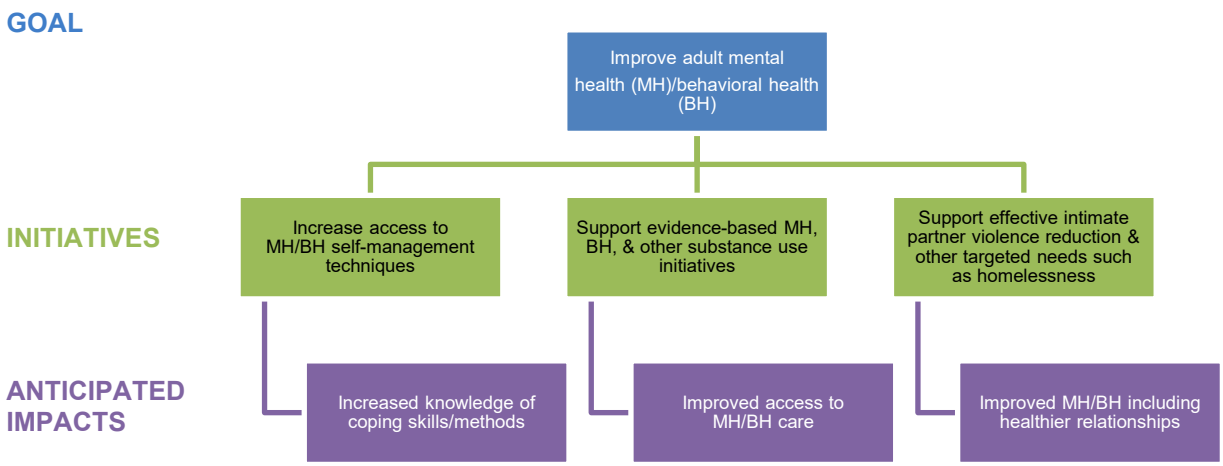
Even prior to the pandemic, data indicated that behavioral health (including mental health, trauma, and substance use) was a significant health need, especially with respect to the supply of providers. Community input during the 2022 CHNA emphasized how much worse and more widespread behavioral health issues have become due to the pandemic. Therefore, in addition to supporting initiatives to improve community members' access to mental and behavioral health care, El Camino Health chose goals that support more direct approaches to improving the mental and behavioral health of both youth and adult community members. By using a two-pronged approach, addressing access to care and care itself, El Camino Health expects to be able to make a positive impact by improving community members' mental and behavioral health, including contributing to improved coping skills, healthier relationships, and reduced substance use.



Goal	Initiative	Anticipated Impact
1. Improve mental/ behavioral health care access for community members	A. Support in-person and virtual expanded access to evidence-based counseling, addiction treatment, behavioral health case management, etc. [81, 82, 83, 84, 85]	(i) Improved access to mental/behavioral health programs and services (ii) More community members receiving effective mental/ behavioral health services
	B. Care management to support community members' self-management and mental health[86, 87]	(i) Improved coordination of mental/behavioral services (ii) Improved mental/behavioral health among those served



Goal	Initiative	Anticipated Impact
2. Improve mental/ behavioral health of youth in the community	A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[88, 89]	(i) Increased knowledge among youth served about methods of coping with stress and depression
	B. Support for substance abuse initiatives with evidence of effectiveness[90, 91, 92]	(i) Improved mental health among those served, including reduced substance use
	C. Programs that prevent or reduce youth and young adult intimate partner and sexual violence and promote healthier relationships[93, 94]	(i) Improved mental health among those served, including healthier relationships
	D. Programs that reduce or prevent suicide with evidence of effectiveness[95, 96]	(i) Improved mental health among those served, including improved coping skills



Goal	Initiative	Anticipated Impact
3. Improve mental/ behavioral health of adults in the community	A. In-person or virtual programs for assisting community members in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[97, 98, 99]	(i) Increased knowledge among those served about methods of coping with depression, anxiety, and stress
	B. Support for screening, accurate diagnosis, effective treatment, and follow-up for mental/ behavioral health and substance use/ addiction treatment services[100, 101, 102]	(i) Improved access to mental and behavioral health services among those served
	C. Programs that support targeted unmet needs such as supporting individuals experiencing or at risk of homelessness or intimate partner violence[103, 104]	(i) Improved mental health among those served (ii) Improved utilization of clinical and community resources among those served

BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA) PROPOSAL RECOMMENDATIONS

Agency	New	DNF	Dual Request	Requested	FY2024 Approved (if applicable)	HCBC Rec.
Adolescent Counseling Services				$25,000	$25,000	$25,000
Bill Wilson Center				$25,000	$25,000	$25,000
Child Advocates of Silicon Valley				$40,000	$40,000	$40,000
Cupertino Union School District			X	$135,000	$130,000	$130,000
LifeMoves			X	$65,000	$50,000	$50,000
Los Gatos Union School District				$200,000	$120,000	$120,000
Momentum for Health			X	$40,000	$40,000	$40,000
Peninsula Healthcare Connection: Medication Management				$90,000	$90,000	$90,000
Almaden Valley Counseling Service				$80,000	$40,000	$25,000
Caminar	X	X		$50,000	N/A	$ -
El Camino Health- Women's and Newborn Services	X			$38,058	N/A	$38,000
Jewish Family Services of Silicon Valley				$149,286	$75,000	$75,000
LGS Recreation				$75,260	$15,000	$15,000
Next Door Solutions to Domestic Violence				$90,000	$90,000	$88,000
Pacific Clinics (Formerly Uplift Family Services)				$230,000	$220,000	$215,000
Parents Helping Parents Inc				$45,000	N/A	$35,000
To Be Empowered				$60,000	$35,000	$30,000
Banyan Tree Women's Collective	X	X		$30,000	N/A	$ -
Counseling and Support Services for Youth	X	X		$104,114	N/A	$ -
Kingdom Family Resources	X	X		$85,000	N/A	$ -
NCEFT - National Center for Equine Facilitated Therapy	X	X		$5,000	N/A	$ -
Positive Alternative Recreation Teambuilding Impact	X	X		$70,000	N/A	$ -
Recovery Cafe San Jose Inc.	X	X		$30,000	N/A	$ -
South Bay Kidpower Teenpower Fullpower (commonly known as Kidpower)	X	X		$30,000	N/A	$ -

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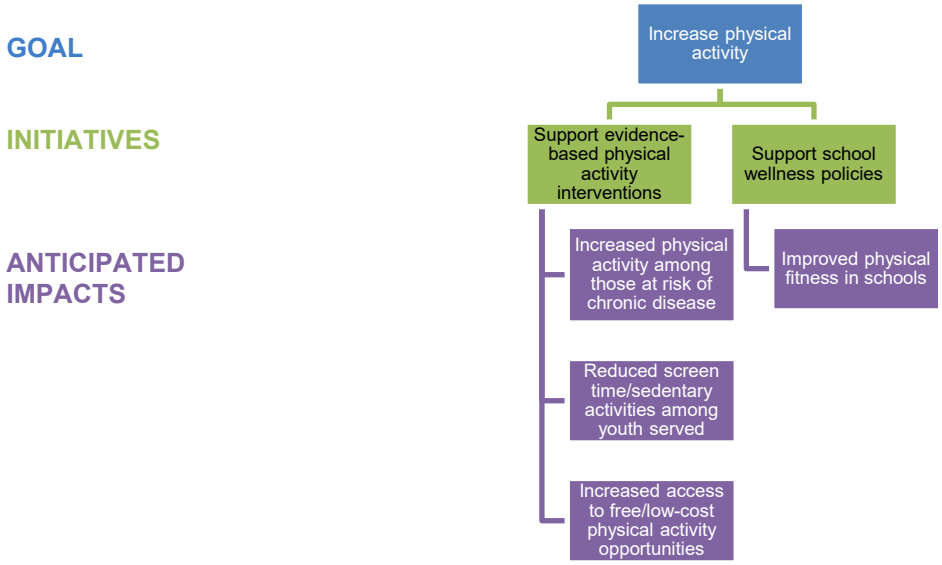
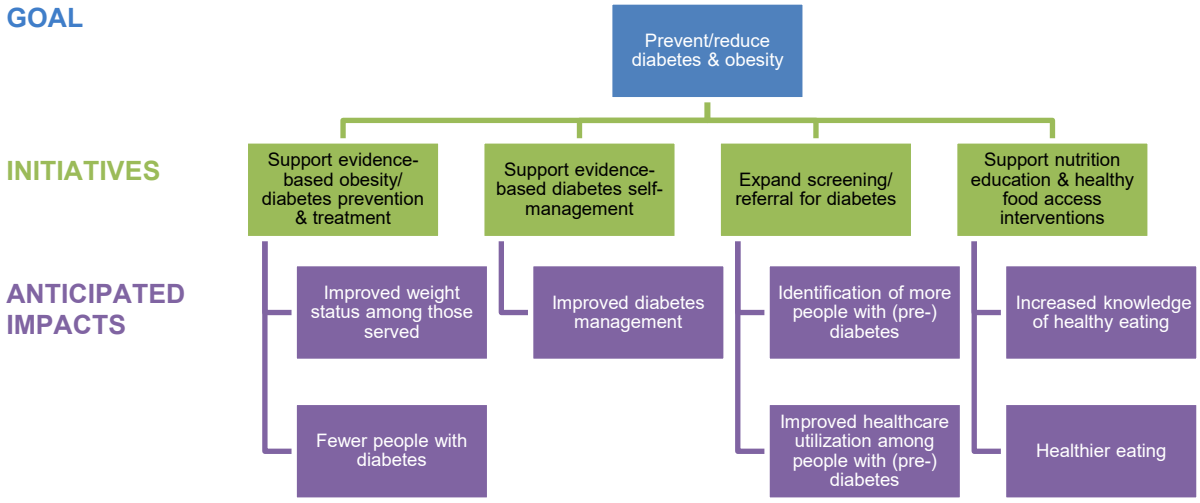
DIABETES & OBESITY

During the 2022 CHNA, community members provided input on poor food access and the lack of physical activity, both of which are drivers of diabetes and obesity. Additionally, CHNA data indicated issues with the food environment, geographic disparities in walkability, and ethnic disparities in youth fitness, among other things. Experts also indicated that diabetes rates are trending up in Santa Clara County. Therefore, El Camino Health chose goals that support initiatives that prevent or reduce obesity and diabetes, as well as those that increase physical activity, reduce food insecurity, and increase healthy food access among community members. The hospital expects these efforts will make a positive impact by contributing to improved weight status, improved diabetes management, and reduced rates of obesity & diabetes in the community.



Goal	Initiative	Anticipated Impact
1. Increase physical activity among community members	A. Support physical activity interventions shown to contribute to weight loss and reduced screen time among youth and adults[105, 106, 107, 108]	(i) Increase in physical activity among youth and adults at elevated risk of chronic health conditions (ii) Reduced screen time & time on sedentary activities among youth served (iii) Increased access to and utilization of free/low-cost opportunities for physical activity
	B. Support implementation of school wellness policies for promoting physical activity[109]	(i) Improved physical fitness among students in schools served



Goal	Initiative	Anticipated Impact
2. Prevent/ reduce obesity & diabetes among community members	A. Support obesity/diabetes prevention and obesity treatment programs with evidence of effectiveness[110, 111, 112, 113, 114, 115, 116, 117, 118]	(i) Improved weight status in youth and adults served (ii) Long-term reduction in the number of community members with diabetes
	B. Support diabetes treatment/self-management programs with evidence of effectiveness[119, 120, 121, 122, 123]	(i) Improved diabetes management in participants served
	C. Expand screening and referral for abnormal blood glucose/pre-diabetes and type 2 diabetes[124, 125]	(i) Identification of more individuals with diabetes and pre-diabetes (ii) Improved healthcare utilization for individuals with diabetes and pre-diabetes
	D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[126, 127, 128, 129]	(i) Increased knowledge and understanding about healthy eating among people served (ii) Healthier eating among community members receiving interventions

DIABETES & OBESITY PROPOSAL RECOMMENDATIONS

Agency	New	DNF	Dual Request	Requested	FY2024 Approved (if applicable)	HCBC Rec.
Chinese Health Initiative			X	$30,000	$20,000	$30,000
South Asian Heart Center, El Camino Health			X	$60,000	$50,000	$60,000
West Valley Community Services				$185,000	$185,000	$185,000
West Valley Community Services - Seniors Program				$50,000	$45,000	$50,000
African American Community Service Agency				$40,000	$35,000	$40,000
Bay Area Women's Sports Initiative			X	$72,787	$15,000	$20,000
Gardner Family Health Network, Inc. dba Gardner Health Services				$343,173	$320,000	$320,000
Indian Health Center of Santa Clara Valley				$105,000	$90,000	$95,000
Playworks			X	$41,200	$40,000	$40,000
Valley Verde				$70,000	$60,000	$70,000
AbilityPath	X	X		$20,000	N/A	$ -
Roots Community Health Center				$114,206	$35,000	$35,000
Union School District	X	X		$183,606	N/A	$ -
Vasona Hill Foundation	X	X		$33,113	N/A	$ -

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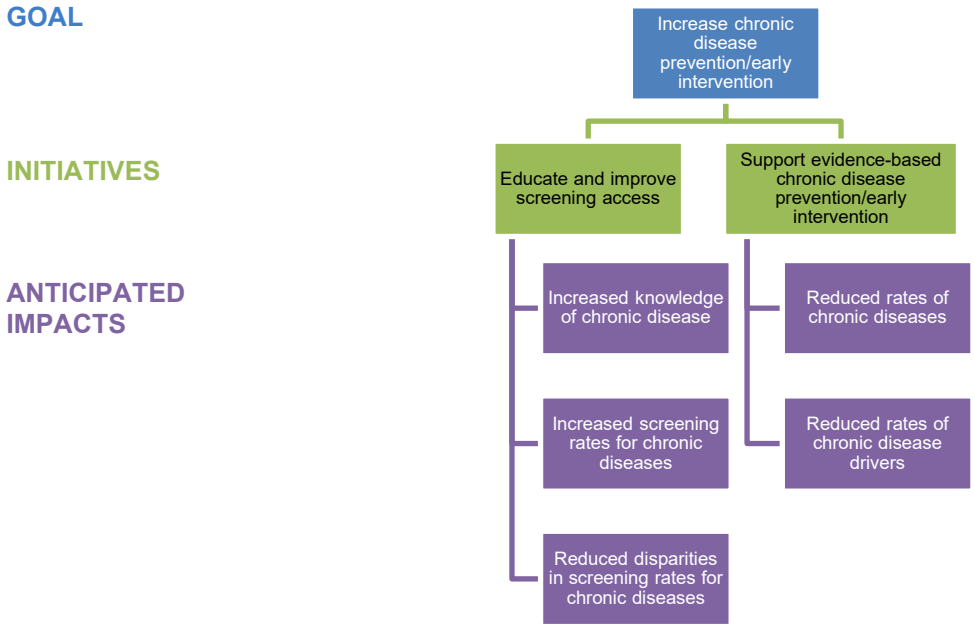
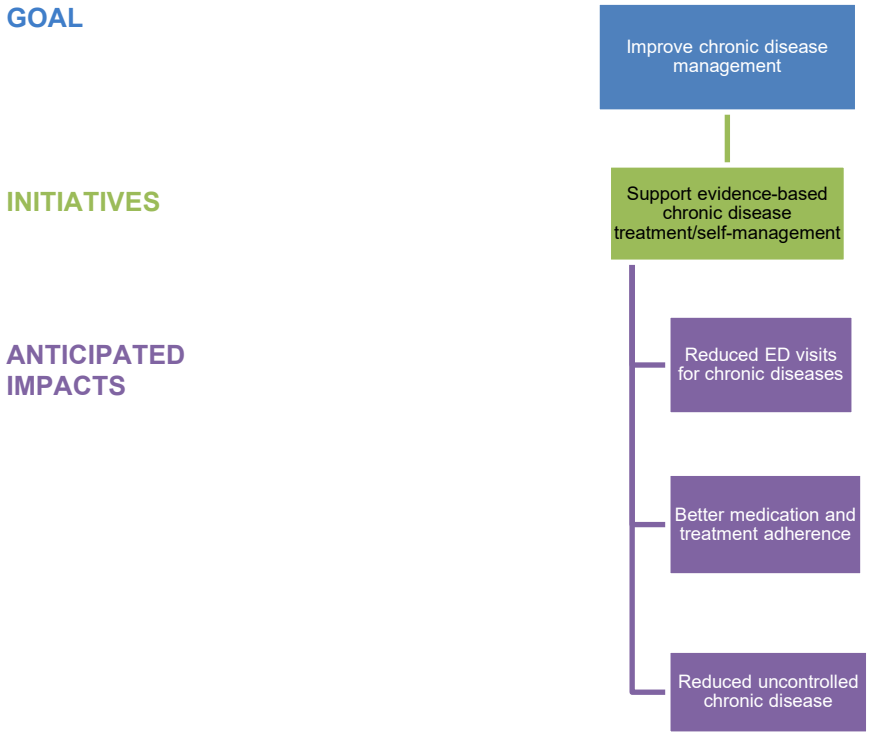
OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

Many chronic diseases are among the top causes of death in Santa Clara County. CHNA data show there are disparities in chronic conditions such as cancer, asthma, heart disease, and stroke. Therefore, El Camino Health chose goals that support initiatives to increase prevention and early intervention of chronic diseases and to improve chronic disease management among community members. By addressing these issues, El Camino Health believes it will make a positive impact through improved screening for chronic conditions, reduced rates of uncontrolled chronic diseases, lower levels of the drivers of chronic conditions, and, in the long term, reduced rates of chronic diseases.



Goal	Initiative	Anticipated Impact
1. Increase prevention and early intervention of chronic diseases in the community	A. Provide education and improve access to screenings[130, 131, 132, 133, 134, 135, 136]	(i) Increased knowledge of chronic disease among community members (ii) Increased rates of screening for chronic disease (iii) Reduced disparities in chronic disease screening rates
	B. Support evidence-based chronic disease prevention and early intervention programs[137, 138, 139]	(i) Reduced rates of chronic diseases (ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc.



Goal	Initiative	Anticipated Impact
2. Improve chronic disease management among community members	A. Support evidence-based chronic disease treatment and self-management programs[140, 141, 142]	(i) Reduced rates of ER/ED visits for chronic diseases (ii) Improved medication and treatment adherence (iii) Reduced rates of uncontrolled chronic disease

OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY) PROPOSAL RECOMMENDATIONS

Agency	New	DNF	Dual Request	Requested	FY2024 Approved (if applicable)	HCBC Rec.
Breathe California of the Bay Area: Children's Asthma Services				$52,000	$40,000	$51,000
Latinas Contra Cancer				$75,000	$40,000	$55,000
Cancer CAREpoint				$30,000	$30,000	$30,000
Pink Ribbon Good				$30,000	$25,000	$30,000
Alzheimer's Disease and Related Disorders Association, Inc	X	X		$70,000	N/A	$ -
American Heart Association	X	X	X	$61,128	N/A	$ -

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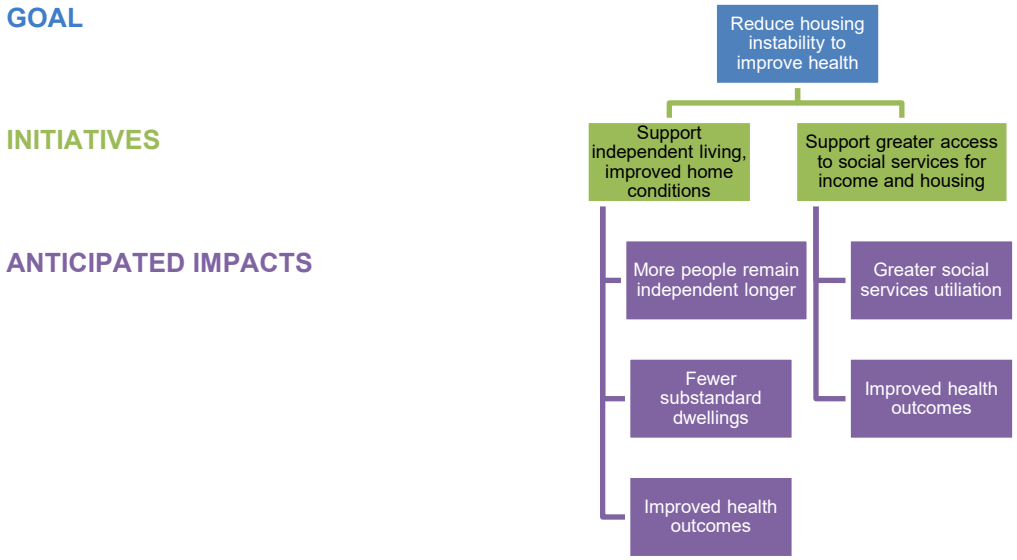
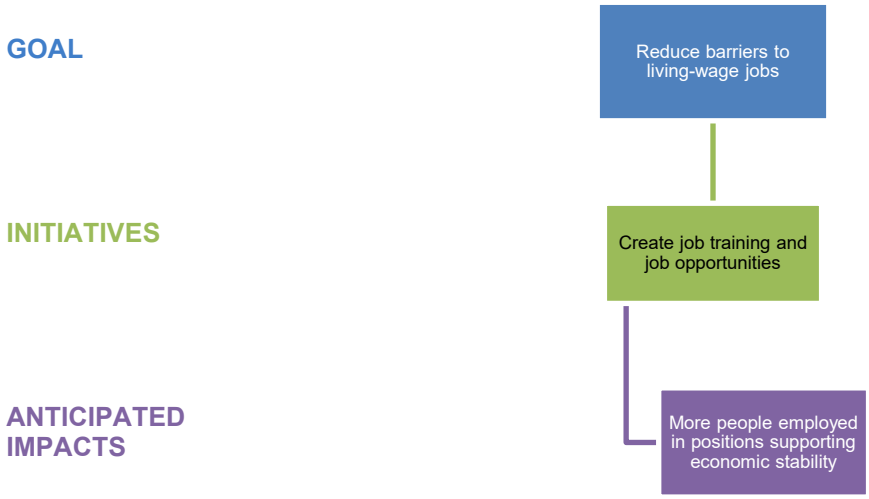
ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS)

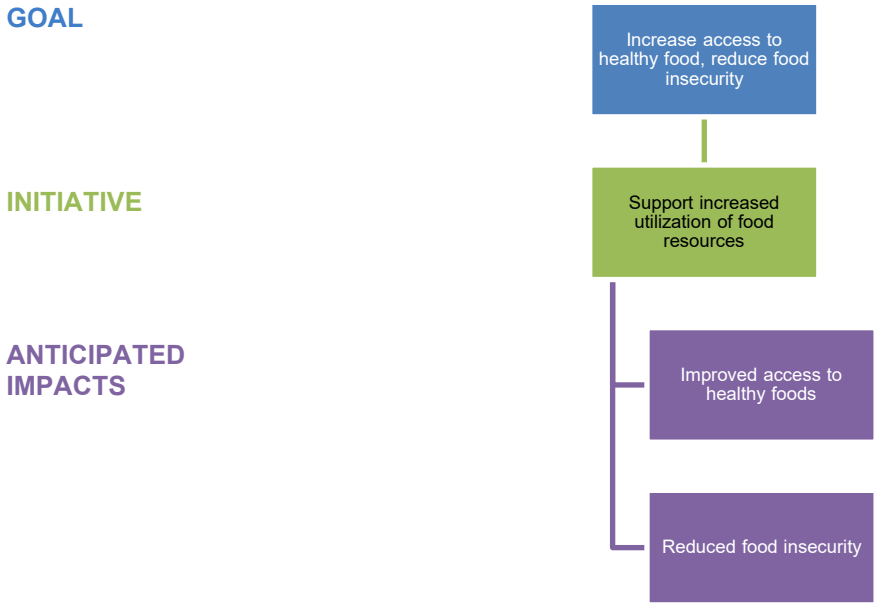
Economic stability was a top priority for the community in the 2022 CHNA, supported by data showing inequities in income, education, housing affordability, and job opportunities. When food, housing, and health care are difficult to afford, health outcomes are likely to suffer. Therefore, El Camino Health chose goals that support initiatives to reduce housing instability, food insecurity, and barriers to living-wage employment. Through efforts to address community members' basic needs, El Camino Health believes it will make a positive impact via increased utilization of social services and improved well-being and health outcomes among community members.



Goal	Initiative	Anticipated Impact
1. Reduce housing instability among community members	A. Support independent living and efforts to improve substandard living conditions[143, 144, 145]	(i) More community members remain independent longer (ii) Reduced number of sub-standard dwellings (iii) Improved health outcomes for those at-risk of and/or experiencing homelessness
	B. Support efforts to improve access to social services that address income and housing insecurity[146, 147, 148]	(i) Increase in social services utilization (ii) Improved health outcomes for those at-risk of and/or experiencing homelessness



Goal	Initiative	Anticipated Impact
2. Reduce barriers to employment/ careers that provide community members with a living wage	A. Create workforce training and employment opportunities for underrepresented populations[149, 150, 151, 152]	(i) More community members employed in positions that support economic stability



Goal	Initiative	Anticipated Impact
3. Reduce food insecurity and increase healthy food access for low-income community members	A. Support increased utilization of healthy/ culturally appropriate food through CalFresh/SNAP enrollment, existing food banks, and other sites[153, 154]	(i) Improved access to healthy food options (ii) Reduced food insecurity

ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS) PROPOSAL RECOMMENDATIONS

Agency	New	DNF	Dual Request	Requested	FY2024 Approved (if applicable)	HCBC Rec.
El Camino Health - intern program				$67,000	$44,000	$67,000
School of Arts and Culture at MHP	X			$30,000	N/A	$30,000
Hope Services	X			$25,000	N/A	$25,000
Mama D 2nd Chance	X	X		$25,000	N/A	$ -
Midtown Family Services	X			$30,000	N/A	$30,000
Parents Helping Parents	X	X		$60,703	N/A	$ -
Rebuilding Together Silicon Valley		X		$31,500	$30,000	$ -
Shine Together (Formerly Teen Success)		X		$20,000	$20,000	$ -
Sunday Friends Foundation	X	X		$50,000	N/A	$ -
Community Seva	X	X		$30,000	N/A	$ -
Downtown Streets Team	X	X	X	$30,000	N/A	$ -
Humane Society Silicon Valley	X	X		$25,000	N/A	$ -
No Time To Waste	X	X		$10,000	N/A	$ -
The Salvation Army, a California Corporation	X	X		$62,500	N/A	$ -

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IX. EVALUATION PLANS

As part of El Camino Health's ongoing community health improvement efforts, we partner with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through our triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

El Camino Health will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, El Camino Health will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report mid-year and year-end performance on annual outcomes metrics, which are shared broadly with the public as well as state and federal regulatory bodies.

X. HEALTH NEEDS THAT EL CAMINO HEALTH DOES NOT PLAN TO ADDRESS

Cancer: El Camino Health merged the Cancer health need into the "Other Chronic Conditions" health need and will address cancer through addressing other chronic conditions.

Climate/Natural Environment: This topic is outside of El Camino Health's core competencies (i.e., El Camino Health has little expertise in this area) and the hospital feels it cannot make a significant impact on this need through community benefit investment. Also, this need was of lower priority to the community than the needs that El Camino Health selected.

Community Safety (i.e., violence): This need was of lower priority to the community than the needs that El Camino Health selected. While El Camino Health lacks expertise to address this health need, behavioral health issues such as substance abuse, stress, and anxiety have been shown to be drivers of violence. El Camino Health believes that initiatives intended to address the community's behavioral health need have the potential to increase community safety as well.

Maternal & Infant Health: El Camino Health merged the Maternal & Infant Health need into the "Health Care Access & Delivery" health need and will address maternal and infant health through health care access and delivery initiatives.

Oral/Dental Health: El Camino Health merged the Oral/Dental Health need into the "Health Care Access & Delivery" health need and will address oral and dental health through health care access and delivery initiatives.

Sexually Transmitted Infections: El Camino Health is better positioned to address drivers of this need via initiatives related to health care access and delivery. Additionally, this need was of lower priority to the community than the needs that El Camino Health selected.

Unintended Injuries/Accidents: This need was of lower priority to the community than the needs that El Camino Health selected. Moreover, El Camino Health is better positioned to address this need via initiatives related to education about healthy lifestyles (i.e., physical fitness) and health care access and delivery.

APPENDIX A

IRS Implementation Strategy Checklist

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
(1) Implementation Strategy	The implementation strategy is a written plan that, with respect to each significant health need identified through the CHNA, either: (i) describes how the hospital facility plans to address the health need; or (ii) identifies the health need as one it does not intend to address and explains why the hospital facility does not intend to address the health need (Treas. Reg. § 1.501(r)-3(c)(1)).		
	A hospital facility will have described a plan to address a significant health need identified through a CHNA if the implementation strategy: (i) describes the actions the hospital facility intends to take to address the health need and the anticipated impact of these actions;	Y	Section VIII
	(ii) identifies the resources the hospital facility plans to commit to address the health need; and	Y	Section VIII
	(iii) describes any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need (Treas. Reg. § 1.501(r)-3(c)(2)).	Y	Section VIII
	In explaining why the hospital facility does not intend to address a significant health need, a brief explanation for the hospital facility's reason for not addressing the need is sufficient. Under the final regulations, such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority and/or a lack of identified effective interventions to address the need (Treas. Reg. § 1.501(r)-3(c)(3)).	Y	Section X
(2) Joint implementation	A hospital facility may develop an implementation strategy in collaboration with		

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
strategies	other hospital facilities or other organizations, including, but not limited to, related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations. In general, a hospital facility that collaborates with other facilities or organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific resources. However, a hospital facility that adopts a joint CHNA report (described in Checklist § 3(9), above) may also adopt a joint implementation strategy that, with respect to each significant health need identified through the joint CHNA, either describes how one or more of the collaborating facilities or organizations plan to address the health need or identifies the health need as one the collaborating facilities or organizations do not intend to address and explains why they do not intend to address the health need. For a collaborating hospital facility to meet the implementation strategy adoption requirement, such a joint implementation strategy adopted for the hospital facility must—		
	(i) Be clearly identified as applying to the hospital facility;	N/A	N/A
	(ii) Clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and	N/A	N/A
	(iii) Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility. (Treas. Reg. § 1.501(r)-(3)(c)(4))	N/A	N/A
(3) Adoption of the implementation strategy	Under the final regulations, an implementation strategy must be adopted by an "authorized body of the hospital facility" (see Checklist §	Y	Section I

IRS Requirement	Information Request/ Regulatory Language and Section References	IS Report Complies with Requirement (Y/N)	Report Section
	3(1), above) on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility completes the final step for the CHNA, regardless of whether the hospital facility began working on the CHNA in a prior taxable year (Treas. Reg. § 1.504(r)-3(a)(2) and (c)(5)(i)).		

Additional regulations not applicable to this hospital:

- Section 6: Exception for acquired, new, and terminated hospital facilities (Treas. Reg. § 1.501(r)-3(d))

ENDNOTES

[1] El Camino Hospital is the legal and funding entity for El Camino Health's community benefit program. The community benefit requirement applies to 501(c)(3) tax-exempt hospitals.

[2] https://www.elcaminohealth.org/about-us/community-benefit

[3] Census data in this and prior paragraphs from https://www.census.gov/quickfacts

[4] The Federal Poverty Level, the traditional measure of poverty in a community, does not take into consideration local conditions such as the high cost of living in the San Francisco Bay Area. The California Self-Sufficiency Standard provides a more accurate estimate of economic stability in both counties.

[5] Center for Women's Welfare, University of Washington. (2021). *Self-Sufficiency Standard Tool.* "Family" is considered as two adults, one infant and one school-age child. http://www.selfsufficiencystandard.org

[6] Redfin. (2021.) *Santa Clara County Housing Market*. Retrieved from https://www.redfin.com/county/345/CA/Santa-Clara-County/housing-market

[7] U.S. Census American Community Survey, 2015-2019.

[8] Alaban, L. (2021). Minimum wage goes up in South Bay -- with mixed reaction. *San Jose Spotlight*. Retrieved from https://sanjosespotlight.com/minimum-wage-in-san-jose-goes-up-splitting-business-and-economic-leaders/

[9] The Neighborhood Deprivation Index consists of 13 indicators and ranges from -3.5 to 3.5; scores above zero are considered worse. The U.S. is scored at 0.0, while Santa Clara County is scored at -0.8. For more information, see originators: Messer, L.C., Laraia, B.A., Kaufman, J.S., Eyster, J., Holzman, C., Culhane, J., Elo, I., Burke, J.G. & O'Campo, P. (2006). The development of a standardized neighborhood deprivation index. *Journal of Urban Health*, 83(6):1041-1062. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3261293/

[10] The Gini index "measures the extent to which the distribution of income… among individuals or households within an economy deviates from a perfectly equal distribution." Zero is absolute equality, while 100 is absolute inequality. Organisation for Economic Co-operation and Development (OECD). (2006). *Glossary of Statistical Terms*. Retrieved from https://stats.oecd.org/glossary/detail.asp?ID=4842

[11] The definition of a health need is a poor health outcome and its health driver, or a health driver associated with a poor health outcome that has not yet arisen as a need. Further definitions of terms and specific criteria for health needs identification may be found in El Camino Health's 2022 CHNA report.

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[15] California Dept. of Education, Staff Assignment and Course Data (Jan. 2020) & DataQuest (Mar. 2019).

[16] California Dept. of Public Health, California EpiCenter. 2015.

[17] Center for Medicare and Medicaid Services, National Provider Identification. (2020).

[18] National Center for Health Statistics - Mortality Files. 2017-2019.

[19] California Dept. of Public Health, California EpiCenter. 2015.

[20] County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2017-2019.

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[23] California Dept. of Justice, Crime Statistics: Arrests; California Dept. of Finance, Population Estimates and Projections. 2018.

[24] Valley Medical Center's Barbara Arons Pavilion provides 60 acute inpatient psychiatric beds; however, its facility is "in poor condition [with]…serious design flaws." Santa Clara County is currently building a new facility to replace the Pavilion, slated to be completed in late 2023, with 42 beds for adults and 31 beds for children and teens. Forestieri, K. (2021). Santa Clara County unveils plans for a $233M psychiatric hospital serving kids and adults. *Palo Alto Online.* Retrieved from https://paloaltoonline.com/news/2021/02/27/santa-clara-county-unveils-plans-for-a-233m-psychiatric-hospital-serving-kids-and-adults

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[28] U.S. Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas. 2016.

[29] UCLA Center for Health Policy Research, California Health Interview Survey. 2018.

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[31] National Cancer Institute, Surveillance, Epidemiology, and End Results (SEER) Program Research Data (Nov. 2018); U.S. Cancer Statistics Working Group, U.S. Cancer Statistics Data Visualizations Tool (Jun. 2018).

[32] U.S. Centers for Medicare & Medicaid Services, Mapping Medicare Disparities Tool. 2018.

[33] County Health Status Profiles. California Department of Public Health, Center for Health Statistics and Informatics, Vital Statistics Branch. 2019.

[34] National Cancer Institute. (2020). *Cancer Disparities.* Retrieved from https://www.cancer.gov/about-cancer/understanding/disparities

[35] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030. (Undated). *Economic Stability.* Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability

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k. Approve FY25 Committee Goals as Reviewed and Recommended for Approval by the Governance Committee

El Camino Health

FY25 COMMITTEE GOALS

Compliance and Audit Committee

PURPOSE

The purpose of the Compliance and Audit Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its exercise of oversight of Corporate Compliance, Privacy, Internal Audits, Financial Audit, Enterprise Risk Management, and Cybersecurity. The Committee will accomplish this by monitoring the compliance policies, controls, and processes of the organization and the engagement, independence, and performance of the external financial auditor. The Committee assists the Board in oversight of any regulatory audit and in assuring the organizational integrity of ECH in a manner consistent with its mission and purpose.

STAFF: **Diane Wigglesworth**, Compliance/Privacy Officer (Executive Sponsor)

The Sr. Director, Corporate Compliance, shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team or outside consultants may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

GOALS	TIMELINE	METRICS
1. Review proposed modifications to the Conflict of Interest (COI) policy, disclosure form, and the recommended process of annual reviews.	Q1 FY25	Committee reviews and provides feedback to the Compliance Officer.
2. Participate in education regarding the 2024 revised FTC antitrust enforcement actions regarding proposed mergers and acquisitions or other compliance or regulatory issues around the ambulatory expansion of the health system.	Q2 FY25	Committee receives education and training regarding the changes and impact to organization.
3. Review ongoing progress on implementation of the 2027 Strategic Plan and provide feedback regarding any recommended compliance assessments.	Q3 FY25	Committee provides recommendations if compliance assessments are needed for any new strategies the organization may undertake.

SUBMITTED BY:

Chair: Jack Po, MD
Executive Sponsor: Diane Wigglesworth

El Camino Health

FY25 COMMITTEE GOALS AND PACING PLAN

Executive Compensation Committee

The purpose of the Executive Compensation Committee (the "Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee will advise the Board to meet all legal and regulatory requirements as it relates to executive compensation.

STAFF: **Deanna Dudley**, Chief Human Resources Officer (Executive Sponsor)

The CHRO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration and for developing and disseminating in a timely manner management's recommendations to the Committee and appropriate supporting information to facilitate the Committee's deliberations and exercise of its responsibilities. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

GOALS	TIMELINE	METRICS/PACING PLAN
1. Provide oversight and approvals for compensation-related decisions, including performance incentive goal-setting and plan design	**Q1** (-)	- Review and approve FY25 executive base salaries - Review and recommend FY24 Organizational Incentive Score - Review and approve FY24 individual incentive scores - Review and approve FY24 executive payout amounts
	Q2 (-)	- Process Review: Executive Performance Management - Process Review: Succession and Development Planning
	Q3 (-)	- Recommend FY26 ECC Committee goals - Receive update on ECH Q2 strategic plan - Review potential ECC policy changes - Process Review: Executive Goal Setting
	Q4 (-)	- Review and recommend proposed FY26 organizational incentive goals - Review and approve FY26 individual executive goals
2. Evaluate the effectiveness of the independent compensation consultant	**Q4** (-)	- Conduct annual evaluation of ECC consultant

SUBMITTED BY: **Chair**: Bob Miller | **Executive Sponsor**: Deanna Dudley

El Camino Health

FY2025 FINANCE COMMITTEE GOALS

PURPOSE:

The purpose of the Finance Committee (the "Committee") is to provide oversight, information sharing, and financial reviews related to budgeting, capital budgeting, long-range financial planning and forecasting, and monthly financial reporting for the El Camino Hospital (ECH) Hospital Board of Directors ("Board"). In carrying out its review, advisory, and oversight responsibilities, the Finance Committee shall remain flexible in order to best define financial strategies that react to changing conditions.

STAFF: **Carlos Bohorquez**, Chief Financial Officer (Executive Sponsor)

The CFO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair.

GOALS	TIMELINE	METRICS
1. Summary of Physician Financial Agreements	Q3	March 2025
2. Review Progress on Opportunities / Risks identified by Management for FY2025 and Managed Care Update	Q2, Q3	Progress on Opportunities / Risks (December 2024), Managed Care update (January 2025)
3. Review Strategy, Goals and Performance of ECHMN, Joint Ventures / Business Affiliates, Impact of Strategic Initiatives on Market Share and progress on Implementation of 2027 Strategic Plan	Q1	Overview & Financial Performance JVs / Business Affiliates (August 2024)
	Q2	Progress on 2027 Strategic Plan (December 2024), Foundation – Strategic Update (December 2024)
	Q3	Impact of Strategic Initiatives – Market Share Update (January 2025), ECHMN (January 2025), Hospital Community Benefits Program (March 2025),
	Q4	Progress on 2027 Strategic Plan (May 2025)
4. Fiscal Year End Performance Review	Q1	FYE 2024 Review of Operating, Financial and Balance Sheet Performance and KPIs (August 2024)

SUBMITTED BY: **Chair**: Don Watters | **Executive Sponsor**: Carlos Bohorquez, Chief Financial Officer

El Camino Health

PROPOSED FY25 COMMITTEE GOALS

COMMITTEE PURPOSE

The purpose of the Governance Committee (the "Committee") is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in matters related to governance, board development, board effectiveness, and board composition, *i.e.*, the nomination and appointment/reappointment process. The Governance Committee ensures the Board and Committees are function at the highest level of governance standards.

GOALS	ACTIONS/METRICS	STATUS
1. Enhance Board Composition, Development, and Effectiveness	- In conjunction with the ECHD Re-Appointment and Recruitment, provide a method for regular competency and skills assessment of the Board. - Organize education sessions on industry trends and best governance practices. - Maintain resource section on Boardvantage of pertinent conferences, resources, newsletters, and professional organizations. - Implement regular and comprehensive board and committee assessments. - Develop Board Action plan - based on assessment results. - Develop onboarding mentorship program pairing experienced and new Board/Committee members.	-
2. Review and Update Governance Documents and Policies	- Schedule regular reviews of Bylaws and policies. - Develop communication and/or training as necessary for policy updates.	-
3. Support Board Advisory Committee Alignment with Organizational Strategy and Goals	- Ensure regular review of Advisory Committee goals and charters. - Hold joint education sessions between Board, Advisory Committees, and organizational leadership to ensure alignment with organizational needs.	-
4. Promote ethical behavior and ensuring that the organization is acting in accordance with its values and principles.	- Monitor the frequency of Code of Conduct revision to ensure it remains current with the organization's culture and external factors - Monitor the annual acknowledgement of Conflict of Interest policy.	-

El Camino Health

FY2025 COMMITTEE GOALS
Investment Committee

PURPOSE

The purpose of the Investment Committee is to develop and recommend to the El Camino Hospital (ECH) Board of Directors ("Board") the investment policies governing the Hospital's assets, maintain current knowledge of the management and investment funds of the Hospital, and provide oversight of the allocation of the investment assets.

STAFF: Carlos Bohorquez, Chief Financial Officer (Executive Sponsor)

The CFO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional members of the Executive Team or hospital staff may participate in the meetings upon the recommendation of the CFO and at the discretion of the Committee Chair. The CEO is an ex-officio member of this Committee.

GOALS	TIMELINE	METRICS
1. Review performance Surplus Cash and Cash Balance Portfolios & Recommendations of Adjustments to Managers / Allocations	Each Quarter	Committee review / approval of recommendations by management / consultant (if needed)
2. Implementation of Updated Investment Policy	FY2025 Q1-Q4	August 2024 – May 2025: Alternative Investments
3. Review 403(b) Performance	FY2025 Q2	December 2024
4. Enterprise Risk Management Update	FY2024 Q3	February 2025
5. Investment Policy Review	FY2025 Q4	May 2025: Committee approval of updated policy (if needed)
6. Education Topics - <TOPICS TBD>	FY2025: Q2 & Q4	December 2024: TBD; May 2025: TBD

SUBMITTED BY:
Chair: Brooks Nelson
Executive Sponsor: Carlos Bohorquez, CFO

El Camino Health

FY25 COMMITTEE GOALS

Quality, Patient Care, and Patient Experience Committee

PURPOSE

The purpose of the Quality, Patient Care, and Patient Experience Committee ("Quality Committee" or the "Committee") is to advise and assist the El Camino Hospital Board of Directors ("Board") to monitor and support the quality and safety of care provided at El Camino Health ("ECH"). The Committee will utilize the Institute of Medicine's framework for measuring and improving quality care in these five domains: **s**afe, **t**imely, **e**ffective, **e**fficient, **e**quitable, and **p**erson-centered (STEEEP).

STAFF: Chief Quality Officer (Executive Sponsor)

The CQO and Senior Director of Quality shall serve as the primary staff to support the Committee and are responsible for drafting the Committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Ensure the metrics included on the Quality Committee dashboards are in alignment with the El Camino Hospital Board strategic plan.	Q4FY24 review and update which measures to include on the FY25 Quality Dashboards.	Quality and experience performance measures aligned with the STEEEP domains of; safe, timely, effective, efficient, equitable, and person-centered.
2. Monitor Quality, Patient Care, and Patient Experience performance in accordance with the pacing plan to track progress towards achieving targets.	Q4FY24 review FY25 Incentive Goal recommendations for Quality, Safety, and Patient Experience pillars.	Performance measures on the Quality Dashboards. ▪ Monthly Quality Dashboard ▪ Quarterly Board Level Quality Dashboard
3. Identify and reduce health care disparities for ECH patients.	Biannual report to Quality Committee FY25.	Monitor the effectiveness of ECH activities to reduce healthcare disparities through review of the biannual "health equity report".
4. Foster a culture of collaboration, transparency, and continuous improvement within the Quality Committee.	Fiscal Year 2025	• Attend a minimum of 6 meetings in person. • Actively participate in discussions at each meeting. • Review of annual committee self-assessment results as facilitated by the Director of Governance.
5. Committee members participate in ongoing training and development to deepen their knowledge of quality, patient care, and patient experience topics.	Fiscal Year 2025	Attend a conference and/or session with a subject matter expert. • Verbal/Written report of key learnings to the Quality Committee.

Chair: Carol Somersille, MD
Executive Sponsor: Chief Quality Officer

I. Approve FY25 Committee Pacing Plans as Reviewed and Recommended for Approval by the Governance Committee

El Camino Health

Compliance and Audit Committee
FY24 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	MAY		JUN
STANDING AGENDA ITEMS												
Results of Internal Audits			✓		✓			✓		✓		✓
Cybersecurity Program					✓			✓				✓
Enterprise Risk Management Metrics					✓					✓		
Discussion Items/Committee Actions												
Review FY 23 Annual Enterprise Compliance Program Report			✓									
Review FY 23 Annual Patient Safety/Claims Report			✓									
Review next FY Enterprise Compliance Work Plan												✓
Review Status of Current FY Compliance Work Plan Activity Completed												✓
Receive FY 23 Financial Auditors Consolidated Financial Statements, 403(b) and Cash Balance Audit results			✓									
Review Management's Summary Report of Physician Financial Agreements								✓				
Approve next FY Committee Goals and Meeting Dates										✓		
Review FY 24 Annual Financial Audit Plan with Financial Auditors								✓				
Review OIG Work Plan and Management's Response								✓				
Review Internal Audit Risk Assessment and next FY Internal Audit Work Plan										✓		
COMMITTEE GOALS												
Review revised ERM Metrics based on feedback from Hospital Board or new areas of strategic focus					✓							
Review Vision 2027 Strategic Plans					✓							
Review process and timeline for succession plan for Compliance/ Privacy Officer Role								✓		✓		

El Camino Health

FY25 COMMITTEE GOALS AND PACING PLAN

Executive Compensation Committee

The purpose of the Executive Compensation Committee (the "Committee") is to assist the El Camino Hospital (ECH) Hospital Board of Directors ("Board") in its responsibilities related to the Hospital's executive compensation philosophy and policies. The Committee will advise the Board to meet all legal and regulatory requirements as it relates to executive compensation.

STAFF: **Deanna Dudley**, Chief Human Resources Officer (Executive Sponsor)

The CHRO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair's consideration and for developing and disseminating in a timely manner management's recommendations to the Committee and appropriate supporting information to facilitate the Committee's deliberations and exercise of its responsibilities. The CEO, and other staff members as appropriate, may serve as a non-voting liaison to the Committee and may participate at the discretion of the Committee Chair. These individuals shall be recused when the Committee is reviewing their individual compensation.

GOALS	TIMELINE	METRICS/PACING PLAN
1. Provide oversight and approvals for compensation-related decisions, including performance incentive goal-setting and plan design	**Q1** (-)	- Review and approve FY25 executive base salaries - Review and recommend FY24 Organizational Incentive Score - Review and approve FY24 individual incentive scores - Review and approve FY24 executive payout amounts
	Q2 (-)	- Process Review: Executive Performance Management - Process Review: Succession and Development Planning
	Q3 (-)	- Recommend FY26 ECC Committee goals - Receive update on ECH Q2 strategic plan - Review potential ECC policy changes - Process Review: Executive Goal Setting
	Q4 (-)	- Review and recommend proposed FY26 organizational incentive goals - Review and approve FY26 individual executive goals
2. Evaluate the effectiveness of the independent compensation consultant	**Q4** (-)	- Conduct annual evaluation of ECC consultant

SUBMITTED BY: **Chair**: Bob Miller | **Executive Sponsor**: Deanna Dudley

El Camino Health

FY2025 Finance Committee Pacing Plan												
AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/26	SEPT	10/14	NOV	12/5	1/27	2/24	3/31	APR	5/26	JUN
STANDING AGENDA ITEMS												
Standing Consent Agenda Items		✓		✓		✓	✓		✓		✓	
Minutes		✓		✓		✓	✓		✓		✓	
Period Financials Report (Approval)		✓		✓		✓	✓		✓		✓	
Board Actions		✓		✓		✓	✓		✓		✓	
APPROVAL ITEMS												
Candidate Interviews & Recommendation to Appoint (If required to add/replace committee member)												
Financial Report Year-End Results		✓										
Next FY Committee Goals, Dates, Plan									✓		✓	
Next FY Org. Goals											✓	
Next FY Community Benefit Grant Program											✓	
Physician Contracts		✓		✓		✓	✓		✓		✓	
DISCUSSION ITEMS												
Financial Report (Pre-Audit Year-End Results)		✓										
Financial Performance JVs/ Business Affiliates		✓										
Progress on Opportunities/ Risks						✓						
Medical Staff Development Plan (every 2 years)									✓			
Impact of Strategic Initiatives/Market Share Update							✓					

El Camino Health

FY2025 Finance Committee Pacing Plan													
AGENDA ITEM	Q1			Q2			Q3			Q4			
	JUL	8/26	SEPT	10/14	NOV	12/5	1/27	2/24	3/31	APR	5/26	JUN	
Progress Against Committee Goals & Pacing Plan (Quarterly)						✓			✓		✓		
Foundation Strategic Update						✓							
ECHMN Update							✓		✓				
Community Benefit Grant Application Process						✓			✓				
Progress Against 2027 Strategic Plan						✓					✓		
Managed Care Update							✓						
Long-Range Financial Forecast (Joint FC / IC Meeting)								✓					
Next FY Budget and Preliminary Assumptions Review									✓				
Review FY Operational / Capital Budget for Recommendation to Board									✓		✓		
Summary Physician Financial Arrangements									✓				
Post Implementation (as needed)													
Other Updates[1] (as needed)													

1. Includes updates on special projects/joint ventures/real estate, ad-hoc updates

El Camino Health

Proposed FY25 Governance Committee Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
Minutes			✓			✓			✓			✓
Review Progress Against Goals			✓			✓			✓			✓
Board Action Plan Development			✓									
ECHD Reappointment Support			✓									
Board/Committee Onboarding Plan			✓									
ECHB Policy Review						✓						
Board Education						✓						
Board Assessment Plan Overview									✓			
Plan for Joint Education Session									✓			
Develop next FY GC Goals									✓			
Review Advisory Committees Next FY Goals												✓
Review Advisory Committee and Committee Chair Assignments												✓
Finalize Next FY Master Calendar												✓

El Camino Health

FY2025 Investment Committee Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	8/12	SEP	OCT	NOV	12/9	2/10	2/24	MAR	APR	5/12	JUN
STANDING AGENDA ITEMS												
Standing Consent Agenda Items		✓				✓	✓				✓	
Minutes		✓				✓	✓				✓	
CFO Report Out		✓				✓	✓				✓	
APPROVAL ITEMS												
Next FY Committee Goals, Dates, Plan							✓				✓	
Next FY Org. Goals											✓	
Progress Against Committee Goals						✓	✓				✓	
Review/Approval of Updated Investment Policy											✓	
DISCUSSION ITEMS												
Capital Markets Review & Portfolio Performance		✓				✓	✓				✓	
Tactical Asset Allocation Positioning & Market Outlook		✓				✓	✓				✓	
Long-Range Financial Forecast								✓				
Asset Allocation & Enterprise Risk Framework							✓					
403(b) Investment Performance						✓						
Education Topic: Topics TBD						✓					✓	

Quality, Patient Care, and Patient Experience Committee
FY25 Pacing Plan

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
STANDING AGENDA ITEMS												
Consent Calendar[1]		✓	✓		✓	✓		✓	✓		✓	✓
Verbal Committee Member Expertise Sharing or Chair's Report		✓	✓		✓	✓		✓	✓		✓	✓
Patient Experience Story		✓	✓		✓	✓		✓	✓		✓	✓
Serious Safety/Red Alert Event (as needed)		✓	✓		✓	✓		✓	✓		✓	✓
Recommend Credentialing and Privileges Report		✓	✓		✓	✓		✓	✓		✓	✓
Quality Council Minutes		✓	✓		✓	✓		✓	✓		✓	✓
SPECIAL AGENDA ITEMS – OTHER REPORTS												
Quality & Safety Review of reportable events		✓			✓			✓			✓	
Quarterly Board Level Quality/ Experience Dashboard Review		✓			✓			✓			✓	
El Camino Health Medical Network Report		✓			✓			✓			✓	
Committee Self-Assessment Results Review												✓
Annual Patient Safety Report			✓									
Annual Culture of Safety Survey Report			✓									
Patient Experience Report			✓						✓			
Health Equity Report						✓						✓
Recommend Safety Report for the Environment of Care					✓							
PSI Report						✓						
Value-Based Purchasing Report									✓			
Recommend Quality Assessment & Performance Improvement Plan (QAPI)					✓							
Refresh Quality/Experience Dashboard measures for FY26												✓
Artificial Intelligence Report						✓						
COMMITTEE/ORGANIZATIONAL GOALS/CALENDAR												
Propose Committee Goals									✓			
Recommend Committee Goals											✓	
Propose FY Committee Meeting dates									✓			
Recommend FY Committee Meeting dates											✓	
Propose Organization Goals									✓			
Recommend Organization Goals											✓	
Propose Pacing Plan									✓			
Recommend Pacing Plan											✓	
Review & Revise Charter									✓			
Recommend Charter											✓	

1: Includes Approval of Minutes (Open & Closed), Current FY Monthly Quality/Experience Dashboard, Progress Against FY Committee Goals (Quarterly), Current FY Pacing Plan (Quarterly), CDI Dashboard (November), Core Measures (Semi-Annual), Leapfrog (June)

o. Approve QAPI as Reviewed and Recommended for Approval by the Quality Committee

Status Draft PolicyStat ID 15949052

Origination	05/2018
Last Approved	N/A
Effective	N/A
Last Revised	N/A
Next Review	N/A

Owner	Michael Coston: Director Quality and Public Reporting
Area	Quality
Document Types	Plan

Quality Improvement & Patient Safety Plan (QIPS)

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

ORGANIZATION OVERVIEW

El Camino Hospital (ECH), doing business as El Camino Health, is a comprehensive health care institution that includes two hospital campuses; a 275-bed acute hospital with 36 acute psychiatric beds headquartered in Mountain View (MV), California and a 143-bed acute hospital in Los Gatos (LG), California. Both campuses have associated outpatient services and clinics. ECH in Mountain View has achieved Joint Commission certification as a Thrombectomy-capable Stroke Center, in Joint Replacement for Hip and Knee, Hip Fracture, for Sepsis and Patient Blood Management. The Los Gatos campus has been certified as a Primary Stroke Center, in Joint Replacement for Hip and Knee, Spinal Fusion and as a "baby friendly hospital" by WHO/ UNICEF.

The ECH Medical Staff includes 1100 active, telemedicine, provisional and consultant, 328 affiliate physicians, and 116 independent practitioners with representation covering nearly every clinical specialty (e.g., Anesthesiology, Cardiology, Emergency, Gastrointestinal, Family Practice, Neonatology, Obstetrics, Gynecology, Pediatrics, Pulmonary Medicine, Radiology, Ophthalmology, Orthopedics, Neurology, Endocrinology, Urology, General Surgery, Cardiovascular Surgery, Pediatrics, Pathology, Internal Medicine, and Neurosurgery. Performance Improvement activities are selected and prioritized based on the hospital's scope of service.

El CAMINO HEALTH MISSION

Our Mission is to heal, relieve suffering and advance wellness as your publicly accountable health partner.

El CAMINO HEALTH VISION

To provide consumers in the South Bay with a high quality, locally-oriented health system, across the full care continuum.

El CAMINO HOSPITAL VALUES

Quality: We pursue excellence to deliver evidence-based care in partnership with our patients and families.

Compassion: We care for each individual uniquely with kindness, respect and empathy.

Community: We partner with local organizations, volunteers and philanthropic community to provide healthcare services across all stages of life.

Collaboration: We partner for the best interests for our patients, their families and our community using a team approach.

Stewardship: We carefully manage our resources to sustain, grow and enable services that meet the health needs of our community.

Innovation: We embrace solutions and forward thinking approaches that lead to better health.

Accountability: We take responsibility for the impact of our actions has on the community and each other.

DEFINITIONS:

El Camino Hospital has adopted the Institute of Medicine's (IOM) Quality Framework – STEEEP – as its definition of quality. These six aims for a healthcare system comprise ECH's approach to quality:

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Efficient:** Avoiding wastes, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

SERVICES/PROGRAMS

ECH provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:	**Emergency Services**	**Outpatient Services**
Acute Rehabilitation	Basic Emergency	Advanced Care & Diagnostics Center
Cardiac Catheterization		Behavioral Services – Outpatient

Services		
Cardiovascular Surgery		Cancer Center
Intensive & Critical Care Unit		Cardio Pulmonary Wellness Center
Labor and Delivery (L&D)		Endoscopy
Medical/Surgical/Ortho		Infusion Services
Mental Health and Addiction Services (Inpatient Psychiatry)		Interventional Services
Mother/Baby		Occupational Therapy/Physical Therapy
Level II and Level III Neonatal Intensive Care Unit (NICU)		Outpatient Surgical Units
Operating Room (OR)		Pre-admission Service/ Pre-op/ Short Stay Unit (2B)
Ortho Pavilion		Radiation Oncology
Pediatrics		Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI, Breast Health Center, Mobile Imaging)
Post-Anesthesia Care Unit (PACU)		Rehabilitation
Progressive Care Unit (PCU) (Step-down)		Speech Therapy
Telemetry/Stroke		Wound Care Clinic

Section I Quality Improvement Plan

PURPOSE

The Quality Improvement Plan, as equivalent to CMS' Quality Assessment Performance Improvement (QAPI), describes the multidisciplinary, systematic quality improvement framework utilized by El Camino Hospital (ECH) to improve patient outcomes and reduce the risks associated with healthcare in a manner that embraces the mission of ECH.

OBJECTIVES

1. Provide safe, effective, patient centered, timely, efficient, and equitable care (STEEEP).
2. Establish and maintain an ongoing, comprehensive and objective mechanism to improve performance, clinical outcomes, and patient safety based on the complexity of the ECH's services/ programs.
3. Identify known, suspected or potential problems or hazards in patient care delivery, as well as opportunities for further improvement in currently acceptable care.
4. Establish priorities/goals for the investigation and resolution of concerns and problems by focusing on those with the greatest potential impact on patient care outcome, patient safety, and patient satisfaction.
5. Define corrective action and document resolution of known and potential problems and evidence of patient care improvement.

6. Communicate performance activities and findings to all pertinent Hospital and Administrative Staff, Medical Staff, and the Governing Board, as appropriate.
7. Identify continuing education needs of clinical, administrative, and support personnel relative to Quality and Patient Safety.
8. Coordinate Performance Improvement activities and findings with those of the facility's Management of the Environment, Surveillance, Prevention and Control of Infection, Information Management, Management of Human Resources, Ethics/Rights/Responsibilities, Provision of Care, Medication Management, and Leadership functions to the extent possible.
9. Monitor and comply with policies, standards, regulations and laws set by the Governing Board, Medical Staff, The Joint Commission, State and Federal governments and other regulating or accrediting bodies.
10. Enhance uniform performance of patient care processes throughout the organization, reducing variability.
11. Provide a mechanism for integration of quality improvement activities throughout the hospital for colleagues, medical staff, leadership, volunteers and governance.
12. Respond to external hospital environment or community needs in regards of providing equitable care and positive quality outcomes.

ACCOUNTABILITY FOR QUALITY, PERFORMANCE IMPROVEMENT

Governing Board

As described in the Governing Board Rules and Regulations, the Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Governing Board shall ensure an ongoing, comprehensive and objective mechanism is in place to monitor and evaluate performance, to identify and resolve documented or potential problems/hazards, and to identify further opportunities to improve patient care and safety. As appropriate, the Board shall delegate responsibility and oversight for implementing the Quality Improvement, Patient Safety, and Patient Experience Plan to the hospital administration, medical staff, and its respective governance committees. Refer to Attachment A on Governance Information Flow.

The Governing Board shall require, consider, and if necessary, act upon Medical Staff reports of medical care evaluation, utilization review, and other matters relating to the quality of care rendered in the Hospital. The executive committee of the Medical Staff shall, through its chairman or designee, is responsible for the preparation and presentation of such required reports to the Governing Board at each Governing Board meeting or otherwise.

The Governing Board shall direct that all reasonable and necessary steps be taken by the Medical Staff and Hospital Administration for meeting The Joint Commission and College of American Pathology accreditation standards, California Code of Regulations including Title 22, CMS Conditions of Participation and complying with applicable laws and regulations.

Other specific responsibilities with regard to quality improvement, patient safety, and risk management are delineated in the Governing Board Rules and Regulations, which shall be reviewed and approved by the

Governing Board.

Medical Executive Committee (MEC)

According to the Bylaws of the Medical Staff, under Article 11.5, the Medical Executive Committee is responsible for the quality and effectiveness of patient care and competent clinical performance rendered by members of the Medical Staff and for the medico-administrative obligations of the medical staff.

The functions of the MEC with respect to quality include, but are not limited, to the following:

1. Fulfill the Medical Staff's responsibility of accountability to the Governing Board for medical care rendered to patients in the hospital;
2. Reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members and make recommendations to the governing board regarding appointments/reappointments, clinical privileges, and corrective action; and
3. Assisting in obtaining and maintenance of accreditation.

Medical Staff Departments and Divisions

The unified El Camino Medical Staff is comprised of three Enterprise departments which are those with constituency at both campuses (including MV & LG). All departments report to an Enterprise Medical Staff Executive Committee. The current departments are; (a complete list of all subspecialties in each department is available from the Medical Staff Office.)

- Medicine to include Radiology, Emergency Medicine, Hospitalists, Psychiatry, Neurology, and Family Medicine
- Surgery to include Pathology, Anesthesia, Orthopedics, Gynecologic Oncology, Otolaryngology, Ophthalmology, Plastic Surgery, Neurosurgery, General Surgery, Urology, Cardio-thoracic surgery, and Vascular Surgery
- Maternal Child Health to include Obstetrics/Gynecology, Pediatrics and Neonatology

Each of these three departments has monthly meetings of their Executive Committees where ongoing quality improvement projects are initiated and progress reported routinely to the Quality Council.

Other specific responsibilities with regard to quality improvement are delineated in the Medical Staff Bylaws. Refer to the Medical Staff Peer Review Policy for specific departmental responsibilities regarding ongoing professional practice evaluation and focused professional practice evaluation. See Appendix A for a graphic depiction of the flow of quality information through committees and to the governing board.

Leadership and Support

The hospital and medical staff leaders have the responsibility to create an environment that promotes quality improvement through the safe delivery of patient care, quality outcomes and high customer satisfaction. The leaders promote a patient safety culture of internal and external transparency, and support the hospital's patient safety program, which seeks to create a culture that values safety, disclosure of errors, and provides for a non-punitive process. The leaders perform the following key functions:

1. Adopt an approach to quality improvement, set expectations, plan, and manage processes to measure, assess, and improve the hospital's governance, management, clinical, and support

activities

2. Ensure that new or modified services or processes are designed well, measured, assessed, and improved systematically throughout the organization
3. Establish priorities for quality improvement and safety giving priority to high-volume, high-risk, or problem- prone processes for performance improvement activities and reprioritize these activities in response to changes in the internal and external environment
4. Participate in interdisciplinary and interdepartmental quality and safety improvement activities in collaboration with the medical staff
5. Allocate adequate resources (i.e. staff, time, and information systems) for measuring, assessing, and improving the hospital's quality performance and improving patient safety; and assess the adequacy of resources allocated to support these improvement activities
6. Assure that staff are trained in quality and safety improvement approaches and methods and receive education that focuses on safety, quality, and high reliability
7. Continuously measure and assess the effectiveness of quality and safety improvement activities, implement improvements for these activities, and ensure sustainability of improvements made
8. Reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities

Medical Staff, Employees, and Contracted Services

Medical staff members, hospital employees and contracted services employees maintain active participation and involvement in organization-wide quality and patient safety initiatives and activities to include participating in identifying opportunities for improvement and data collection efforts, serving on multidisciplinary teams, reporting adverse events, and implementing actions to sustain improvements.

Enterprise Quality Council

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that provides to the Medical Executive Committee and Quality Committee of the Board reports on the quality of medical care provided to patients at ECH by all departments, service lines and medical staff departments. It is chaired by the past chief of staff, their designee, and the Chief Quality Officer. Each department and service line provide at least an annual report including data on key process indicators to the Quality Council. This report also includes an annual assessment for all direct clinical care contracts administered by the department or service line. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly. The Council also serves as the Steering Committee for the Organizational Quality Goal, which for FY 2023 is reduction of the Hospital Acquired Conditions (HAC) Index, and receives a monthly report on the progress of the Quality Teams that work to address this goal. The Council may charter performance improvement teams to address multidisciplinary issues, hospital-wide process and system issues. The Quality Council also receives routine reports on the quality improvement activities of each medical staff department. See Attachment B: FY 23 Quality Council report schedule.

Quality Services Department

A responsibility of the Quality Services Department is to coordinate and facilitate quality management and

improvement throughout the hospital. While implementation and evaluation of quality improvement activities resides in each clinical department, the Quality Department staff serves as internal resources for the development and evaluation of quality improvement activities. Members of this department provide leadership of and participation in several multidisciplinary teams including, but not limited to; the teams addressing the organizational quality, i.e. ERAS (Enhanced Recovery After Surgery) Team and the NV-HAP (non-ventilator hospital-acquired pneumonia) Team. The Quality Services Department also serves as a resource for data collection, statistical analysis, and reporting functions.

The Quality Services Department is also responsible for:

1. Managing the overall flow, presentation, and summarization of quality improvement activities from all departments/service lines
2. Produces and maintains two quality dashboards for the organization and the board of directors: Enterprise Quality, Safety, and Experience Dashboard, and Quarterly Board Quality Dashboard (STEEEP). See Attachments C and D.
3. Assisting hospital leaders and the medical staff in maintaining accreditations and compliance with regulatory requirements
4. Providing clinical and provider data from hospital and external registry data bases as needed for quality improvement (See Attachment E for Data Registries in use)
5. Maintaining a quality improvement and patient safety reporting calendar and communicating it to all groups responsible for quality improvement activities
6. Collaborates with the Risk Management and Patient Safety department on efforts to manage and reduce risk through Root Cause, Apparent Cause and Common Cause Analyses as responses to adverse events and near misses and events reported to regulatory agencies
7. Collaborates on performance of failure mode and effectiveness analysis (FMEA) at least every 18 months with Risk Management and Patient Safety
8. Collaborates with the Medical Staff leaders to ensure effective use of resources through the identification and sharing of "best practices"
9. Supporting Infection Prevention efforts across the Enterprise, coordination with public health, on-going infection surveillance and reporting of hospital –acquired infections and conditions
10. Managing data collection and reporting as required by regulatory agencies and the hospital's strategic plan
11. Providing data as requested to external organizations, see data provided in Attachment F
12. Providing oversight for the hospital's participation in Clinical Registries, see Appendix E for current list
13. Manages the data and reporting process for meeting the IQR CMS reporting requirements for Core Measures and eCQM measures, the MBSAQIP, and all Transfusion review and data
14. Facilitates and maintains hospital and program-specific accreditation through the Joint Commission and works closely with the California Department of Public Health (CDPH) to improve the quality of care and safety of care provided to our patients.
15. Facilitates identification of health care disparities in the patient population by stratifying quality and safety data

Hospital Services

All ECH departments and service lines participate in the Quality Improvement Plan by establishing mechanisms that continuously and systematically evaluate the quality of specific service care processes and outcomes. Service directors and managers annually review and identify their expected quality and performance improvement efforts based on the findings of their measurement activities. Each clinical and non-clinical service is responsible for and supporting ECH completion of at least one (1) quality and performance improvement project annually that improves patient care, safety, and/or experience and demonstrates cost efficiency.

All clinical contracted services will be reviewed, evaluated, and will demonstrate a quality and performance improvement summary/assessment on an annual basis and presented to the Enterprise Quality Council.

IMPROVING ORGANIZATIONAL PERFORMANCE

Improving performance, clinical outcomes, and Patient Safety is systematic and involves a collaborative approach focused on patient and organizational functions. Quality improvement is a continuous process which involves measuring the functioning of important processes and services, and when indicated, identifying changes that enhance performance. These changes are incorporated into new or existing work processes, products or services, and performance is monitored to ensure that the improvements are sustained. Quality improvement focuses on outcomes of treatment, care, and services. Senior Leaders, Directors and Managers establish a planned, systematic, and hospital-wide approach(es) to quality improvement. These leaders set priorities for improvement and ensure that the disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities.

Priorities are based on the organization's mission, vision and values, services provided, and populations served. Prioritization of performance improvement initiatives is based upon the following criteria:

1. Serious Safety Events (SSE) and severity of adverse events and trends of events reported in the electronic adverse event reporting system
2. Results of quality improvement, patient safety and risk reduction activities
3. Information from within the organization and from other organizations about potential/actual risks to patients. (e.g., Institute for Safe Medication Practices (ISMP), California Department of Public Health (CDPH), The Joint Commission Sentinel Event Alerts)
4. Accreditation and/or regulatory requirement(s) of The Joint Commission, Title 22 (California Code of Regulations) and CMS Conditions of Participation.
5. Low volume, high risk processes and procedures
6. Meeting the needs of the patients, staff and others
7. Resources required and/or available
8. External regulatory compliance indicators, i.e. CMS Core measures, etc. See Appendix G.
9. Response to changes not only in the internal, but also in the external environment or the community it serves

Performance Processes

1. **Design**
   The design of processes is in conjunction with the organization's Strategic goals and is based on up-to-date sources of information and performance of these processes; their outcomes are evaluated on a regular basis. Design of new processes, extension of product lines, or significant change to existing functions or processes consider basic information sources. These activities are carried out collaboratively and include the appropriate departments and disciplines involved.

2. **Measurement**
   ECH collects measurement data on important processes and outcomes that have been prioritized and selected by leaders as part of the planning process. With input from senior leaders, the Governing Board sets organizational goals for quality, service and finance. The data collected for priority and required areas is used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and to sustain improvement. All levels of the organization are responsible for reviewing measurable outcomes and acting on improvement opportunities.
   Performance measures are structured to follow The Joint Commission dimensions of performance and are based on current evidenced-based information and clinical experience. Processes, functions, or services are designed/ redesigned well and are consistent with sound business practices. They are:
   a. Consistent with the organization's mission, vision, goals, objectives, and plans;
   b. Meeting the needs of individuals served, staff and others;
   c. Clinically sound and current;
   d. Incorporating information from within the organization and from other organizations about potential/ actual risks to patients;
   e. Analyzed and pilot tested to determine that the proposed design/redesign is an improvement;
   f. Incorporated into the results of performance improvement activities.
   g. Relevant quality outcomes data from public/regulatory quality reporting and quality performance programs
      Data collection includes process, outcome, and control measures including improvement initiatives. Data is collected and reported to appropriate committees in accordance with established reporting schedules. The processes measured on an ongoing basis are based on our mission, scope of care and service provided accreditation and licensure requirements, and priorities established by leadership. Data collection is systematic and is used to:
      a. Establish a performance baseline;
      b. Describe process performance or stability;
      c. Describe the dimensions of performance relevant to functions, processes, and outcomes;
      d. Identify areas for more focused data collection to achieve and sustain improvement.

3. **Analysis**
   Data shall be analyzed on an ongoing basis to identify performance improvement opportunities.

Statistical Quality Control Techniques shall be used as appropriate. The assessment process compares data over time, reflects evidenced-based best practices and to reference databases, both internal and external to the hospital system.
a. When findings relevant to provider's performance are identified, this information is referred to the medical staff's peer review process in accordance with the Medical Staff Peer Review Policy. Department Directors shall act in accordance with Human Resources policies regarding employee performance.
b. ECH analyzes undesirable patterns or trends in performance when the following are identified, which includes, but is not limited to:

a. Performance varies significantly and undesirably from that of other organizations;
b. Performance varies significantly and undesirably from recognized standards;
c. When a sentinel event occurs;
d. Blood Utilization to include confirmed transfusion reactions;
e. Other types of safety events identified in the Safety Event Management and Cause Analysis procedure;

Improvement Model and Methodology

MODEL FOR IMPROVEMENT: This is a simple yet powerful tool designed to accelerate improvement efforts and provide better focus on what it is we are trying to improve. The model is promoted by the Institute of Healthcare Improvement as a proven improvement model, and builds on theory developed by Juran and W. Edward Deming.

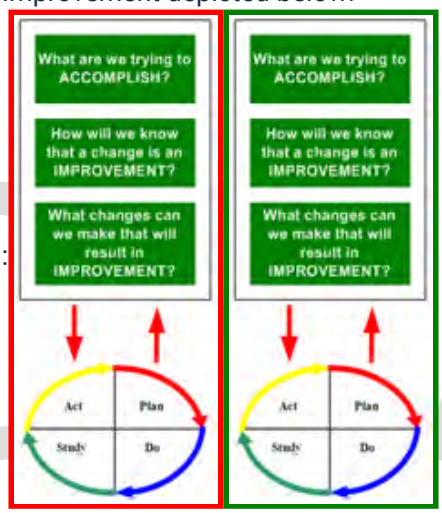
Once a decision has been made to implement an improvement strategy, the organization systematically improves its performance using the Model for Improvement. Multidisciplinary Performance Improvement (PI) Teams are commissioned and use the Model for Improvement to make improvements in a specific process. Unit based PI Teams and other The Plan-Do-Study-Act (PDSA) Teams are utilized and can form on their own to address unit or department specific needs. Decisions to act upon opportunities for improvement in care or patient safety and/or investigate concerns shall be based on opportunities identified, factors involved in measurement, required resources, and the overall mission and priorities for the organization.

The model has two parts:

1. ***Three fundamental questions, which can be addressed in any order.***
    - What are we trying to accomplish?
    - How will we know that a change is an improvement?
    - What changes can we make that will result in improvement?
      This model stresses learning by testing changes on a small scale rather than by studying problems before any changes are attempted. Testing a change is not always easy. There may be unwanted side effects. The (PDSA) Cycle provides an effective framework for developing tests and implementing changes as described next.

2. ***The Plan-Do-Study-Act (PDSA) Cycle***
   The PDSA (Plan, Do, Study, Act) is a framework for an efficient trial-and-learning methodology. The cycle begins with a plan and ends with action based on the learning gained from the Plan, Do, and Study phases of the cycle. The purpose of this cycle is to test and implement changes, by planning it, trying it, observing the results, and acting on what is learned.

Step 1: Plan
Plan the test or observation, including a plan for collecting data. What is the objective of this improvement cycle?
Step 2: Do
Try out the test on a small scale. What did we observe that was not a part of our plan?
Step 3: Study
Set aside time to analyze the data and study the results. Complete the analysis of the data. Compare the data to your predictions. How did or didn't the results of this cycle agree with the predictions that we made earlier?
Summarize and reflect on what was learned.
Step 4: Act
Refine the change, based on what was learned from the test. Determine what modifications should be made. List actions we will take as a result of this cycle. Prepare a plan for the next cycle, if necessary. The cycle is ongoing and continuous.
In summary, combined, the three questions and the PDSA cycle form the basis of the Model for Improvement depicted below:



3. ***Goal Setting and Auditing Methodology***

- S.M.A.R.T. Goals: All goals should utilize the S.M.A.R.T. goal methodology so the goals can be part of every aspect of our organization and provide a sense of direction, motivation, a clear focus, and clarify importance. By setting goals for yourself, you are providing yourself with a target to aim for. A SMART goal is used to help guide goal setting. SMART is an acronym that stands for Specific, Measurable, Achievable, Realistic, and Timely. Therefore, a SMART goal incorporates all of these criteria to help focus your efforts and increase the chances of achieving that goal.
  The acronym stands for:
  S – Specific
  When setting a goal, be specific about what you want to accomplish. Think about this as the mission statement for your goal. This isn't a detailed list of how you're going to meet a goal, but it should include an answer to the popular 'w' questions:
  Who – Consider who needs to be involved to achieve the goal (this is especially important when you're working on a group project).
  What – Think about exactly what you are trying to accomplish and don't be afraid to get very detailed.
  When – You'll get more specific about this question under the "time-bound" section of

defining S.M.A.R.T. goals, but you should at least set a time frame.
Where – This question may not always apply, especially if you're setting personal goals, but if there's a location or relevant event, identify it here.
Which – Determine any related obstacles or requirements. This question can be beneficial in deciding if your goal is realistic. For example, if the goal is to open a baking business, but you've never baked anything before, that might be an issue. As a result, you may refine the specifics of the goal to be "Learn how to bake in order to open a baking business."
Why – What is the reason for the goal? When it comes to using this method for employees, the answer will likely be along the lines of company advancement or career development.

M – Measurable

What metrics are you going to use to determine if you meet the goal? This makes a goal more tangible because it provides a way to measure progress. If it's a project that's going to take a few months to complete, then set some milestones by considering specific tasks to accomplish.

A – Achievable

This focuses on how important a goal is to you and what you can do to make it attainable and may require developing new skills and changing attitudes. The goal is meant to inspire motivation, not discouragement. Think about how to accomplish the goal and if you have the tools/skills needed. If you don't currently possess those tools/skills, consider what it would take to attain them.

R – Relevant

Relevance refers to focusing on something that makes sense with the broader business goals. For example, if the goal is to launch a new product, it should be something that's in alignment with the overall business objectives. Your team may be able to launch a new consumer product, but if your company is a B2B that is not expanding into the consumer market, then the goal wouldn't be relevant.

T – Time-Bound

Anyone can set goals, but if it lacks realistic timing, chances are you're not going to succeed. Providing a target date for deliverables is imperative. Ask specific questions about the goal deadline and what can be accomplished within that time period. If the goal will take three months to complete, it's useful to define what should be achieved half-way through the process. Providing time constraints also creates a sense of urgency.

- Auditing Methodology is to ensure the process change has been hardwired and will be able to sustain the change needed for the focused improvement. This methodology will allow for a sample size to ensure the auditing has encompassed the correct % of needed audit to be statically valid.
  Measure of Success (MOS) auditing process has specified the following minimums:
  - Sample all cases for a population size of fewer than 30 cases
  - Sample 30 cases for a population size of 30–100 cases
  - Sample 50 cases for a population size of 101–500 cases
  - Sample 70 cases for a population size of more than 500 cases
  - Sample 100 cases for a population greater than 500 cases

To ensure the methodology is a random sample the sample size should be defined in utilizing the every third or every fifth or every tenth chart or patient.

Process Improvement and the El Camino Health Operating System

ECH is on a journey of continuous improvement and operational excellence. Process Improvement is a set of concepts, principles, and tools used to create and deliver the most value from the customer's perspective while consuming the fewest resources. High Reliability Organizations deliver exactly what is needed, at the right time, in the right quantity, without defects, and at the lowest possible cost.

The Process Improvement department has been in existence since 2012, and has adopted the use of Lean methodology and principles as the foundation for our interventions. We also use tools from Six Sigma, Change Management, and PDCA, to support our transformation in becoming a High Reliability Organization. We do this by focusing on both incremental improvement over time, and breakthrough improvements all at once, with our Management System (ECHOS) as the foundation.

The Process Improvement department provides resources to the organization for problem solving, as well as deploying ECHOS, our El Camino Health Operating System. The dedicated team is comprised of Process Improvement Advisors with both clinical and industry expertise. We align our work to support and achieve the overarching Enterprise Strategic Goals. This is accomplished through large Value Stream initiatives, unit level process improvements, coaching and training ECH leaders, and partnering with all levels of the organization.

The success of Process Improvement is dependent on robust education and training programs. Our PI Academy, a 90-day project based training program designed to encourage and support all staff to be problem-solvers, is an example of how we engage with front line staff in continuous improvement. We also provide ad hoc training sessions covering Lean/PI tools and methods throughout the enterprise to assist departments with project completion.

The Process Improvement department also has a year-long fellowship program, which has been designed to develop and grow talented, high performing and high potential leaders by providing an accelerated and intensive hands-on learning opportunity with focus on the ECHOS Daily Management and Performance Improvement Systems. Participants leave their current department and join the Performance Improvement team to gain a foundation in core management and improvement system behaviors, methods, and tools to build on their talents. They do this through high-impact assignments that help the organization drive continuous improvement to achieve the highest level outcomes across patient experience, quality, safety, affordability and physician and staff engagement.

ECHOS: El Camino Health Operating System

The El Camino Health Operating System is the framework in which we manage our business. It is comprised of the processes, methods and tools that we use to run the various functions of our work, and, includes leader behaviors that support our teams. It is the way that we lead and accomplish work at EL Camino Health. Our True North incorporates our mission, vision and values, and is supported by our True North pillars. ECHOS as our foundation, is built on the Lean principles of respect for people and pursuit of continuous improvement. These concepts, methods and tools, support our overall Daily Management System.

The Daily Management System, with our patients as the focus, has three components which define how we:

1. **Align** the goals of the organization from the Executives to the Front Line with annual *Strategy Deployment*
2. **Engage** our people in daily front line problem solving daily through the *Daily Management System* using Tiered Huddles, Linked Visual Systems, Gemba, Standard Calendar, and Leader Standard Work
3. **Continuously Improve** our processes across departments, using structure and tools that enable both local and large cross-functional processes to be improved and even transformed

Quality Improvement Link with Organizational Goals

ECH's Quality Improvement Plan focuses on specific quality measures in three areas: quality & safety, service and finance. See below for the Fiscal Year 2024 Organizational Performance Goals.

The organization's Quality Goals are supported by quality improvement teams composed of front line staff, managers/directors and medical staff who meet frequently to identify and address opportunities to improve the goals. In support of the Hospital Acquired Conditions Index, ECH formed four teams to address opportunities with Hospital-acquired Pneumonia (nvHAP), C. Difficile infections, Central Line-Associated Bloodstream Infection (CLABSI), and Cather-Associated Urinary Tract Infection (CAUTI). Monthly reports on progress are provided to the Quality Council that acts as the Steering Committee for this quality goal.

Pillar	Goal	Measurement Defined			
		FY 23	Minimum	Target	Stretch
Quality & Safety	HAC Index	1.453	1.424	1.410	1.395
Service	Likelihood to Recommend (LTR) – Inpatient	78.5	74.7	76.4	78.1
	LTR – El Camino Health Medical Network	82.7	80.0	81.3	82.6
People	Culture of Safety	3.98	3.95	4.00	4.02
Finance	Operating EBIDA Margin	256.9M	$221M	$233M	$245M

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Commitment to Patient Experience

ECH has embraced the concept of an exceptional patient experience as foundational. It is our goal to form trusting partnerships among health care practitioners, staff members, and our patients and families that have been proven to lead to better outcomes and enhance the quality, safety and experience of patients and the health care team. Consequently, ECH solicits and captures feedback from a myriad of sources to ensure that the Patient/Family voice is embedded in all that we do. The comments and insights received through our feedback cards and patient satisfaction surveys are shared on a regular basis with our service lines and departments and used for recognition and improvement efforts. Understanding the experience of our patients throughout the continuum of care is imperative as we embark on our high reliability journey. In addition to the regular feedback received through these mechanisms, ECH has also engaged prior patients to work collaboratively with our organization. The Patient and Family Advisory Council (PFAC) was established as a mechanism for involving patients and families in shared decision making as we explore performance improvement efforts, policy and program decision-making and other operational processes. The patient and family advisors partner with our various service lines and departments, providing unique perspective and aiding us in achieving the ideal patient experience. They are engaged in reviewing communication to patients and families to ensure messaging is consistent, and easily understood. Also serving as members of hospital committees, our patient and family advisors collaborate and co-design alongside our team members. They provide insights on the services they value and what is important to them as we look closely at our processes.

To deliver upon our goal for exceptional, personalized care, always, ECH established the WeCare service standards. Exceptional patient experience is not a one size fits all – it is a focus on understanding and tailoring care and services to meet patient needs and engage them as a part of the care team. The WeCare service standards highlights the importance of personalizing our interactions to help bridge relationships and establish trust. They are the framework of standards that guide behaviors and communication with our

patients, their families and our colleagues. By embedding these service standards across the organization and enterprise, ECH is dedicated to provide a consistent message of compassion and respect through every interaction. Ongoing coaching, and monthly communication on the WeCare service standards has allowed this to remain at the forefront and demonstrates the emphasis and commitment ECH continues to place on delivering exceptional patient experience.

SECTION II: Patient Safety Plan

PURPOSE

El Camino Health (ECH) is committed to the health of our community. That means we provide the highest quality, personalized care to everyone who comes through our doors — treating them not simply as a patient, but as a whole person. Fundamental to that care is our culture of Safety First/Mission Zero. In each action, decision and process, we accept nothing less than putting safety first to achieve our mission of zero harm for our patients, visitors and workforce.

El Camino Health uses the diagram above to depict the organization's Mission, Vision and Values and True North Pillars. El Camino Health is on a contuing journey to build a culture of high reliability with a focus on safety to eliminate preventable harm to patients, visitors and our workforce-what we call Safety First/ Mission Zero. El Camino Health uses the following high reliability principles to support patient safety: Preoccupation with Failure, Sensitivity to Operations, Reluctance to Simplify, and Commitment to Resilience and Deference to Expertise. El Camino Health has established leadership expectations found in Attachment H and has also established universal SAFETY skills and behaviors that all of our workforce have been trained to use to eliminate preventable harm (See Attachment I).

The intent of this Patient Safety Plan is to communicate and support our focus and commitment to providing care that is safe and compassionate while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk and promote a culture of safety that protects patients from harm. The Patient

Safety Plan outlines a comprehensive program that will ensure our people, policies and procedures and performance are aligned, supports Strategic Plan priorities, the Quality Improvement Plan and ongoing quality and patient safety initiatives. In addition, the Patient Safety program at ECH strives to accomplish the requirements listed out in Leapfrog and the NQF Safe Practices in implementation of its program.

GUIDING PRINCIPLES

1. We believe that patient safety is at the core of a quality healthcare system.
2. We value the perspectives, experiences and contributions of all staff, medical staff, volunteers, patients, caregivers and the public in their role in patient safety.
3. Patient Safety is a continuous pursuit and is embedded in how we do all of our work.
4. Accountability for patient safety is everyone's business: from the Board of Directors to frontline staff to volunteers.
5. We promote a safety culture in which our workforce feel safe reporting adverse events, errors and near misses. These reports inform our improvements to care.
6. We will foster a culture that respects diversity and inclusivity as a shared responsibility promoting access and equity for our workforce and patients.

OBJECTIVES

1. Deliver high quality safe care for every patient.
2. Engage our workforce and patients in safe practices at work at all levels of the organization using SAFETY skills (universal skills).
3. Promote a culture of safety.
4. Build processes that improve our capacity to identify and address patient safety issues.
5. Classify patient safety events and perform cause analysis to better undertand cauess of errors and areas of improvement using the root cause or apparent cause analysis tools as delineated in the Safety Management and Cause Analysis procedure.
6. Educate workforce, patients and caregivers about the Patient Safety program and initiatives that are aimed at improving patient safety and preventing harm.
7. Encourage organizational learning about medical/health care errors.
8. Incorporate recognition of patient safety as an integral job responsibility.
9. Encourage recognition and reporting of medical/health care errors and risks to patient safety without judgment or placement of blame.
10. Collect and analyze safety data, evaluate care processes for opportunities to reduce risk and initiate actions.
11. Report internally what has been found and the actions taken with a focus on processes and systems to reduce risk.
12. Support sharing of knowledge to influence behavioral changes.

ORGANIZATION AND FUNCTIONS

Structures that Support Patient Safety

There are a number of integral and connected structures at El Camino Hospital that address Patient Safety.

Governing Board

The Governing Board of El Camino Health bears ultimate responsibility for the quality and safety of patient care services provided by its medical, other professional and support staff. The Board shall delegate responsibility for implementing this Patient Safety Plan to the medical staff and hospital administration and the committees noted below.

Quality Committee of the Board

The Quality Committee of the Board oversees Patient Safety at the hospital. They review patient safety indicators on an ongoing basis and provide direction and input to senior leadership on patient safety concerns and initiatives. An annual report of the Patient Safety program, which includes a summary of incident reports, regulatory activity and summary of reports made to the Department of Public Health and actions taken to address patient safety, shall be presented to the Quality Committee of the Board

Enterprise Hospital Committees

The Medical Staff Bylaws describe the composition and duties of the **Enterprise Quality Council** as a combined hospital and medical staff committee that oversees hospital patient safety related activity. Enterprise Quality, Safety and Experience Dashboard reflects metrics of the organization's quality and safety goals and is reviewed monthly.

The **Enterprise Patient and Employee Safety Committee (PESC)** receives reports and monitors data from the following hospital committees and reports: Medication Safety, Falls, Pressure Injuries, Hospital-acquired Infection Teams (CAUTI, CLABSI, C. Diff), Culture of Safety surveys, National Patient Safety Goals, Safety/ Security, Leapfrog Hospital Survey and Safety Grade, Hand Hygiene, Employee Injuries and the Grievance Committee. (See Attachment G: Patient and Employee Safety Dashboard). It is a multidisciplinary committee with hospital and medical staff representation, and the minutes and dashboard are shared with Quality Council monthly. The PESC is responsible for initiating performance improvement related to patient and employee safety concerns based on identified trends and concerns. Aggregated reports of patient safety events and actions taken to promote patient safety are reported quarterly to the Patient and Employee Safety Committee.

The ~~**Root**~~ **Cause Analysis** ~~**(RCA)/Cause Analysis**~~ **Oversight Steering Committee** is a subcommittee and reports to the Enterprise Patient Safety Oversight Committee (PSOC). This committee is responsible for providing oversight and monitoring of the Cause Analysis program described in Safety Event Management and Cause Analysis procedure. This group is responsible for ensuring that action plans are implemented for root cause analyses and overall effectiveness of the Cause Analysis program. The **Enterprise Patient Safety Oversight Committee (PSOC)** is a hospital senior leadership committee that meets weekly to review new patient safety events and prioritize actions needed for patient safety. Information reviewed is brought forward by Risk and Patient Safety, Medical Staff leadership, Quality and Regulatory leaders. These leaders

provide direction to the organization and the medical staff in addressing identified issues, problems and determine opportunities for improving patient safety.

Patient Safety Department

El Camino Hospital has a Patient Safety Department consisting of a Senior Director of Risk Management and Patient Safety (designated as the Patient Safety Officer), Assistant Director of Risk Management and Patient Safety ~~Manager and Patient~~and Risk Safety Specialists. These individuals work closely with members in the Risk Management and Quality Department on implementation of the patient safety program as described below. The Risk and Patient Safety Department works across disciplines and with team members across the organization to support and promote patient safety and drive our goal of Zero Preventable Harm.

The scope of the Patient Safety program includes the following but is not limited to:

1. Evaluation of patient safety events reported in the hospital's electronic incident reporting system to assist in assignment of Safety Event Classification pursuant to Safety Event Management and Cause Analysis Procedure.
2. Coordination of an annual Common Cause Analysis to identify trends in patient safety events and opportunities for improvement.
3. Facilitation of root cause analyses events defined in Safety Event Management and Cause Analysis Procedure.
4. Review National Patient Safety Goal (NPSG) and collaborate with Accreditation to conduct gap analyses.
5. Ongoing education and promotion of Safety First Mission Zero High Reliability Program, including development and sustainment of a Mission Zero Safety Coach and Leader Mentor program as well as development of a Patient Safety Academy.
6. In partnership with Risk Management and Quality, performance of Failure and Effects Mode Analysis (FMEA).
7. In partnership with Risk Management, implementation of performance improvement related to culture of safety, patient safety based on trends or needed risk mitigation.
8. Regulatory follow up needed related to patient safety
9. Promote transparency of errors and mistakes through sharing lessons learned
10. Annual assessment of culture of safety and identified opportunities for improvement

PATIENT SAFETY PLAN

The mechanism to ensure all components of the organization are integrated into the program is through a collaborative effort of multiple disciplines.

1. Incident reporting is a cornerstone of Safety First/Mission Zero and our Culture of Safety. Training is provided to all workforce members upon hire and with refreshers on reporting concerns using ISAFE, the hospital's electronic incident reporting system with the expectation that all workforce members (clinical and non clinical) should report safety concerns. The ISAFE system supports the documentation and tracking of patient safety incidents, findings, recommendations and actions/ improvements. The ISAFE system also allows for reporting of and follow through on feedback from staff, patients and caregivers. Our Patient Experience Office manages the Feedback reports to

ensure timely response and follow-up, track and trend feedback themes and inform quality improvement opportunities.

2. Safety events are classified using the HPI methodology for safety event classification using attached algorithm (Attachment J) with identification of a Serious Safety Event Rate whose continued reduction is a strategic goal for the organization.
3. As this organization supports the concept that errors occur due to a breakdown in systems and processes and a fair and just culture, workforce members involved in an event with an adverse outcome will be supported by:
    a. A non-punitive approach and without fear of reprisal, as evidenced by the Fair and Just Culture policy.
    b. Voluntary participation into the root cause analysis for educational purposes and prevention of further occurrences.
    c. Resources such as Support our Staff (SOS) or EAP should the need exist to provide support for our workforce after an event
    d. Culture of Safety surveys about their willingness to use our safety reporting systems
4. PESC Dashboard and Patient Safety Targets, Refer to Attachment G. The PESC establishes a dashboard annually to monitor patient and employee safety events with desired quality targets based on any available benchmarks and organizational goals.
5. Patient Safety Priorities are based on the following:
    a. Serious Safety Events as identified by the Safety Event Classification team whose process is described in the Safety Event Management and Cause Analysis procedure
    b. Other patient safety events that are not classified as an SSE but raise concerns due to aggregate trend or potential for harm
    c. Information from internal assessments related to patient safety such as tracers
    d. Information from external organizations related to patient safety such as the Joint Commission Sentinel Event Alerts, ISMP
    e. Accreditation and regulatory requirements related to patient safety
    f. Fallouts from PESC dashboard.

Patient Safety Initiatives

• Safety First Mission Zero SAFETY skill program • Safety First Mission Zero Leader Skill program which includes use of Tiered Daily Safety Huddles, Visual Learning Boards, Apparent Cause Analysis • Hand Hygiene Audits • Monthly Leader and Executive Rounding using 4C SAFETY skill scripts • New hire and manager Orientation to include SAFETY skill education • HeRO Recognition and Award Program	

Quality Indicators of Patient Safety:	
• Nurse Sensitive Indicators (Medication Safety, Falls) • Healthcare Associated Infections • Surgical site infections • Surgical Safety Checklist	• Pressure Injuries • Transfusion reactions/ blood/blood product administration • Use of Restraints • Employee Safety • Serious Safety Event Rate • Culture of Safety Survey results
Safety Programs:	
• Central Safety Committee • Emergency Preparedness Committee • Infection Prevention and Control Program (including Hand Hygiene and PPE support)	• Antimicrobial Stewardship Program • Radiation Safety Committee
Data from Environmental Safety Issues:	
• Product Recalls • Drug Recalls • Product/equipment malfunction	• Air Quality • Security incidents • Workplace Violence

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN

Allocation of Resources

The CEO and the Senior Leadership Team provide sufficient qualified staff, time, training, and information systems to assist the Enterprise Quality Council, the Enterprise Patient and Employee Safety Committee, Medical Staff, Nursing, and Clinical Support Services in designing, implementing and maintaining effective performance improvement activities. The Directors/Managers of the organization allocate staff time to participate in performance improvement activities. Both external and internal education determined to be reflective of organizational priorities will be provided through monies allocated in expense budgets. Budgetary planning shall include resources for effective information systems, when appropriate.

Confidentiality

The Quality Improvement & Patient Safety Program of El Camino Hospital has been designed to comply with all applicable confidentiality and privacy laws. All data, reports, and minutes are confidential and shall be respected as such by all participants in the Quality Improvement and Patient Safety Program. Confidential information may include, but is not limited to meeting minutes, electronic data gathering and reporting, serious safety event and adverse event reporting, and clinical profiling. Information may be presented to not

identify specific medical staff members, patients, or other health care practitioners. These protections are provided via the Health Care Quality Improvement Act of 1986 and when applicable, California's Evidence Code 1157.

Data, reports, and minutes of the Quality Improvement and Patient Safety Program are the property of ECH. This information is maintained in the Quality, Risk Management and Patient Safety Departments and in departmental or administrative offices, as appropriate. Quality review data, reports and minutes shall be accessible only to those participating in the program. All other requests for information from the program shall be in writing stating the purpose and intent of the request, and shall be addressed to the Chief Quality Officer, Sr. Director, Quality Services Department, Director of Risk Management or Patient Safety or the Compliance Officer.

Annual Evaluation

The Chief Quality Officer or the Sr. Director of Quality Services, and the Director of Risk Management and Patient Safety shall coordinate the annual evaluation of the Quality and Patient Safety program and written plan for submission to the Enterprise Quality Council, the Medical Executive Committee and the Governing Board. The annual appraisal shall address both program's effectiveness in improving patient care, patient safety, and clinical performance, resolving problems, and achieving program objectives. The adequacy of the program, including data and information effectiveness, structure, and cost-effectiveness of the program will also be addressed.

Modifications will be implemented as needed to assure that the program is effective and efficient in monitoring patient care and clinical performance. The written plan may be modified at any time with the approval of the Quality Council, Medical Executive Committee, and the Governing Board.

Attachments

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY24)

Att C Enterprise Quality, Safety and Experience Dashboard FY24

Att D Board Quality and Safety Dashboard FY24

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicators 2023

Att G Patient and Employee Safety Dashboard FY24

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skill Toolkit

Att J HPI Safety Event Classification Algorithm

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

Att A Governance Information Flow

Att B Quality Council Reporting Calendar (FY24).pdf

Att C Enterprise Quality, Safety and Experience Dashboard FY24.pdf

Att D STEEEP FY24Q1 for Board

Att E Abbrev Registries List

Att F External Regulatory Compliance Indicator 2023

Att G Patient and Employee Safety Dashboard FY24

Att H Safety First / Mission Zero Leader Skill Toolkit

Att I Safety First / Mission Zero Universal Skills Toolkit

Att J HPI Classification Tools for SEC

Approval Signatures

Step Description	Approver	Date

A18q2. ECHB - June 2024 - Period 10 & YTD FY2024 Financials

El Camino Health

Summary of Financial Operations

Fiscal Year 2024 – Period 10

7/1/2023 to 04/30/2024

Operational / Financial Results: Period 10 (April 2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'Aa3'	S&P 'AA'	Fitch AA-	Performance to Rating Agency Medians
Activity / Volume	ADC	302	316	(15)	(4.6%)	314	(12)	(3.9%)	---	---	---	---
	Total Acute Discharges	1,855	1,905	(50)	(2.6%)	1,835	20	1.1%	---	---	---	---
	Adjusted Discharges	3,700	3,653	47	1.3%	3,414	286	8.4%	---	---	---	---
	Emergency Room Visits	6,047	6,603	(556)	(8.4%)	6,079	(32)	(0.5%)	---	---	---	---
	OP Visits / OP Procedural Cases	12,111	11,990	121	1.0%	10,059	2,052	20.4%	---	---	---	---
	Gross Charges ($)	536,519	533,366	3,153	0.6%	464,213	72,307	15.6%	---	---	---	---
Operations	Total FTEs	3,461	3,473	(12)	(0.3%)	3,345	116	3.5%	---	---	---	---
	Productive Hrs. / APD	29.1	29.0	0.2	0.6%	29.0	0.2	0.5%	---	---	---	---
	Cost Per CMI AD	18,538	19,005	(467)	(2.5%)	19,551	(1,013)	(5.2%)	---	---	---	---
	Net Days in A/R	52.5	54.0	(1.5)	(2.7%)	54.6	(2.1)	(3.9%)	47.9	49.7	45.9	
Financial Performance	Net Patient Revenue ($)	123,655	125,395	(1,741)	(1.4%)	113,747	9,907	8.7%	329,311	115,267	---	
	Total Operating Revenue ($)	132,554	130,472	2,082	1.6%	120,587	11,967	9.9%	373,348	142,369	146,668	
	Operating Margin ($)	**10,376**	**11,761**	**(1,384)**	(11.8%)	**11,169**	**(792)**	(7.1%)	**4,066**	**6,122**	**1,613**	
	Operating EBIDA ($)	**18,863**	**19,634**	**(771)**	(3.9%)	**19,381**	**(518)**	(2.7%)	**24,030**	**13,952**	**9,533**	
	Net Income ($)	(1,217)	14,293	(15,510)	(108.5%)	20,060	(21,277)	(106.1%)	16,237	9,681	4,107	
	Operating Margin (%)	**7.8%**	**9.0%**	**(1.2%)**	(13.2%)	**9.3%**	**(1.4%)**	(15.5%)	**1.1%**	**4.3%**	**1.1%**	
	Operating EBIDA (%)	**14.2%**	**15.0%**	**(0.8%)**	(5.4%)	**16.1%**	**(1.8%)**	(11.5%)	**6.4%**	**9.8%**	**6.5%**	
	DCOH (days)	266	325	(59)	(18.3%)	258	8	3.0%	262	336	243	

Moody's Medians: Not-for-profit and public healthcare annual report; September 7, 2023. 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 7, 2023. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; July 25, 2023. Dollar amounts have been adjusted to reflect monthly averages.

Notes: DCOH total includes cash, short-term and long-term investments.
OP Visits / Procedural Cases includes Covid Vaccinations / Testing.

El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Operational / Financial Results: YTD FY2024 (as of 04/30/2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Variance to Prior Year	Variance to Prior Year	Moody's 'A1'	S&P 'AA'	Fitch AA-	Performance to Rating Agency Medians
Activity / Volume	ADC	308	298	10	3.4%	305	3	0.9%	---	---	---	---
	Total Acute Discharges	18,635	18,362	273	1.5%	18,310	325	1.8%	---	---	---	---
	Adjusted Discharges	36,488	35,780	708	2.0%	35,350	1,138	3.2%	---	---	---	---
	Emergency Room Visits	67,257	64,739	2,518	3.9%	63,349	3,908	6.2%	---	---	---	---
	OP Visits / OP Procedural Cases	114,521	121,598	(7,077)	(5.8%)	113,287	1,234	1.1%	---	---	---	---
	Gross Charges ($)	5,257,610	5,128,621	128,990	2.5%	4,756,175	501,435	10.5%	---	---	---	---
Operations	Total FTEs	3,386	3,472	(86)	(2.5%)	3,295	91	2.7%	---	---	---	---
	Productive Hrs. / APD	28.2	29.5	(1.3)	(4.4%)	28.0	0.2	0.7%	---	---	---	---
	Cost Per CMI AD	18,772	19,005	(233)	(1.2%)	17,973	800	4.4%	---	---	---	---
	Net Days in A/R	52.5	54.0	(1.5)	(2.7%)	54.6	(2.1)	(3.9%)	47.9	52.6	45.9	
Financial Performance	Net Patient Revenue ($)	1,229,453	1,231,547	(2,095)	(0.2%)	1,144,945	84,507	7.4%	3,293,111	1,152,671	---	
	Total Operating Revenue ($)	1,294,146	1,286,018	8,128	0.6%	1,191,471	102,675	8.6%	3,733,478	1,423,693	1,466,683	
	Operating Margin ($)	**122,197**	**112,971**	**9,227**	8.2%	**112,780**	**9,417**	8.4%	**40,655**	**61,219**	**16,134**	
	Operating EBIDA ($)	**205,930**	**194,014**	**11,916**	6.1%	**192,163**	**13,767**	7.2%	**240,297**	**139,522**	**95,334**	
	Net Income ($)	235,145	140,093	95,053	67.9%	198,273	36,872	18.6%	162,370	96,811	41,067	
	Operating Margin (%)	**9.4%**	**8.8%**	**0.7%**	7.5%	**9.5%**	**(0.0%)**	(0.2%)	**1.1%**	**4.3%**	**1.1%**	
	Operating EBIDA (%)	**15.9%**	**15.1%**	**0.8%**	5.5%	**16.1%**	**(0.2%)**	(1.3%)	**6.4%**	**9.8%**	**6.5%**	
	DCOH (days)	266	325	(59)	(18.3%)	258	8	3.0%	262	336	243	

Moody's Medians: Not-for-profit and public healthcare annual report; September 7, 2023. Dollar amounts have been adjusted to reflect monthly averages.
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Notes: DCOH total includes cash, short-term and long-term investments.
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El Camino Health

Unfavorable Variance < 0.99%
Unfavorable Variance 1.00% - 4.99%
Unfavorable Variance > 5.00%

Consolidated Balance Sheet (as of 04/30/2024)

($000s)

ASSETS

CURRENT ASSETS	April 30, 2024	Audited June 30, 2023
Cash	201,499	230,765
Short Term Investments	98,540	129,245
Patient Accounts Receivable, net	216,278	218,528
Other Accounts and Notes Receivable	31,909	20,413
Intercompany Receivables	17,823	15,186
Inventories and Prepaids	42,934	45,037
Total Current Assets	**608,984**	**659,174**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	22,909	20,731
Plant & Equipment Fund	488,880	407,526
Women's Hospital Expansion	31,596	30,735
Operational Reserve Fund	210,693	207,898
Community Benefit Fund	17,567	17,743
Workers Compensation Reserve Fund	13,498	13,498
Postretirement Health/Life Reserve Fund	23,147	24,242
PTO Liability Fund	37,629	35,252
Malpractice Reserve Fund	1,713	1,885
Catastrophic Reserves Fund	32,199	28,042
Total Board Designated Assets	**879,831**	**787,551**
FUNDS HELD BY TRUSTEE	**18**	**-**
LONG TERM INVESTMENTS	**635,705**	**474,670**
CHARITABLE GIFT ANNUITY INVESTMENTS	**950**	**948**
INVESTMENTS IN AFFILIATES	**35,898**	**33,262**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,014,700	1,862,363
Less: Accumulated Depreciation	(860,908)	(791,528)
Construction in Progress	155,731	168,956
Property, Plant & Equipment - Net	**1,309,523**	**1,239,791**
DEFERRED OUTFLOWS	56,349	57,204
RESTRICTED ASSETS	32,229	36,339
OTHER ASSETS	156,828	166,528
TOTAL ASSETS	**3,716,315**	**3,455,466**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	April 30, 2024	Audited June 30, 2023
Accounts Payable	62,001	50,862
Salaries and Related Liabilities	40,406	24,408
Accrued PTO	38,622	36,104
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	13,213	11,295
Intercompany Payables	14,047	12,362
Malpractice Reserves	1,863	1,863
Bonds Payable - Current	10,820	10,400
Bond Interest Payable	4,604	7,890
Other Liabilities	12,596	11,968
Total Current Liabilities	**200,471**	**169,450**
LONG TERM LIABILITIES		
Post Retirement Benefits	23,147	24,242
Worker's Comp Reserve	13,498	13,498
Other L/T Obligation (Asbestos)	27,060	29,543
Bond Payable	440,597	454,806
Total Long Term Liabilities	**504,303**	**522,088**
DEFERRED REVENUE-UNRESTRICTED	**1,467**	**1,103**
DEFERRED INFLOW OF RESOURCES	**88,041**	**91,871**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,662,682	2,417,300
Minority Interest	(1,114)	-
Board Designated	216,281	209,043
Restricted	44,184	44,611
Total Fund Bal & Capital Accts	**2,922,033**	**2,670,954**
TOTAL LIABILITIES AND FUND BALANCE	**3,716,315**	**3,455,466**

El Camino Health

AB18k1. Leadership Policy

Status **Pending** PolicyStat ID **14189408**

Origination	11/2006	Owner	Edwin Braxton: Director Total Rewards
Last Approved	N/A	Area	Administration
Effective	Upon Approval	Document Types	Policy
Last Revised	01/2016		
Next Review	3 years after approval		

Leadership Policy

COVERAGE:

All El Camino Hospital Leadership

PURPOSE:

To provide a consistent process for leadership's role and responsibility

STATEMENT:

It is the policy of the Board of Directors of El Camino Hospital that leadership's role and accountability be clearly established in writing and reviewed at least every three years.

PROCEDURE:

I. **Role of Leadership**

A. Leadership begins with establishing the organization's mission, then defining and communicating the organization's vision. Leadership has the authority and responsibility to carry out the four processes of leadership: (1) planning, (2) directing, (3) implementing and coordinating, and (4) improving services. .

B. Leaders help create an environment that enables the hospital to fulfill its mission and meet or exceed its goals. Within this environment, leadership:

1. Supports the Board of Directors in developing, regularly updating, and implementing the strategic mission, vision, values and goals for the organization;

2. Coordinates the development and implementation of strategic plans to achieve the vision, including the annual quality improvement plan and the annual budget;
3. Nominates, screens, and selects improvement projects;
4. Assigns teams to projects;
5. Ensures that teams have the resources and support necessary to accomplish their objectives, including appropriate staff, time, materials, team leaders, training, follow up, and incentives;
6. Monitors progress against objectives, including budget monitoring;
7. Establishes organizational standards consistent with the applicable accrediting regulatory and licensing agencies;
8. Implements strategies to improve organizational performance;
9. Defines the organizational structure and facilitates effective implementation of operation standards;
10. Serves as role models and promotes shared values.

II. **Management Rights and Responsibilities**

A. There are established rights and responsibilities of hospital management in fulfilling hospital objectives. Labor agreements and mandatory subjects of bargaining may necessitate negotiations to bargain the effect of management decisions. As such, El Camino Hospital leadership management staff has the right to exercise the customary functions of management including, but not limited to, the rights to:

1. Manage and control the premises and equipment;
2. Select, hire, train/develop, promote, suspend, dismiss, assign, supervise, and discipline staff;
3. Determine and change starting times, quitting times and shifts;
4. Transfer staff within departments or into other departments and other classifications;
5. Determine and change the size, composition and qualifications of the work force;
6. Adopt, establish, change, and abolish operational standards, rules and procedure;
7. Determine and modify job descriptions, job evaluations, and job classifications;
8. Determine and change methods and means of operations, as needed, for efficient and effective delivery of services;
9. Assign duties to staff in accordance with needs and requirements, as determined by hospital management;
10. Carry out all ordinary functions of management;
11. Plan, organize, staff, lead, control, train, review and budget.

III. **Executive Leadership**

A. **President and CEO**

The Board appoints a President and Chief Executive Officer (CEO) who possesses the management and leadership skills to effectively direct the delivery of services for the organization. The CEO has the ultimate responsibility for the management and leadership of the organization as defined in the El Camino Hospital Bylaws.

B. **Executives**

The CEO appoints an Executive Team, consisting of the various Chiefs, Officers, Presidents and Vice-Presidents to lead the organization. Goals and compensation for leaders designated as "executives" are reviewed and approved by the El Camino Hospital Board of Directors ("Board.").

C. **Division Executives** provide leadership, direction, and administration of specific hospital operational and functional areas. They are responsible for performance improvement and change management initiatives across the enterprise to achieve cultural and operational effectiveness in improving outcomes, reducing waste (variability), reducing costs, and increasing satisfaction. They collaborate with each other in developing strategy, setting and achieving goals, and management of resources.

In addition, they provide strategic leadership to the leaders of the departments reporting to them including setting goal and objectives, measuring and reporting goal achievement, and financial performance. Division Executives are coaches to the leaders reporting to them supporting achievement of goals and professional growth and development.

The Hospital maintains organizational charts showing reporting relationship and span of control for each division executive.

D. **Presidents**

A President is an executive position reporting to the CEO of El Camino Hospital who is the chief executive of a separate corporation ("subsidiary"). When the position is not full-time, the CEO may appoint a division executive or vice president to serve as the subsidiary's President. Presidents will have profit and loss accountability, oversee operations of the subsidiary, and ensure strategic alliance with strategic goals and initiatives of the El Camino Hospital.
A subsidiary organization will typically have a separate board of directors or advisory board. A President will effectively manage and leverage relationships with the Board, advisors, medical staff, and/or community members to achieve the subsidiary's mission and vision and position the organization for long term sustainability.

E. **Vice Presidents**

The CEO may appoint non-executive leaders to manage complex enterprise-wide functions and operations that have a significant impact on the Hospital's current or

future operations. A Vice President may report to the CEO or to a division executive. A Vice President is accountable for comprehensive leadership of their function(s) including : 1) development and implementation of strategy; 2) risk assessment and management; 3) staffing and resources; and 4) achievement of goals.

IV. **Service Line Leadership**

A. **Service Lines** are designated by executive leadership as a means of increasing clinical excellence, enhancing the patients' experience of care, and revenue and services growth through collaboration among physicians (different groups, different specialties), clinical and support staff.

B. **Directors of Service Lines** are responsible for the effective development, program direction, marketing, revenue and expense management, clinical quality and patient experience of the service line. This is accomplished in collaboration with staff in finance, business development and clinical operations. The service line includes a Medical Advisory Committee and a Fundraising Committee of the Hospital Foundation that is dedicated to the service line and may include an optional Community Advisory Committee.

V. **Department/Division Leadership**

El Camino Hospital's leadership through managers and other staff implement systems, processes, integration of functions, staff performance development to enhance patient care.

A. **Directors**

Directors are responsible for the organization's success in achieving annual organizational goals. Directors either have large and/or complex and financially significant areas of operational responsibilities or responsibility for driving direction and strategy for an area of expertise across the organization. Directors may have responsibility and accountability for multiple departments and/or provide direction to outside consultants or services to achieve annual goals and objectives. Directors may have managers reporting to them based on the scope and complexity of their area of responsibility. Directors who do not have managers reporting to them also fulfill the manager responsibilities for their area of responsibility.

1. **Operational Directors--** Operational Directors are responsible for insuring the link between El Camino Hospital's mission, vision, values, goals, strategic plan and organizational goals, and the department goals. They are directly accountable, either personally or through delegation, for their area(s) of responsibility to:

    a. **Accomplish organizational goals, operational expectations, and departmental growth targets in their area.** Operational Directors work collaboratively with Strategic Planning and Business Development to develop strategies and growth plans for their area of responsibility. Additionally, Operational Directors work collaboratively with functional departments for support and expertise in Quality, Human Resources, Finance, Compliance, Materials Management, etc.

b. **Provide effective, efficient, and financially sound department operations.** This includes meeting or exceeding budget and productivity targets, and staffing their area with competent and trained staff.

c. **Assure patient safety and accreditation and regulatory compliance.**

d. **Assure patient, employee, and physician satisfaction.**

2. **Functional Directors--** Functional Directors are responsible for staff functions that support the entire organization. Functional Directors have expertise in areas such as Strategic Planning, Business Development, Financial Analysis, Human Resources, Materials Management, etc. Functional Directors are responsible for providing organizational expertise and direction across the enterprise plus directing the operations of their area. They may achieve results through matrix management or outside services and providers.

3. **Senior Directors—**Senior directors have a broad organization-wide responsibility involving a high level of accountability due to a higher level of risk for the activities s/he oversees. In most cases, senior directors will oversee several departments headed by managers and directors.

B. **Managers**

Managers are assigned areas of responsibility more specifically defined than those of Directors but the functions are relatively similar in nature and scope. In general, Managers have a smaller scope and focus than Directors. Managers are responsible for planning, organizing, hiring, and controlling the work in assigned areas of responsibility. Managers translate overall goals set by executive leaders into individual and team goals, develop plans for accomplishing goals, and direct and review progress.

Managers are responsible for their department's results where success is measured through departmental indicators. Managers communicate goals and accomplish results through delegation to staff.

1. **Operational Managers - Operational Managers are responsible and accountable for their area to provide:**

a. **Effective, efficient and financially sound department operations.** This includes meeting or exceeding budget and productivity targets, and staffing their area with competent and trained staff.

b. **Assure accreditation and patient safety and regulatory compliance.**

c. **Assure patient, employee and physician satisfaction.**

d. **Assess employee competency and conduct performance evaluations.**

e. **Provide orientation, training and education to their staff.**

f. **Communicate relevant organizational information to employees.**

2. **Functional Managers -** Functional Managers are responsible for functions that support the entire organization. These managers have expertise in areas that include Marketing, Training and Development, Process Improvement, Clinical Effectiveness, Finance, etc. Managers are responsible for providing organizational expertise and direction across the organization plus managing the operations of their area. Functional Managers have a more focused area of responsibility and scope than Functional Directors.

3. **Senior Managers-** Senior managers have broader and more complex management responsibilities than other operational managers. In most cases, senior managers will oversee multiple functions led by supervisors and managers.

4. **Assistant Managers** – Assistant managers may function as a first-line supervisor to staff and/or partner with a functional manager or director to help manage and large department or unit(s). Assistant Managers coordinate and supervise daily work activities supporting hospital operations. Assistant managers coach, train, assess, and review performance of team members and support process improvement and change management activities.

VI. Functional Officers

A. Certain functions and programs require the Hospital to appoint a designated point of contact for leadership. Functional officers have enterprise-wide responsibility. Serving as a functional officer is a job assignment. Samples include: Corporate Compliance, Hospital Safety, IT Security, Patient Safety, and Privacy.

B. Responsibilities of the functional officer include:

1. Develop, implement, communicate, and monitor the effectiveness of the function/program.
2. Develop, recommend, and execute management plan for assigned function/program
3. Ensure compliance with Hospital policy, standards, and legal requirements
4. Implement actions to correct deficiencies and improve the effectiveness of the program.
5. Chair an interdepartmental committee to aid in monitoring, managing and communicating the program.
6. Make recommendations and submit reports to Executive Leadership and Board

VII. Hospital Supervisors

The Hospital Supervisor has responsibility for the operations of the hospital during times when other leadership are not on the premises and has the authority to initiate whatever administrative or emergency measures may be necessary to preserve the safety of the hospital and individuals. As appropriate, the Hospital Supervisor notifies the "Administrator On-Call" or appropriate leader in the chain of command.

As "Administrator On-Call" the Hospital's executives rotate responsibility for remaining accessible to the hospital via telephone or pager in the event administrative direction or assistance is needed by on-site supervision. The Board maintains authority and responsibility for the overall operations of the organization.

VIII. **Supervisors**

Supervisors are responsible for supervising daily work activities of a defined unit(s) supporting hospital operations and functions. They are responsible for improving and maintaining efficiency and accomplishing operational objectives within established policies, procedures, and performance standards. They are involved in hiring and selecting employees and are responsible for staff training, coaching, and assessment including conducting performance appraisals. In addition to direct supervision, they build and maintain contacts and relationships to effectively accomplish work objectives, address customer needs, assess operational requirements, and improve processes,

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	05/2024
	Edwin Braxton: Director Total Rewards	08/2023

AB18k2. Certified Nurse Midwives Scope of Service-Changes

Status **Pending** PolicyStat ID **14363612**

Origination	09/2020	Owner	Heather Freeman: Executive Director - Women's and Newborn Services
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval	Document Types	Scope of Service/ADT
Last Revised	05/2024		
Next Review	3 years after approval		

Certified Nurse Midwives Scope of Service

Types and Ages of Clients Served:

~~As per the~~The certificate to practice nurse-midwifery in California ~~Board of Registered Nursing document NPR-B-31 November 2001, Nurse-~~authorizes the holder to attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn, consistent with the Core Competencies for Basic Midwifery Practice ~~as conducted by Certified Nurse Midwives~~ (Business and Professions Code § 2746.5(a). The certificate to practice nurse-midwifery in California also authorizes a holder to care for patients outside of the statutory definition of low-risk, with mutually agreed upon policies and protocols with a physician (Business and Professions Code § 2746.5(b)). Acting under the supervision of a qualified physician, a member of the ECH Medical Staff with Active status, CNM management of women's healthcare focuses particularly on pregnancy, childbirth, family planning and gynecological needs of women. The CNM practices within a healthcare system that provides for consultation, collaborative management, or referral to physicians as indicated by the health status of the patient and the CNM's~~)~~ practice in accordance with the Standards for Practice of Nurse-Midwifery, as defined by the American College of Nurse-Midwives. The CNM is ~~the independent, comprehensive management of women's health care in a variety of settings. Acting under the supervision of a qualified physician, a member of the ECH Medical Staff with Active status, CNM management of women's healthcare focuses particularly on pregnancy, childbirth, family planning and gynecological needs of women. The CNM practices within a healthcare system that provides for consultation, collaborative management, or referral to physicians as indicated by the health status of the patient and the CNM's practice in accordance with the Standards for Practice of Nurse-Midwifery, as defined by the American College of~~

~~Nurse-Midwives. The CNM is~~ a certified nurse-midwife with a license issued by the Board of Registered Nursing in California.

Locations Permitted for the Process/Procedure:

Labor and Delivery and the Emergency Department

Assessment Methods:

A. Review of Process/Procedure:
    1. Evaluation of care provided by CNM will be assessed through the established medical staff process.
    2. All procedures are developed collaboratively and approved by the Interdisciplinary Practice Committee (IDPC) whose membership consists of nurses, Nurse Practitioners, Certified Nurse Midwives, Physicians, and administrators, and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR, Section 1474.
    3. This process/procedure should be reviewed every three years or as practice changes, with approval by the IDPC and MEC.

Circumstances for the Process/Procedure:

1. Setting: Inpatient area at El Camino Health
2. Indications: Practice guidelines for CNM
3. The scope of supervision: Supervising physician of record

Training and Education Requirements:

A. Currently licensed as a registered nurse in California.
B. Completion of a nurse-midwifery program approved by the American College of Nurse-Midwives.
C. Certification by examination by the American College of Nurse-Midwives.
D. Current certification by the Board of Registered Nursing as a nurse-midwife in California.
E. Current BCLS certification in cardiopulmonary resuscitation is required.
F. Continuing Education consistent with requirements of the American College of Certified Nurse Midwives and the California Board of Registered Nursing.
G. Current certification by the BRN to furnish drugs (as required by Section 2746.51 of the California Business and Professions code).
H. CNM must function within the scope of currently held licensing/certification and the supervision of a qualified obstetrician/gynecologist who must hold all clinical privileges necessary to supervise and assume care from the nurse-midwife as required. Both the nurse-midwife and supervising obstetrician/ gynecologist shall be approved by the OB/GYN MV Department Executive Committee or the Maternal-Child Health LG Department Executive

Committee, Credentialing Committee, Medical Executive Committee and the Governing Board.

I. For each CNM, there must be a written agreement for obstetrician/gynecologist supervision and backup by a Medical Staff member in good standing within OB/GYN MV Department Executive Committee and the Maternal-Child Health LG Department Executive Committee.

Staff Competence and Evaluation:

A. Initial:
    1. Vaginal deliveries-5 deliveries proctored by MD supervising physician or his/her designee
    2. First assist cesarean section-3 proctored by MD supervising physician or his/her designee
    3. Ultrasound-3 proctored by MD supervising physician or his/her designee

B. Continuing evaluation of competence is assessed

Appropriateness, Necessity and Timeliness of Services

A. **Patient admission/delivery:**
    1. Triage-CNM may evaluate a patient presenting for pregnancy related care.
    2. CNM may admit patients to the Labor and Delivery Suite and care for such patients through delivery and discharge as defined in this Scope of Practice section, and subject to the exclusions, supervision, and transfer of care requirements in this document. Each patient admitted by a nurse-midwife will have access to an obstetrician/gynecologist who can supervise and assume care if required.
    3. Prenatal records must be available in Labor and Delivery.
    4. CNM will be notified of the arrival of their patients.
    5. CNM will evaluate the patient to determine the status of labor, complete a history and physical examination and document in the medical record.
        a. CNM will be responsible for clinical management of the patient during labor and delivery.
    6. ~~CNM will be responsible for clinical management of the patient during labor and delivery.~~
    7. CNM may order diagnostic tests and interpret laboratory data.
    8. CNM may use ultrasound to assess fetal presentation and fluid volume as indicated.

B. **Management Practices:** CNM may order or perform the following prenatal and intrapartum practices and procedures:
    1. Labor:
        a. Evaluate the progress of labor.

b. Assess fetal status and uterine contractions through external or internal electronic monitoring, palpation or periodic auscultation of fetal heart rate.

c. Initiate the use of appropriate medications and solutions according to standardized procedure.

d. Perform amniotomy when indicated.

e. Administer appropriate antibiotics for patients identified as GBS positive or at risk for chorioamnionitis in accordance with current guidelines.

f. CNM may order intravenous fluid infusions according to approved list.

g. Order amnioinfusion as indicated ~~after consultation with supervising physician~~.

h. Administer O2 by mask.

i. Evaluate the need for and initiate appropriate analgesia including oral, intramuscular, inhalational or intravenous medications within the CNM formulary.

j. Decide with the patient the need for epidural anesthesia and inform anesthesiologist.

k. Administer local infiltration anesthesia.

l. Identify deviations from normal and initiate appropriate interventions including consulting with ~~supervising~~consulting physician.

2. Delivery:

a. Manage spontaneous normal vaginal delivery.

b. Initiate attendance of NICU staff or Neonatologist as deemed appropriate.

c. Administer local infiltration anesthesia according to the hospital formulary.

d. Perform episiotomy and repair midline and variations of midline episiotomy.

e. Assess and repair birth canal trauma which does not include third or fourth degree lacerations.

f. Conduct delivery of infants with meconium-stained fluid ~~after notifying MCH personnel and supervising obstetrician/gynecologist~~.

g. Collect cord blood and tissue specimens as indicated, including cord blood gases.

h. Deliver placenta and membranes, inspect for completeness and examine for pathology as needed.

i. Perform an intrauterine exam when indicated. This procedure shall not include manual removal of the placenta and membranes except in an emergency situation.

j. Perform inspection of the cervix when indicated.

k. Identify complications such as hemorrhage, retained placenta, shoulder dystocia, etc., and institute emergency measures according to hospital

protocol, until physician assistance is obtained.

l. Assess for postpartum hemorrhage by evaluation of vital signs, amount of bleeding, consistency of the uterus, prophylactic treatment with oxytocic agents.

m. Obtain cultures as indicated.

n. Remove epidural catheter when appropriate.

o. Sign orders and institute clinical pathways.

3. Postpartum:
    a. Manage stable postpartum patients.
    b. Round daily on postpartum patients under their care.
    c. Order postpartum medications according to the postpartum clinical pathways as well as following standardized procedure for furnishing medications.

4. Documentation:
    a. CNM is responsible for documenting care provided to the patient in the Electronic Health Record (EHR) including consultation with physician when appropriate.

5. First Assist During Cesarean Section:
    a. First assistance for cesarean birth is done under the direct observation and supervision of the physician for the procedure.
    b. Aids physician with visualization, hemostasis and delivery.
        - Placing and holding surgical retractors
        - Suctioning
        - Swabbing/sponging of tissue
        - Hemostasis using pressure and suture tension
        - Fundal pressure during delivery
        - Stapling of skin for final closure

6. CNM may not:
    a. Perform incision
    b. Cauterize
    c. Suture

C. **Medication Furnishing by CNM:**

1. Nurse-midwives shall make medications available to their patients in accordance to the standardized procedure for furnishing medications. The furnishing of medications by nurse midwives will generally follow approved clinical pathways for Labor, Delivery, Postpartum and Post C-section. Nurse midwives can also furnish

medications from the hospital formulary for patients' pre-existing conditions as well as acute self-limiting ailments according to the standardized procedure for furnishing medications in the reference to the list below. The standardized procedure for nurse-midwives furnishing medications in El Camino Hospital is enclosed.

2. ~~The medications prescribed by nurse-midwives includes the following classes of medications:~~
    - ~~non-opioid analgesics~~
    - ~~oral antihistamines~~
    - ~~antihypertensive~~
    - ~~antibiotics~~
    - ~~laxatives~~
    - ~~iron and vitamin supplementations~~
    - ~~antitussives~~
    - ~~expectorants~~
    - ~~decongestants~~
    - ~~anti-asthmatics~~
    - ~~bronchodilators~~
    - ~~vaccines~~
    - ~~anti-emetics~~
    - ~~thyroid replacement~~
    - ~~topical corticosteroids~~
    - ~~oral hypoglycemic~~
    - ~~sleeping aids~~
    - ~~medication patient is currently prescribed~~
3. ~~All medications listed in Labor, Delivery, Postpartum and, Post C-section pathways.~~
4. ~~Schedule II and Schedule III Controlled Substances according hospital policy~~
5. The medications prescribed by nurse-midwives includes the following classes of medications:
    a. All medications in accordance with DEA license
    b. All medications listed in Labor, Delivery, Postpartum and, Post C-section pathways.
    c. All medications patient is currently prescribed
    d. Schedule II and Schedule III Controlled Substances according hospital policy

D. **Definitions of Physician Consultation and Midwife/Physician Co-management:**
All patients under midwifery care shall be screened for high risk factors. At any time, the

patient may be referred for physician consultation, collaborative management or complete physician management, depending upon the development, continuation or resolution of clinical problem (s). Physician evaluation requests shall be initiated by the CNM and the disposition is the joint responsibility of the CNM and the physician consultant.

1. Physician consultation: Process where the CNM maintains primary care management of the patient, and seeks the advice/opinion from the supervising physician or his/her designee when deviations from normal occur. The consultation including the name of physician and plan of care should be documented in the EHR by the CNM, who retains primary responsibility for patient's care. Therefore the supervising physician or his/her alternate need not be physically present at the time of delivery but shall be available within 30 minutes of the delivery unit. Physician consultant to acknowledge consultation with a note in the patient's medical record.
2. Physician Co-management: Collaborative management is the process whereby a CNM and a physician jointly manage the care of a patient who has become medically or obstetrically complicated. The scope of collaboration may encompass the physical care of the patient, including delivery by the CNM, according to a mutually agreed upon plan of care. A note by physician in the EHR is required for co-management.
3. Transfer of care from the CNM to the physician: Unstable high-risk patients are to be managed by a physician. Additionally, if the CNM believes that optimal care for a patient should be physician care, she/he has the obligation to decline to care for that patient.

E. **Certified Nurse Midwives Guidelines for CNM Management, Physician Consultation, Physician Co-Management, and Physician**

1. Introduction
   Certified nurse midwives do play an important and valued role in the care of pregnant patients at El Camino Health. This care is directed at low risk pregnancies. As consistent with ACOG's national guidelines for Perinatal Care, medical, surgical or fetal complications that may arise in the course of a low risk pregnancy require appropriate consultation from an attending/supervising obstetrician/gynecologist
2. CNM Management
   a. Meconium stained amniotic fluid with normal electronic fetal heart pattern.
   b. Group B streptococcus prophylaxis according to protocols.
   c. UTI- diagnosis and treatment
   d. Spontaneous Rupture of Membranes (ROM) without labor of <48 hours and no other risk factors.
   e. Internal and External Fetal Monitoring.
   f. Intrauterine pressure catheter.
   g. Amnioinfusion.
   h. Artificial Rupture of Membranes.

i. Performance episiotomy and repair when indicated.

j. Repair of first and second degree lacerations.

k. Gestational Diabetes, diet controlled.

l. Evaluation and treatment of patients presenting for triage starting at 34 weeks of gestation.

3. Physician Consultation

a. Antepartum testing with abnormal finding.

b. Preterm labor between 34 and 36 weeks- decision to deliver patient will be made by physician, CNM may then manage the labor and deliver the patient.

c. ~~Manage the labor and deliver the patient.~~

d. Pre-eclampsia without severe features.

e. ~~Thick particulate meconium stained fluid.~~
Arrest of labor/protracted 2nd stage > 2 hours without descent.

f. ROM > 48 hours without risk factors.
Induction of labor/augmentation.

g. Chorioamnionitis.

h. Third stage of labor > 30 minutes.

i. ~~Gestational Diabetes, diet controlled.~~

j. Persistent category 2 fetal monitoring tracings.

k. Gestational cholestasis.

l. Other medical conditions increasing risk to mother and/or fetus.

m. Patient with BMI>40.

n. Other medical conditions increasing risk to mother and/or fetus.

4. Physician Co-Management

a. Significant exacerbation of chronic medical condition, including chronic hypertension (a physician manages medications).

b. Evaluation and treatment of patients presenting for triage before 34 weeks of gestation.

c. Abdominal pain other than labor.

d. Pregnancy over 42 week's gestation.

e. Stable, chronic medical conditions including chronic hypertension on medication (diastolic BP < 100 mm Hg) systolic <160

f. Postpartum suspected endometritis.

g. Uncomplicated gestational hypertension or chronic hypertension.

h. Preeclampsia with severe features on Magnesium Sulphate.

i. Diabetes Mellitus on insulin or oral agents in good control (a physician manages medications).
j. Postpartum care and discharge of cesarean, and of bilateral tubal-ligation surgeries.
k. Intrauterine growth restriction.
l. Suspected fetal weight > 4,500 gm.
m. Excessive bleeding in labor.
n. Suspected shoulder dystocia (physician must be on L&D for delivery).
o. Antepartum fetal death.
p. Immunodeficiency (a physician manages medications).
q. No prenatal care- physician to determine dating, CNM may deliver if EGA is > 34 weeks without major complicated history.
r. Thrombophilia not on, ~~not~~or on ~~anticoagulations~~anti-coagulation agents in labor.
s. Fetal anomalies.
t. Vulvovaginal abnormalities (e.g. septum, infibulations).
u. Uterine Anomalies.
v. Category 3 fetal monitoring tracings.
w. Trial of Labor (TOLAC)
x. Uncomplicated twin gestation (Dichorionic/Diamnionic twins when the presenting twin is vertex).

5. Physician Transfer of Care
    a. Active coagulopathy.
    b. ~~Thrombophilia on anti-coagulation agents in labor.~~
    c. Eclampsia and Acute Fatty Liver
    d. Diabetes with poor glucose control.
    e. Complicated multiple gestations.
    f. Breech presentation in labor.
    g. ~~Active third trimester vaginal bleeding not in labor.~~
    h. Failure to descend.
    i. Operative vaginal delivery.
    j. Medical Condition requiring physician care during delivery.
    k. Fetal distress requiring immediate operative delivery.
    l. Seizure activity.
    m. Placenta accreta.
    n. Placenta previa.

o. Potential placental abruption.

p. Retained placenta.

q. Gestational age < 34 weeks in labor.

r. Third and fourth degree lacerations.

s. Prolapsed cord.

t. ~~Third stage of labor lasting > 30 minutes.~~

u. ~~Sickle cell disease.~~

v. Active Herpes (vaginal or vulvar).

w. ~~Category 3 fetal monitoring tracings not responding to interventions.~~

x. ~~Severely contracted pelvis.~~

6. If a situation requiring physician transfer of care to physician resolves, CNM may then resume care of the patient at physician's discretion with co-management with physician or consultation as appropriate.
7. PHYSICIAN NOTIFICATION:
    a. The above is not meant to be, nor can it be, an exhaustive listing of risk factors. Clinical scenarios will arise not specifically listed above. The purpose of the CNM service is to provide safe obstetric care.
8. Transfer of care from the CNM to the physician
    a. If a patient cared for by the CNM becomes significantly more complicated and the CNM feels that she/he cannot safely continue to care for the patient, she/he has the obligation to transfer care of the patient to the physician. The physician, in turn, has the obligation to accept the transfer.
    b. The final decision as to whether transfer of care is needed belongs to the attending/supervising obstetrician/gynecologist. In addition, with mutual agreement, shared management may be arranged on a case by case basis.
9. The CNM's routine practice does not authorize the following functions; however, she/he may assist the physician when appropriate:
    a. Version
    b. Breech deliveries
    c. Vacuum extraction or forceps deliveries
    d. Manual removal of placenta (except in emergency situations while waiting for physician assistance).
    e. Amniocentesis
10. If the transfer of care is for a transient condition such as an operative vaginal delivery or laceration repair, care can be transferred back to the CNM at physician's discretion once the condition is resolved with consultation or co-management as appropriate.

11. Emergency Management
    a. The CNM may initiate emergency procedure for patients requiring immediate medical attention while awaiting assistance from the appropriate physician.

Staffing:

Twenty-four hour coverage by Certified Nurse Midwife or designee.

Level of Service Provided:

The level is consistent with the needs of the patient as determined by Scope and Complexity of Service.

Performance assessment and improvement processes are approved through IDPC Privileging activities in conjunction with the multi-disciplinary health care professionals who provide services.

Standard of Practice:

~~Board of Registered Nursing – Certified Nurse-Midwife Practice Explanation of Standardized Procedures for CNM 11-16-2011~~

~~Board of Registered Nursing- General Information: Nurse-Midwife Practice 11-16-2011~~

California Business and Professions Code Commencing with Section 2746.5

American College of Nurse-Midwives- Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives Dec ~~2011~~2021

American College of Nurse-Midwives Core Competencies for Basic Midwifery Practice May 2020

American College of Nurse-Midwives- Standards for the Practice of Midwifery

~~California Legislative Information Assembly Bill No 1308 midwifery 2013-2014~~

~~Credentialing Resource Center Journal 781-639-1872 9/14 Clinical Privileges White Paper Certified nurse-midwife~~

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending

MEC	Michael Coston: Director Quality and Public Reporting [PS]	05/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	05/2024
MCH Executive Committee	Heather Freeman: Executive Director - Women's and Newborn Services	04/2024
IDPC	Ryan Nhan: Medical Staff Coord	03/2024
	Heather Freeman: Executive Director - Women's and Newborn Services	09/2023

AB18k3. Generative Artificial Intelligence Policy

Status **Pending** PolicyStat ID **15137673**

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

Owner	Melissa Flitsch: Cybersecurity Risk & Compliance Manager
Area	Information Security
Document Types	Policy

Generative Artificial Intelligence Policy

COVERAGE:

This policy applies to all workforce members, medical staff and affiliated parties working with or on behalf of El Camino Hospital. For purposes of this policy, workforce members include El Camino Hospital staff, contingent workers and contractors. It governs all interactions and communication with generative Artificial Intelligence (AI) technologies, including but not limited to ChatGPT and similar conversational AI systems.

PURPOSE:

With the increasing popularity and prevalence of generative Artificial Intelligence (AI) technologies, such as OpenAI's ChatGPT and Epic's drafting of clinical notes, it has become necessary to outline the proper use of such tools while working at El Camino Hospital. Generative AI refers to technology capable of generating human-like content, including text, images and audio.

While we remain committed to adopting new technologies to aid our mission, we also understand the risks and limitations of generative AI and must ensure its safe and responsible use.

There are, however, risks in using generative AI, including discriminatory bias, uncertainty about who owns the AI-created content, and security/privacy concerns with inputting proprietary organizational information or sensitive information about an employee, patient, vendor, etc. Additionally, the accuracy of AI-created content cannot be relied upon, as the information may be outdated, misleading or — in some cases — fabricated.

POLICY STATEMENT:

Generative AI technologies must be used safely and responsibly to protect patients, employees, vendors and El Camino Hospital from harm. This policy, as well as supporting practices and procedures, will align to the NIST Artificial Intelligence Risk Management Framework.

DEFINITIONS:

- **Artificial Intelligence (AI):** Computer systems able to perform tasks that normally require human intelligence.
- **Bias:** In the context of AI models, unwanted or unintended discrimination in predictions or recommendations.
- **Generative AI:** A subset of AI that involves models and algorithms capable of generating new, previously unseen outputs based on the data it has been trained on.
- **Protected Health Information (PHI):** Any individually identifiable personal health information created, stored, transmitted or received by El Camino Hospital or its business associates.

GUIDING PRINCIPLES

The use of generative AI technologies at El Camino Hospital will be guided by the following principles:

- **Ensure Safe Patient Interaction:** Generative AI systems shall not provide medical advice to patients unless the outputs are strictly controlled and thoroughly vetted by both industry experts and the relevant regulatory bodies. The distinct risk of AI hallucinations and biases in healthcare necessitates medical professionals, who are trained and experienced, to supervise interactions. Medical professionals are essential in ensuring the accuracy and reliability of the advice given, recognizing the limitations of AI, and preventing potential harm to patients.
- **Safeguard Privacy and Security:** The confidentiality and integrity of all personally identifiable information shall remain paramount. Given the emergence of potentially insecure AI services, adherence to established healthcare standards and regulatory guidelines is required. Implementing rigorous privacy protocols and security provisions is vital to uphold trust and protect the interests of our community.
- **Adhere to Evidence-Based Medicine:** Misinformation and biases are prevalent, even in reputable sources across the internet. Generative AI in healthcare must be anchored in evidence-based medicine, relying on trusted, scientific sources to inform its knowledge base. A stringent, proactive approach is essential to mitigate the risk of circulating harmful and inaccurate data points, improving the accuracy, reliability and safety of the AI-generated outputs.
- **Commit to Transparency and Prudence:** Generative AI systems have a potential for errors — even when utilized by trained medical professionals. Given the inherent intricacies of generative AI, it is essential to provide clarity regarding its limitations. Medical professionals must monitor AI outputs with a critical eye and exercise due diligence to discern potential inaccuracies, avoid biases and safeguard patient well-being.

PROCEDURE:

A. **Governance of Generative AI Technologies**

1. The Generative AI Steering Committee will maintain an Approved Application Roster, listing approved generative AI technologies along with the limitations and requirements for their use.
2. Approval is required for all new generative AI technologies, even those that are not cloud-based.
    a. Any workforce member seeking to use a new generative AI technology must complete the Generative AI Intake Form in ServiceNow. The Generative AI Intake Form assists the Generative AI Taskforce in reviewing the proposed use case, including the establishment of any requirements and restrictions. It also helps identify productive follow-up questions.
    b. The Generative AI Application Review Taskforce will review the submitted Generative AI Intake Form. The Taskforce may send clarifying and/or follow-up questions to the requester via email. Alternatively, the Taskforce may schedule a meeting with the requester to discuss clarifying and/or follow-up questions.
    c. The Generative AI Application Review Taskforce will strive to provide its recommendation to the Generative AI Steering Committee within five (5) business days of receiving the Generative AI Intake Form.
    d. The Generative AI Steering Committee will review the recommendation of the Generative AI Application Review Taskforce. Following its review, the Generative AI Steering Committee will deliver its decision to the requester:
        i. Approval. If the request is approved, the requester will receive an email with the approval and any restrictions or necessary accommodations.
        ii. Denial. If the request is denied, the requester will receive an email with reasons for the denial.
        iii. Deferment. If the request is deferred, the requester will receive an email with additional steps required for approval. This could include additional requirements such as submitting the request through Conga or completing a Security Risk Assessment (SRA).
3. Confidential, PHI or proprietary information must not be entered into generative AI technologies unless that application and information type is permitted in the Approved Application Roster.
4. All third parties that provide generative AI chatbot services to El Camino Hospital must have a HIPAA Business Associate Agreement (BAA) in effect before use. This includes all use, even if PHI is not intended to be entered into the service.

B. **Use of Approved Generative AI Technologies**

1. Users of approved applications must receive sufficient training to understand the capabilities and limitations of generative AI in the healthcare context, as well as

being made aware of resources to report biases, inaccuracies or anomalies.

2. Users of approved applications must review AI-generated content for biases, inaccuracies or anomalies before relying on it for work purposes, including clinical care. If a reliable source cannot verify factual information generated by the AI, that information must not be used for work purposes. The ultimate responsibility for AI-generated content and decisions regarding its use rests with the user.
3. As generative AI may produce content that could be considered plagiarized from its knowledge base, including copyrighted works, no text generated or partially generated from generative AI will be eligible to have an El Camino Hospital copyright, trademark or patent at this time.
4. Users of approved applications must adhere to applicable standards and requirements. For example, use of the El Camino Hospital AI Copilot must follow Microsoft's Responsible AI Principles.
5. When creating documentation, users of approved applications must be aware of, and comply with, the latest conventions and standards for citing and disclosing the use of generative AI in the creation of that documentation.
6. Use of approved applications must comply with all relevant El Camino Hospital policies, including but not limited to those related to conduct and anti-discrimination, intellectual property and acceptable use. For instance, generative AI must not be used to create content that is inappropriate, discriminatory or otherwise harmful to others or the organization.

COMPLIANCE:

Violations of this policy must be reported to the Chief Information Security Officer or the Compliance Officer. Alternatively, violations may be reported anonymously as outlined in *Compliance Hotline* procedure, available in PolicyStat.

AUDITING:

At any time, the Chief Information Security Officer or the Compliance Officer may authorize the audit of the ECH environment, including its systems and services, for compliance with this policy.

REFERENCES:

National Institute of Standards and Technology (2023) *Artificial Intelligence Risk Management Framework (AI RMF 1.0)*. https://doi.org/10.6028/NIST.AI.100-1

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	05/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	05/2024
InfoSec - CISO, Technical Services Director, CIO	Joshua Spencer: Interim Asst VP – Chief Information Security	04/2024
	Melissa Flitsch: Cybersecurity Risk & Compliance Manager	04/2024

AB18k4. Environment of Care Medical Equipment Management Plan-Changes

Status **Pending** PolicyStat ID **13272741**

Origination	04/2018	Owner	Jeff Hayes: Dir Clinical Engineering IT
Last Approved	N/A	Area	Clinical Engineering
Effective	Upon Approval	Document Types	Plan
Last Revised	04/2024		
Next Review	01/2024		

Environment of Care Medical Equipment Management Plan

COVERAGE:

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

PROGRAM OBJECTIVES, INTENT AND CORE VALUES:

El Camino Hospital is committed to providing a safe, accessible and effective Environment of Care (EOC), consistent with its mission, services and applicable governmental ~~mandate~~mandates. This commitment includes the provision of a physical environment that minimizes hazards and risks to patients, employees and visitors. This plan describes a comprehensive facility-wide Medical Equipment Management Plan that describes the process for: The Mountain View and Los Gatos campuses as well as all associated clinics where El Camino patients are cared for. To that end, it is the intent of this plan to describe a comprehensive facilities-wide management system that promotes safe and effective use of medical equipment, the objectives of which include:

- Maintaining a current accurate ~~***inventory***~~***inventory*** of equipment included in the program
- Ensuring all equipment receives an ~~***initial inspection***~~ ***initial inspection*** prior to use
- Ensuring ~~***preventive maintenance***~~***preventive maintenance*** is performed pursuant to a risk-based equipment maintenance strategy and schedule
- Providing timely and effective ~~***corrective maintenance services***~~***corrective maintenance services***
- ~~***Reporting, investigating and resolving***~~***Reporting, investigating and resolving*** incidents, problems and failures involving equipment in a timely and effective fashion

- Assist in the development and/or provide training materials in coordination with Hospital Educator
- Ensuring equipment is ~~***cybersecurity***~~***cybersecurity*** safe and providing support for medical ~~***device integration***~~***device integration***.

~~Developing and providing training materials in coordination with Hospital Educator~~

SCOPE AND APPLICATION:

This plan applies to select medical equipment, devices and technology and the uses thereof, which are generally included within a designed environment of care management program.

The items, processes, and critical functions addressed in this plan include, but are not limited to the following:

- Program planning/design, implementation, and the measurement of outcomes and performance improvements
- Medical equipment which is purchased, rented, leased, borrowed, cosigned and supplied for ~~demonstration~~evaluation
- Equipment identification, risk assessment, inventory and maintenance
- Equipment Device-related hazard alerts and product recalls
- Equipment involved in incidents that have, or may have, contributed to ~~death, serious injury or illness~~adverse effect pursuant to the Safe Medical Device Act (SMDA)
- Clinical and technical consultative services relative to medical equipment, such as pre-purchase evaluation, end user training, and equipment life -cycle analysis.
- Oversight of the hemodialysis equipment ~~service refer to~~in collaboration with Chief of Dialysis.

REFERENCES:

~~1. Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC.02.04.01, EC.02.04.03~~

~~2. California Code of Regulations, Title 22, sections 70837, 70853~~

~~3. NFPA 99,2012~~

~~4. HITRUST~~

~~5. NIST~~

- Joint Commission Accreditation Manual for Hospitals, Environment of Care, EC.02.04.01 and EC.02.04.03
- California Code of Regulations, Title 22, sections 70837, 70853
- NFPA 99,2012
- HITRUST
- NIST

AUTHORITY:

In accordance with its bylaws, the Central Safety Committee has the authority to ensure this plan is formulated, appropriately set forth and carried out. The authority and responsibility for program strategic design and operational oversight has been delegated to the Director of Clinical Engineering.

PROGRAM ORGANIZATION AND RESPONSIBILITIES

A. Executive Management (i.e. the organization's governing body, the facility Leadership Team) provides the program vision, leadership, support and appropriate resources through the development, communication and institutionalizing of pertinent business fundamentals.

B. The Clinical Engineering Department, has been given the responsibility for:

1. Cataloging all medical devices and equipment and determining which devices are deemed critical and to be included in the scheduled maintenance program
2. Maintaining an accurate inventory of all the devices deemed critical
3. Performing initial safety tests and inspections of all medical equipment
4. Inspecting and maintaining equipment that does not meet the criteria to be listed individually in the maintenance program through a series of scheduled environmental inspections and testing
5. Performing and documenting maintenance activities through the design and implementation of the equipment management program, to include coordination of the initial risk assessments
6. Developing written plans and operating procedures
7. Identifying training needs of the maintenance staff
8. Providing technical consultation and assistance with equipment end user training
9. Initial response to, investigation and reporting of incidents, for potential Safe Medical Devices Act issues and Sentinel Events

C. Each Department Manager/Director is responsible to develop and manage department specific elements of the equipment management program to include:

1. Ensuring all equipment, regardless of the type or ownership, receives an initial inspection before being introduced into the patient care environment and is functionally tested prior to each use insofar as it is recognized that each use of the device constitutes a functional test.
2. Maintaining the proper use of medical equipment through the development and management of department-specific elements of the equipment management program, including user training, and assessing program effectiveness.
3. Implementation of procedures to address failed devices:
    a. How to respond to equipment failure
    b. How staff should contact Clinical Engineering when equipment repair is

required

c. How to pro-actively identify equipment that is in disrepair or in need of assessment

d. How to ensure failed equipment is properly tagged and taken out of service

e. Assurance before use ~~that~~ the proper maintenance has been performed

D. A multi-disciplinary Central Safety Committee (CSC) ensures that the program remains in alignment with the core values, direction, and goals of the organization by providing leadership, determining priority and assessing the utility and efficacy of changes to the program. The CSC ~~maintains and tracks all~~is also the central hub of the applicable ~~information through the Safety Trends report~~Information Collection and Evaluation System (ICES) and acts as a clearinghouse for action items and recommendations, as well as a forum for leveraging issues, and developing program imperatives.

The CSC meets regularly throughout the year and, as part of the standing agenda, receives and reviews reports and summaries of actions taken, deficiencies, issues and performance improvement relative to equipment management, as well as several other pertinent functions and disciplines.

E. Employees (all those who use equipment, to include contract employees, registry/on-call personnel, etc.) are responsible to participate in equipment training and demonstrate core competencies relative to safe, effective equipment operations (including the performance of routine functional testing of equipment to verify integrity with each use). Employees must ensure their work practices and processes are safe and are in accordance with departmental procedures, training, provisions of this plan, and sound clinical judgment.

RISK ASSESSMENT

The clinical, informational and physical risks associated with the management of medical equipment are discerned through the following facility-wide processes:

- Risk-based initial & scheduled inspections, testing and maintenance
- Ongoing Equipment Safety Management methods and protocols, including those designed to address operator/user errors and equipment failures
- Incident Report review/evaluation through the applicable Information Collection and Evaluation System and the EM/ISC
- Device-related hazard alerts and product recalls
- Environmental and Hazard Surveillance rounds
- Communications with customers (end users)
- Root Cause Analysis of medical equipment related to significant adverse events
- Information Technology Security

PROGRAM IMPLEMENTATION AND

PROCESSES OF PERFORMANCE

A. ~~The selection and acquisition of medical equipment is accomplished through local and clinical specialty evaluation committees and through the utilization of medical technology and product line manuals. Conformance to pre-established standards, as appropriate, is ensured through the purchasing process.~~

B. The selection and acquisition of medical equipment is accomplished through local and clinical specialty evaluation committees and through the utilization of medical technology and product line materials. Conformance to pre-established standards, as appropriate, is ensured through the purchasing process.

1. The risk-based criteria for inclusion in the medical equipment preventive maintenance (PM) program includes:
2. Equipment function/clinical application (e.g. diagnostic, therapeutic, or monitoring)
3. Physical/clinical risks associated with use and/or failure
4. Maintenance requirements
5. Equipment classification incident history
6. Environment of equipment use (areas of equipment use)
7. Information/Network Security

Clinical Engineering is responsible for establishing appropriate PM schedules based upon the foregoing risk ~~based~~ criteria ~~for inclusion in the~~, experience, and ongoing monitoring and evaluation of equipment performance, reliability and use. All medical equipment ~~preventive~~, regardless of the type of ownership, receives inspection, maintenance ~~(PM) program includes:~~

- ~~Equipment function/clinical application (e.g. diagnostic, therapeutic, or monitoring)~~
- ~~Physical/clinical risks associated with use and/or failure~~
- ~~Maintenance requirements~~
- ~~Equipment classification incident history~~
- ~~Environment of equipment use (areas of equipment use)~~
- ~~Information / Network Security~~

Clinical Engineering is responsible for establishing and testing at appropriate ~~PM schedules based upon the foregoing~~frequencies using approved methodologies, commensurate with relative risk ~~criteria, experience, and ongoing monitoring and evaluation of equipment performance, reliability and use. All medical equipment, regardless of the type ownership, receives inspection, maintenance and testing at appropriate frequencies using approved methodologies, commensurate with relative risk.~~, criticality and priority.

C. Medical device product recalls and alert notifications are managed through a system involving Clinical Engineering, Facility Services, Materials Management, Safety, Risk and the equipment user departments. As medical equipment alerts, product recalls and manufacturer letters are received, they are researched through the Clinical Engineering department.

When the alert or the recall involves equipment supported by Clinical Engineering, the equipment/product user department and Clinical Engineering check inventory and take action, as prescribed in the notice. Clinical Engineering provides the CSC with relevant data where it is tracked and monitored for follow up on the alert.

D. The investigation and reporting of device-related incidents involving death, serious injury, serious illness, or posing a significant impact on care or an occupational hazard are managed through an ad hoc administrative investigation team (~~Incident Reporting System~~Quality Review Report (QRR). The Team is comprised of individuals who collectively possess the technical, clinical, and operational skill sets necessary to effectively evaluate the surrounding circumstances and determine the need for reporting under the Safe Medical Devices Act (SMDA) requirements.

   The SMDA investigation process and ensuing investigative reports are instrumental in discovering user error issues that provide impetus for training improvements. In instances when the governmental criteria are met, the investigation and root cause analysis is documented on the FDA "~~"~~*MedWatch*"~~"~~ report form, in accordance with the SMDA policy. In addition, the user's department under the direction of Risk Management completes ~~an incident report~~a QRR form. This ~~report~~form is used to document user errors; as well as other equipment use management issues such as cannot duplicate problem, equipment abuse, and unsafe practices.

E. Clinical, information/network security and physical risks relative to the use of equipment are identified and assessed through processes involving periodic performance assessment, user feedback, safety rounds, and incident reporting/review.

F. Education and Training for the end users of equipment (including use, reporting failures, emergency procedures, etc.) is area/department specific and provided through the individual department manager. Educational topics include:

   - ~~Capabilities, limitations and special applications of equipment~~
   - ~~Basic operations and safety precautions~~
   - ~~Emergency procedures~~
   - ~~Skills necessary to perform equipment maintenance~~
   - ~~Processes for reporting program problems, failures, and user errors.~~

   1. Capabilities, limitations and special applications of equipment
   2. Basic operations and safety precautions
   3. Emergency procedures
   4. Skills necessary to perform equipment maintenance
   5. Processes for reporting program problems, failures, and user errors.

   Clinical Engineering will provide technical consultation, as appropriate. Department managers/ Administrators, in concert with the Education Department will verify that each employee possesses the required core competencies relative to the safe and effective use and

maintenance of equipment, as required. Education and training for maintainers of equipment (e.g. Clinical Engineering) is provided through the equipment vendors and ongoing technical, educational and professional development programs. An engineer's equipment training is based upon a training needs assessment and coordinated through the Director of Clinical Engineering. Required competencies are established, monitored and documented through the Director of Clinical Engineering.

Training materials and programs are developed and periodically revised to reflect:

- ~~Assessment of educational needs~~
- ~~Organization-wide experiences~~
- ~~New technologies, equipment, and systems~~
- ~~Results of risk assessments, environmental rounds, audits, and inspections~~
- ~~Changes in pertinent laws, codes, and standards~~
- ~~CSC recommendations~~

1. Assessment of educational needs
2. Organization-wide experiences
3. New technologies, equipment, and systems
4. Results of risk assessments, environmental rounds, audits, and inspections
5. Changes in pertinent laws, codes, and standards
6. CSC recommendations

G. Procedures are developed by the Clinical Engineering Department in conjunction with the user Departments. They include processes to ensure failed or deficient devices are immediately taken out of service. In these cases, the user enters pertinent information onto a repair tag and Clinical Engineering is notified, without delay. Other aspects included within the user-specific departmental procedures address failure procedures, emergency clinical interventions in the event of critical equipment failure~~,~~ and obtaining emergency back-up equipment and repair services~~.~~

PERFORMANCE MEASURE

~~**FY-2022 Performance Indicators**~~

FY24 Performance Indicators

This year the performance ~~improvement~~improvement will ~~focus~~focused on Asset Management and Cybersecurity.

- ~~Raise the asset confidence level currently at 95% to 98%. This confirms 98% of medical devices receive a completed maintenance.~~
- ~~Create network micro segmentation to greater than 98% of all networked medical devices.~~
- Raise the percentage of the total database completed that is currently at 96.77% to 98%. This

will confirm that 98% of all inventoried medical devices received a completed maintenance within the last 12 months.

- Reduce open ECRI recall/alerts by 80%. Currently at 331 open ECRI alerts.

PROGRAM EFFECTIVENESS

The effectiveness of the equipment management program, including the appropriateness of the program design, training, maintaining equipment integrity, issues, and behaviors will be monitored and assessed on an ongoing basis. Relevant reports and concurrent and retrospective data relative to the management of equipment will be garnered and tracked through the applicable Information Collection and Evaluation System (ICES). The CSC ~~in the meeting minutes and the Safety Trends Report. The CSC~~ will receive periodic reports and give approvals or make recommendations, as indicated. These reports include summaries of monitoring results relative to performance standards, but are not limited to:

- Reports of SMDA issues, investigations, and follow up
- Relevant device/product related hazard alerts/product recalls and follow up
- Reports of equipment related significant events
- Trends or clusters of; cannot duplicate reported equipment problems, user errors, and equipment that cannot be located for scheduled preventive maintenance
- Efficient scheduled and corrective maintenance completion

ANNUAL PROGRAM EVALUATION

Results of this evaluation process will form the basis for performance improvement standards, strategic goal setting, planning, and verifying the continued effectiveness of program on an annual basis, the ~~Medical Equipment~~Utility Systems Management Plan/Program is evaluated relative to its ~~***objectives, scope, effectiveness and performance.***~~ ***objectives, scope, effectiveness and performance.*** This evaluation process is coordinated through Engineering, in conjunction with the Facilities Director, and includes an evaluation of:

- The continued appropriateness and relevance of program objectives, as well as whether or not these objectives were met.
- The Scope of the program, relative to its continuing to comprise meaningful aspects, relevant equipment, technology and system, items that add value and elements conducive to continuous regulatory compliance.
- 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, 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

Medical Equipment Risk Level Assignment Form.doc

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	05/2024
ePolicy	Patrick Santos: Policy and Procedure Coordinator	05/2024
Patient and Employee Safety Committee	Delfina Madrid: Quality Data Analyst	04/2024
Central Safety	Matthew Scannell: Director Safety & Security Services	04/2024
	Jeff Hayes: Dir Clinical Engineering IT	03/2023

AB18k5. Interpreting Services

Status **Pending** PolicyStat ID **15680783**

Origination	12/1993
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2022
Next Review	1 year after approval
Owner	Christine Cunningham: Chief Experience and Performance Improvement Offic
Area	Patient Experience
Document Types	Policy

Interpreting Services

COVERAGE:

All El Camino Hospital Staff and Medical Staff

PURPOSE:

To ensure that effective communication is facilitated for patients, family members, and or hospital visitors in a manner consistent with state and federal laws, including the Americans with Disability Act.

POLICY STATEMENT:

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. By facilitating effective communication between patients and care teams, interpreter services ensure safe and quality care. It allows for patient to become a participant in their care and treatment decision. It is the policy of El Camino Hospital that when a language or communication barrier prevents effective communication, interpreting services will be facilitated. El Camino Hospital's interpreter services policy takes into account people who speak limited or no English and people with disabilities, including but not limited to visual and or speech and hearing impaired patients. Every patient is informed of the availability of interpreter services.

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.

REFERENCES:

- Health and Safety Code 1259
- JC RI 01.01.03

PROCEDURE:

A. The Patient Guidebook, provided to patients upon admission, contains information about hospital's interpreting services. When possible, patients are asked to notify Patient Registration staff of interpreting needs prior to admission or visit.

B. The need for an interpreter is assessed at the time of admission and throughout the patient's stay. This is documented in the electronic health record (EHR) under either the Communication or Cares/Safety tab under Interpreting Services. See Appendix for screenshot of sample documentation. 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 preferred communication method or interpreter.

D. To assist in effective communication between the care team and the patient, the hospital intranet offers access to communication cards that contain commonly used words with corresponding image in various languages, including pain scale. These files are accessible to staff/medical staff. To access, visit intranet, go to "Patient Education" on home page, next select "Communication Board" and desired language.

E. When interpretation is needed, only certified medical interpreters shall be used.

    1. The hospital has and will maintain a contractual agreement with an Interpreter Services Vendor to provide certified interpreter services in accordance to state, local and federal laws.
    2. Instructions on how to access interpreter services will be provided to all staff based on the current vendor services provider.
    3. Interpretation services are available 24 hours per day. Services include telephone interpreters and secure Video Remote Interpretation

F. Hearing Impaired Patients:

    1. Our Interpreter Services Vendor offers American Sign Language interpreting via secure connection through Video Remote Interpreting.
    2. Hearing impaired patients are identified on admission and interpreter needs documented in the patient's electronic health record. The patient's ability to use other forms of communication will also be documented in the EHR,, including lip reading, written notes and or assisted hearing devices.
    3. At the patient's request, a T.T.Y. phone will be installed at the patient's bedside for use during the hospital stay. It is requested and obtained by staff from Central Supply.
    4. For additional services related to interpreting services, please contact Assistant Hospital Manager/Hospital and or Patient Experience.

G. Vision Impaired Patients:

    1. Audio and braille options available upon request for conditions of admission and

required registration forms. Braille forms are available in select Registration / Patient Access areas. The Audio file deployed to Patient Access areas located in the shared drive.

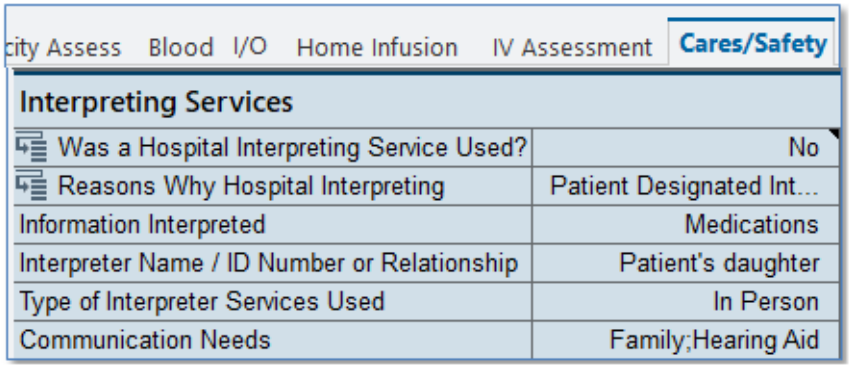
2. Patient can elect authorized representative for signature consent.

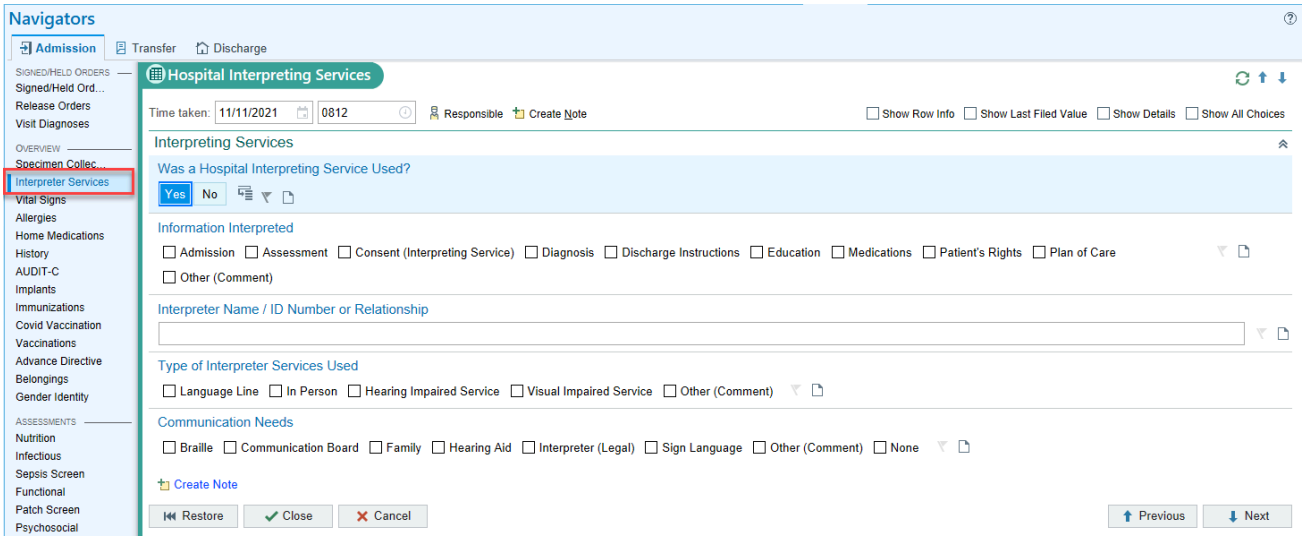
H. Documentation and Refusal of Interpreter:

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 as outlined.
2. Patients may refuse to use the hospital interpreter services 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 must document in the EHR flow-sheet under either Communication or Cares/Safety tab under Interpreting Services, and patient refused and requested an adult family member.

APPENDIX

Now in **Cares/Safety Flowsheet** for easy access
(It's in the **Communication Flowsheet** in L&D/ MBU)





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

Communication Board.pdf

English_icon images.pdf

iPad Voyce Instructions - One pager for devices.pdf

Language Access Poster

LanguageLine InSight Video Interpreting - iPad

Pain Assessment Card.pdf

Telephone Audio Interpretation Instructions

TTY Phone_Ultratec Superprint 4425.pdf

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	05/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	05/2024
	Christine Cunningham: Chief Experience and Performance Improvement Offic	04/2024

AB18k6. Administrative- Visitors Policy-Changes

Status **Pending** PolicyStat ID **15810829**

Origination	08/2011	Owner	Christine Cunningham: Chief Experience and Performance Improvement Offic
Last Approved	N/A	Area	Patient Experience
Effective	Upon Approval	Document Types	Procedure
Last Revised	05/2024		
Next Review	3 years after approval		

Administrative: Visitors Policy

COVERAGE:

All El Camino Hospital staff

PURPOSE:

~~To~~The purpose of the hospital visitor policy is to ensure the safety, security, and well-being of patients, staff, and visitors within the hospital environment. It aims to maintain an environment conducive to patient care, recovery, and privacy. The policy aims to ensure that all visitors of inpatients and or outpatients at El Camino Hospital ~~enjoy equal~~are provided visitation privileges consistent with patient preferences and any of the hospital's justified clinical restrictions~~.~~. The hospital will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.

DEFINITIONS:

1. Justified Clinical Restrictions mean any clinically necessary or reasonable restriction or limitation imposed by the Hospital on a patient's visitation rights which may be necessary to provide safe care to the patient or other patients, and as necessary in order to conduct hospital operations. These justified clinical restrictions may include, but are not limited to, to the following:
    a. A patient's medical condition
    b. The family's health and safety

c. Any court order limiting or restraining contact
d. Behavior disruptive to functioning of the patient care unit
e. Behavior presenting a direct risk or threat to the patient, hospital staff or others in the immediate environment
f. Patient's risk of infection by the visitor
g. Visitors' risk of infection by the patient
h. Substance abuse treatment protocols requiring restricted visitation
i. Patient's need for privacy or rest, including during the immediate post procedural period in the PACU area
j. Need for privacy or rest by another individual in the patient's shared room
k. When a patient is undergoing clinical intervention/procedure and the practitioner believes it is necessary to limit visitation (e.g.,requires sterile environment)
l. Extraordinary protections due to a pandemic or infectious disease Outbreak.
m. In adherence to any regulatory agency, federal, state and or county mandates and guidelines.

2. Patient ~~means~~is defined as anyone admitted as an inpatient or anyone receiving outpatient treatment.
3. Support Person ~~means a~~/ Visitor refers to family member, friend or other individual who is present to support the person during the course of the patient's stay or treatment.

PROCEDURE:

A. ~~El Camino Hospital offers our~~The hospital reserves the right to limit the number of visitors, visiting hours, as well as establish minimum age requirements for child (minor) visitors for patients ~~and visitors an open visiting policy in all settings~~during a designated period based on the clinical needs of the patient, other patients, and or operation of unit. ~~However, the hospital reserves the right to limit the number of visitors for any one patient during a specific period of time as well as to establish minimum age requirements for child visitors based on the clinical needs of the patient or other patients and operation of unit,~~

B. Prior to care being provided, patients (or their designated support person) are informed of visitation rights and any potential clinical restrictions. Visitation information ~~will be~~is also provided via the hospital's ~~"Hello Goodbye Folder"~~patient guide book which is provided to ~~every patient~~patients admitted to the hospital and is posted and available in the Visitor's guide in outpatient areas.

C. Visitation rights include the right to receive the visitors designated by the patient, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), ~~another~~ family member, or a friend, and his/her right to withdraw or deny such consent at any time.

1. If the patient is incapacitated or otherwise unable to communicate his/her wishes and the patient has designated a support person, the hospital is to provide the required notice to this support person and allow that support person to exercise the patient's visitation rights.

2. If the patient is incapacitated as defined above and has not designated a support person in advance, but a support present asserts that s/he is the patient's support person, the hospital can rely on this assertion.

D. The hospital prohibits discrimination in visitation based on age, race, color, ethnicity, religion, culture, ancestry, national origin, immigration status, language, physical or mental disability, socioeconomic status, gender, sexual orientation, and gender identity or expression, or educational background.

E. The hospital has the right to rescind or restrict the visitation hours and rights based upon the safety and welfare of the patient and the hospital staff, and as necessary in order to conduct normal hospital operations by imposing Justified Clinical Restrictions as defined above. The reasons for the clinical restrictions or limitation must be explained to the patient and family.

F. ~~The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of the inpatient or outpatient hospital stay.~~

G. The hospital allows for the presence of support individual of the patient's choice unless the presence infringes on others' rights, safety, or is medically or therapeutically contraindicated.

H. All visitors designated by the patient should enjoy the same visitation privileges as immediate family would enjoy.

I. Hospital staff who are involved with managing and controlling visitor access will be trained and informed on these policies.

J. ~~All newborn visitors to the Mother Baby Unit and~~Newborn visitor(s) to the Inpatient Mental Health and Addiction Services (MHAS) must be accompanied at all times by a designated support person (must be a responsible adult other than the mom/patient). The designated support person must provide all care for the newborn. If the designated support person needs to leave the patient room or hospital for any reason they must take the newborn visitor ~~including overnight. If the designated support person needs to leave the patient room or hospital for any reason~~(s) when they ~~must take the newborn when they~~ leave. The newborn visitor(s) is not to be left alone with the mom/patient at any time for any reason.

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

Approval Signatures

Step Description	Approver	Date
	Christine Cunningham: Chief Experience and Performance Improvement Offic	Pending

AB18k7. Child Passenger Safety Seat Requirement-Changes

Status **Pending** PolicyStat ID **10517559**

Origination	01/2012	Owner	Liliana Bruzzese-Pisegna: Clinical Manager
Last Approved	N/A	Area	Maternal Child Health (MCH)
Effective	Upon Approval	Document Types	Policy
Last Revised	09/2023		
Next Review	3 years after approval		

Child Passenger Safety Seat Requirement

I. COVERAGE:

All El Camino Hospital staff

II. PURPOSE:

State law requires parents or guardians be informed of current child restraint laws for riding in a motor vehicle, the risks of injury or death if not using a system and a listing of child restraint system programs within the county.

III. REFERENCES

CDC. "Child Passenger Safety." *Centers for Disease Control and Prevention*, 14 October 2022, www.cdc.gov/injury/features/child-passenger-safety/index.html#print. Acessed 11 January 2023.

IV. POLICY STATEMENT:

It is the policy of El Camino Hospital to comply with regulations regarding child passenger safety seats to ensure patient safety.

V. PROCEDURE:

A. Before a child under 8 years of age is discharged from the hospital, the parent or guardian will be given ~~a copy of the "Release of a Minor Under 8 Years of Age" (form # 737; available on the unit) and sign that they received it.~~:

   1. A copy of the "Child Passenger Safety Seat Requirement" (form #737; available on

the unit) and sign that they have received it.

2. A copy of CDC's "Keep Child Passengers Safe" (Sept. 2021) will be given with discharge paperwork.

B. The original copy of this form will become a part of the permanent patient record. ~~The canary copy will be given to the person to whom the patient is released.~~

C. Before a child under 8 years of age is discharged from the Emergency Department the parent or guardian is given written instructions and Patient Information that includes notification of the California law requiring car seat safety. It is signed by the parent or guardian.

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Approval Signatures

Step Description	Approver	Date
MEC	Heidi Yamat: Manager Accreditation and Regulatory Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2023
MCH Executive Committee	Patrick Santos: Policy and Procedure Coordinator	09/2023
MCH Executive Committee	Liliana Bruzzese-Pisegna: Clinical Manager	08/2023
Pediatric Department	Melinda Porter: CNS/NP	08/2023
UPC | Staff Meeting	Liliana Bruzzese-Pisegna: Clinical Manager	01/2023
MV | LG Manager	Liliana Bruzzese-Pisegna: Clinical Manager	01/2023

AB18k8. Pharmacy- Tech-Check-Tech Program

Status **Pending** PolicyStat ID **13865399**

Origination	N/A	Owner	Ngan Hoang: Manager Pharmacy Operations
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval	Document Types	Policy
Last Revised	N/A		
Next Review	2 years after approval		

Pharmacy: Tech-Check-Tech Program

COVERAGE:

El Camino Inpatient Pharmacy Staff

PURPOSE:

- To improve the efficiency of our clinical pharmacy program by allowing specially trained pharmacy technicians to check the work of other technicians in filling floor and ward stock and unit dose distribution systems.

POLICY STATEMENT:

- Our hospital maintains an ongoing clinical pharmacy program as described in CR 4052.1. Only under this condition, as per California Code of Regulations, Title 16, Section 1793.8, is the Tech-Check-Tech program allowed.
- This section shall only apply to acute care inpatient hospital pharmacy settings.

REFERENCES:

California Code of Regulations, Title 16, Section 1793.8

California Code of Regulations, Title 16, Section 4052.1

PROCEDURE:

Pharmacist Roles and Deployment:

A. All patient orders must be previously reviewed and approved by a licensed pharmacist before they can be filled by a technician. In hospitals deploying the Tech-Check-Tech program, pharmacists shall be allocated to provide clinical services in inpatient care settings.

Compounded and Repackaged Products:

A. All compounded or repackaged products must have been previously checked by a pharmacist and may then be used by the technician to fill unit dose distribution systems, and floor and ward stock.

Program Components:

A. Pharmacist-in-Charge Responsibility: The overall operation of the Tech-Check-Tech program is the responsibility of the pharmacist-in-charge.

B. Direct Supervision: The program operates under the direct supervision of a pharmacist. The parameters for this supervision are specified in the facility's policies and procedures.

Quality Control and Patient Care - To ensure the highest level of accuracy and quality patient care, the following additional measures are in place:

A. Validation Process: A supervising pharmacist, manager, or Director of Pharmacy will validate the accuracy of a technician authorized to check the work of other technicians. This validation will involve completing a third check on 4 different refill reports, each containing at least 10 different medications. Accuracy will be denoted in percentage of number of correct medication / number of medications check and documented in tech-check-tech validation form (Attached).

B. Validation Frequency: This validation process will occur annual basis, certifying 100% accuracy.

C. Accuracy Requirement: A 100% accuracy rating is required for a technician to continue checking the work of other technicians. If a technician does not achieve 100% accuracy, they will not be permitted to check the work of another technician until they attain 100% accuracy in a subsequent validation.

D. Repeat Validations: Repeat validations can take place on the following day. If a technician fails to achieve 100% accuracy in three consecutive validations, the technician will be barred from checking the work of other technicians for a period of 6 months. After this period, the technician may retest.

E. Medication Error Policy: In the event of 3 medication errors determined to be directly related to inaccuracy of a specific checking technician within a 6 month period, immediate revalidation of this technician will be required. If the technician fails this revalidation, they shall not be allowed to check the work of other technicians for a period of 1 year.

Program Documentation:

A. The hospital pharmacy shall maintain a documented description of the clinical pharmacy program before initiating a Tech-Check-Tech program. All records relating to this program will be kept according to the hospital's record retention policy.

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

Tech_Check_Tech Validation Form.docx

Approval Signatures

Step Description	Approver	Date
MEC	Heidi Yamat: Manager Accreditation and Regulatory Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2023
P&T	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	07/2023
	Ngan Hoang: Manager Pharmacy Operations	06/2023

AB18k9. Fair and Just Culture

Status Active PolicyStat ID 11552633

Origination	08/2022	Owner	Alicia Potolsky: Associate Chief Nursing Officer
Last Approved	08/2022	Area	Human Resources
Effective	08/2022	Document Types	Policy
Last Revised	08/2022		
Next Review	08/2025		

Fair and Just Culture

COVERAGE:

All El Camino Hospital staff and medical staff.

PURPOSE:

To provide a consistent, fair and systematic approach to understanding errors or unsafe acts in a manner that balances a non-punitive learning environment with the equally important need to hold individuals accountable for their actions.

POLICY STATEMENT:

People will inevitably make mistakes or experience misunderstandings in any work environment. When events occur that cause harm or have the potential to cause harm to patients or staff members or place the organization at legal, financial, or ethical risk, a choice exists: to learn or blame. El Camino Health is committed to creating a work environment that emphasizes learning rather than blame.

El Camino Health recognizes the complexity and interdependence of the work environment in all aspects of its operations, including patient care, clinical operations, research, ancillary, support services, and administration. The intent is to promote an atmosphere where any employee can openly discuss errors of commission or omission, process improvements, or systems corrections without the fear of reprisal.

It is well documented that most errors, whether or not they cause harm, are due to breakdowns in organizational systems; however, individual culprits are often sought when an error takes place.Blaming individuals creates a culture of fear and defensiveness that diminishes both learning and the capacity to improve systems. Most errors take place within systems that themselves contribute to the error. Despite this, creating an institutional culture that integrates the understanding that systems failures are the root cause of most errors is challenging. Learning from errors often points to beneficial changes in systems

and management processes and individual behavior.

Promoting a fair and just culture means giving constructive feedback and critical analysis in skillful ways, doing assessments based on facts, and respecting the complexity of the situation. It also means providing fair-minded treatment, having productive conversations, and creating effective structures that help people reveal their errors and help the organization learn from them. A fair and just culture does not mean non-accountable, nor does it mean avoiding critique or assessing competence. Rather, corrective or disciplinary action may be appropriate when incompetence or sub-standard performance is revealed after careful collection of facts, or there is a reckless or willful violation of policies or negligent behavior.

Applying these principles creates an opportunity to enact the core values of El Camino Health. To have the greatest impact and achieve the highest level of excellence, staff must be able to speak up about problems, errors, conflicts, and misunderstandings in an environment where it is the shared goal to identify and discuss problems with curiosity and respect. To achieve excellence, unwanted or unexpected outcomes and inefficiencies of practice must be used as the basis for a learning process. Respect must be shown to all people at every level of the organization.

DEFINITIONS:

System Induced Error - is an error related to organizational or department level processes, policies, procedures, support, or infrastructure that are not in place or proven ineffective.

Unintended Human Error - is an inevitable, unpredictable, and unintentional failure in the way an individual perceives, thinks, or behaves.

Reckless or Negligent Behavior - are different from unintended human errors. They are behavioral choices that are made when individuals have lost the perception of risk associated with the choice or mistakenly believe the risk to be insignificant or justified.

Medical Condition and/or Substance Abuse - an individual's health or substance abuse caused or contributed to the safety incident.

Malevolent or Willful Misconduct - is the conscious disregard of a substantial and unjustifiable risk. In comparison to at-risk behaviors, individuals who behave with willful misconduct know the risk they are taking and understand that it is substantial. They behave intentionally and are unable to justify the behavior *(i.e., do not mistakenly believe the risk is justified*). They know others are not engaging in the behavior (*i.e., it is not the norm*). The behavior represents a conscious choice to disregard what they know to be a substantial and unjustifiable risk. Key to this concept is that the individual must recognize the substantial and unjustifiable risk in order to disregard it. Therefore, they must reasonably foresee that their actions or inaction will or could create a substantial and unjustifiable risk.

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- Meadows, S., Baker, K., & Butler, J. (n.d.). *The incident decision tree: Guidelines for action ...* Retrieved April 5, 2022, from https://www.ahrq.gov/downloads/pub/advances/vol4/Meadows.pdf

PROCEDURE:

A. Employees should strive to:
    1. Avoid causing unjustified risk or harm to patients, visitors, or colleagues
    2. Achieve goals and outcomes
    3. Follow work rules, policies, and procedures
    4. Report safety concerns, near misses, and other events through El Camino Health's occurrence reporting system; look for risks and hazards in the work environment.
    5. Ask for help, seek a supervisor or check the policy when completing an assignment if they are unsure how to proceed.
    6. Complete all required learning obligations, attend department meetings, and remain knowledgeable about policies and organizational initiatives.

B. Leaders are obligated to:
    1. Promote a learning environment and educate all team members about Fair and Just Culture.
    2. Foster an environment that promotes full disclosure of adverse events
    3. Participate in cause analysis reviews, e.g., Root Cause Analysis
    4. Identify and report areas of potential harm, opportunities for improvement, and adverse events
    5. Consistently and uniformly, utilize the Performance Management Decision Guide to evaluate events to identify system and process issues that may require change (*See Attachments*)
    6. Ensure that employees are free from reprisals if reports are made in good faith

C. As part of the normal process for any event, the manager will conduct a thorough investigation to determine the type of behavior that led to the adverse event. Integrity and Accountability are critical El Camino Health values, and it is expected that individuals are cooperative and truthful throughout the process. The event will be assessed objectively and analyzed using a systematic approach as outlined in the attached Performance Management Decision Guide (PMDG). It is important to note that the outcome of the error is never used in determining a fair and just outcome.

D. Exceptions to this approach will occur if an individual knowingly or willingly:
    1. Conceals a safety event

2. Interferes with an investigation
3. Causes an adverse event or unsafe act that results from an illegal act
4. Breaches confidentiality
5. Has a persistent issue not resolved through performance improvement.

E. Performance Management Decision Guide (PMDG) will help determine the necessary course of action in consultation with Human Resources and other professionals within El Camino Health.

CROSS REFERENCE:

- Quality Improvement & Patient Safety Plan (QAPI)

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Approval Signatures

Step Description	Approver	Date
Publish	Patrick Santos: Policy and Procedure Coordinator	08/2022
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	08/2022
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2022
HRO	Alicia Potolsky: Associate Chief Nursing Officer [PS]	08/2022
	Alicia Potolsky: Associate Chief Nursing Officer	08/2022

AB18k10. Heart and Vascular Institute -HVI- Echo & ECG Per Diem Staff Requirements

Status **Pending** PolicyStat ID **13076002**

Origination	N/A	Owner	Purvi Dubal: Manager Service Line Ops
Last Approved	N/A	Area	Advanced Diagnostic Center
Effective	Upon Approval	Document Types	Policy
Last Revised	N/A		
Next Review	3 years after approval		

Heart and Vascular Institute (HVI): Echo & ECG Per Diem Staff Requirements

COVERAGE:

All Per Diem employees in Echocardiography and ECG Department.

PURPOSE:

To establish staffing guidelines that ensure proper staffing levels for the Echo and ECG departments during times of increased activity and PTO/LOA coverage.

REFERENCES:

- HR Policy: Work Status

PROCEDURE:

This procedure is in place to set per diem staff expectations for minimum availability and job requirements. Per diems do not have a regularly assigned work schedule.

A. This procedure is in place to set per diem staff expectations for minimum availability and job requirements. Per diems do not have a regularly assigned work schedule. The following shall be considered minimum requirements to maintain per diem status in the Echo and ECG departments. Per diems who do not meet these requirements or who do not work for a period of three (3) month or more, may be terminated as per HR policy Work Status.

    1. Must be available to work a minimum of four (4) shifts in each 28 day period (2 pay

periods), including two Saturday or Sunday, except for approved waivers.

2. The (2) two shifts each pay period must be on (2) separate days.
3. Per diem employees must provide availability for two (2) of the major ECH recognized holidays. (i.e., New Year's Day, Thanksgiving Day, Christmas Eve, and Christmas Day.)
4. Per diem employees must provide availability for one (1) of the minor ECH recognized holidays, (i.e., Martin Luther King, Jr. Day, President's Day, Memorial Day, Independence Day, Labor Day)
5. Per diems may be assigned to one Major and/or one Minor holiday. Should a per diem experience a conflict in the assignment, they should address the issue with their manager.
6. May have one continuous month per calendar year that the availability requirement is waived. This month will be determined by mutual agreement between the employee and their direct manager. Unavailability will be documented in E-time scheduling.
7. Per diems cannot mark themselves unavailable for more than a total of six (6) weeks in a calendar year. This would include the month waived in A.5 if taken.
8. Per diem must be able and will be required to cross train to work on both Mountain View and Los Gatos campuses.
9. Availability must be provided to the staff scheduler and the employee's manager.
10. Each Per Diem employees must submit their availability through E-time scheduling to the staff scheduler at least six (6) weeks in advance. This availability will be used by the staff scheduler/manager to fill open shifts in either Mountain View or Los Gatos per needs of the department.
11. Per diems are responsible for updating their availability as it changes. Per diems will also mark themselves unavailable when applicable.
12. Must be able to complete all mandatory training required by regulation and/or determined by ECH within the required time frame, e.g., TB testing, HealthStream trainings, CPR certification.
13. Per diem employees are responsible for ensuring their contact information is kept current and are expected to respond to requests within 48 hours.

B. Submission of Availability and Shift's Worked Review Process:

1. The per diem's hours and weekend work shifts worked will be reviewed each (4) four week schedule to confirm compliance with the work requirements.
2. If the per diem fails to work the required hours and/or weekend work shifts in any (4) four week schedule, the per diem is subject to progressive discipline. Failure to meet the hours or weekend work shift requirements is just cause for disciplinary action up to and including termination.
3. <u>Hours and Weekend Work Shifts Requirements:</u>
    a. The per diem's hours and weekend work shifts available will be reviewed each (4) four week schedule to confirm compliance with the work

requirements.

b. If the per diem fails to provide availability to work the required hours and/or weekend work shifts in any (4) four week schedule, the per diem is subject to progressive discipline. Failure to meet the hours or weekend work shift requirements is just cause for disciplinary action up to and including termination.

4. Holiday Requirements:

   a. The per diem's holiday availability will be reviewed annually at the end of the year to confirm compliance with the holiday work requirement.

   b. If the per diem fails to provide availability to work the required holiday, the per diem is subject to progressive discipline. Failure to meet the holiday work requirement is just cause for disciplinary action up to and including termination.

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	04/2023
HR Business Partner	Purvi Dubal: Manager Service Line Ops	03/2023
HVI Leadership	Purvi Dubal: Manager Service Line Ops	02/2023
	Purvi Dubal: Manager Service Line Ops	02/2023

AB18k11. Supply Chain - Departmental Access Policy

Status **Active** PolicyStat ID **12674191**

Origination	01/2023
Last Approved	01/2023
Effective	01/2023
Last Revised	01/2023
Next Review	01/2025
Owner	Abigail Robles: Manager Strategic Sourcing - Supply Chain
Area	Supply Chain
Document Types	Policy

Supply Chain - Departmental Access Policy

COVERAGE:

Supply Chain Department

POLICY STATEMENT:

Access to Supply Chain areas should be restricted to authorized personnel.

PROCEDURE:

A. Controlling access to departmental areas is necessary for the personal security of employees and the safeguarding of organizational property.

B. Access to departmental areas:

1. The Supply Chain department working areas (including the dock and all vehicles) are restricted to authorized Supply Chain staff members.
2. Employees of other departments may access designated Supply Chain areas for official business only.
3. Supplier representatives must visit the Supply Chain Purchasing office prior to visiting any other area.
4. All departmental areas should be secured at the routine close of business each day. Any departmental employee needing access to the area after normal hours should notify his or her supervisor in advance.
5. The storeroom should be secured at all times. If supplies are needed from the storeroom after normal hours, Security should open the area and accompany the individual while the supplies are located. Security should ensure that the supply

issue is documented in the after-hours log.

6. Special attention should be given to the receiving dock area. At no time should truck drivers be left unattended while loading or unloading items. Items should be removed from the dock and breakdown areas as soon as possible.

C. Visitors:

1. Personal visitors, including Supply Chain employees who are off duty or on vacation, are discouraged in the department. Employees may meet personal visitors in the cafeteria or lunchroom when they have scheduled breaks and meals.

D. Personal safety and security:

1. Anyone leaving the building after dark may request a security escort.
2. All staff members should wear their employee identification above the waist at all times.
3. Employees should keep all valuable personal items locked up at all times during working hours. In particular, purses should not be stored in unlocked desks.

E. Security of goods and equipment:

1. No one is be allowed to remove supplies or equipment from departmental areas without proper authorization.
2. Anyone observing an individual acting suspiciously or carrying items from the departmental areas should contact Security.

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Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2023
	Abigail Robles: Manager Strategic Sourcing - Supply Chain	11/2022

AB18k12. Acute Rehab - Utilization Review Plan

Status **Pending** PolicyStat ID **13257922**

Origination	06/2010	Owner	Kris Wittman: Dir Rehabilitation Svcs
Last Approved	N/A	Area	Acute Rehab Unit
Effective	Upon Approval	Document Types	Plan
Last Revised	01/2020		
Next Review	3 years after approval		

Acute Rehab - Utilization Review Plan

COVERAGE:

All El Camino Hospital Staff and Contracted Staff

PURPOSE:

To describe the rehab criteria that will be monitored on a regular basis.

STATEMENT:

All patients admitted to the Acute Rehabilitation Center shall meet appropriate rehab criteria that will be monitored on a regular basis. Admission is deemed reasonable and necessary if the patient requires an intensive therapeutic program utilizing an interdisciplinary approach. This program shall be designed to maximize the patient's functional abilities in order to return him/her to the highest level of independent living setting possible.

PROCEDURE:

1. All patients admitted to the Acute Rehabilitation Center shall meet the following admission criteria. (See also Admission Criteria Policy)
    a. Have a rehabilitation diagnosis resulting in physical deficits and functional deficits, necessitating in the service of at least two therapy disciplines
    b. Require a minimum of 3 hours of at least two disciplines per day, 5 days a week
    c. Must exhibit potential for improvement in functional abilities

    d. Must be medically stable
    e. Must not have been treated in an acute rehabilitation program for the same condition unless changes in medical and/or functional status have occurred
    f. Must be approved for admission by the Medical Director

2. An initial treatment plan and estimated length of stay shall be finalized no later than a week after admission.
3. A weekly team conference shall be conducted for each rehab patient. The interdisciplinary team and Medical Director shall review the patient's progress and status of the short and long-term goals at that time. A summary of the conference will be documented in the medical record.
4. A patient shall be considered for discharge from the Acute Rehabilitation Center when one of the following occurs:
    a. Rehab goals have been achieved.
    b. Patient has plateaued, and no progress is noted in therapy programming for approximately one week.
    c. Patient is unable to tolerate a minimum of 3 hours per day of therapy services.
    d. Patient and/or staff safety is in jeopardy, or the patient refused to participate in the program in spite of intervention.
    e. Patient becomes medically unstable and is transferred to an acute medical hospital.
5. Recommendations for continued therapeutic and/or medical intervention shall be made at the time of discharge.
6. Documentation in the medical record shall reflect appropriateness for continued stay in the program or explanation for a more precipitous discharge.

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	04/2023
Medicine Department Executive Committee	Kris Wittman: Dir Rehabilitation Svcs	04/2023

Acute Rehab Leadership	Kris Wittman: Dir Rehabilitation Svcs	03/2023
	Kris Wittman: Dir Rehabilitation Svcs	03/2023

AB18k13. MyCare Access-Changes

Status **Pending** PolicyStat ID **13087793**

Origination	12/2016	Owner	Kristina Underhill: Manager HIM Ops
Last Approved	N/A	Area	HIM
Effective	Upon Approval	Document Types	Policy
Last Revised	03/2023		
Next Review	3 years after approval		

MyCare Access

COVERAGE:

El Camino Hospital staff

PURPOSE:

All patient information is considered confidential. Information that identifies or potentially identifies a patient, or information about a specific patient, will not be disclosed unless authorized by law or by the patient / legal guardian.

This procedure ensures confidentiality of patient information and allows for limited information to be accessed by the patient, patient's legal representative or designated patient proxy via myCare.

REFERENCES:

1. California Hospital Association Consent Manual, ~~2018~~2021

PROCEDURE:

A. **Patients Requesting myCare Access:**

   1. By default, patients who are registered at El Camino Hospital receive a myCare activation code upon discharge. This information is located on the patients After Visit Summary (AVS).
   2. The auto-generated activation code expires 14 days from the date of discharge or service.

3. Patient may request an activation code via the myCare self sign-up page.
4. Patients can also call the Health Information Management (HIM) Department or contact myCare Help via email to request an activation code.
5. If the patient contacts the HIM Department, the following will occur:
    a. An HIM team member will verify patient demographic information which includes patient name, date of birth, last four digits of the social security number and additional information if needed.
    b. Once the patient's identity has been verified, an activation code is generated and sent to the patient via email, text or USPS.

B. **Requesting Adult Proxy Access of Minor Patient:**

1. Parent, legal guardian or conservator can request Proxy access to a minor's chart by completing a myCare Child Proxy access form.
    a. Exception: Mother of minor child born at El Camino Hospital as of November 2018, will automatically be given proxy access via EHR.
2. El Camino Hospital will validate the parent, legal guardian or conservator relationship of the minor patient.
3. Once validated and approved, a myCare account will be created for proxy use.
4. Limited access is granted based on the minor's age due to state and federal patient privacy regulations.
    a. Minors 0 -11 years of age: Proxy will be able to view general medical record information, schedule appointments and send a message to the provider.
    b. Minors 12 – 17 years of age: Proxy will be able to schedule appointments and send a message to the provider Proxy access of a minor patient will terminate when the minor patient turns 18 years of age.

C. **Requesting Adult Proxy Access of Adult Patient:**

1. A patient 18 years of age and older can designate a proxy by completing a myCare Adult proxy form and a myCare Adult proxy release of protected health information authorization.
2. El Camino hospital will validate the patient's request and authorization.
3. Once validated and approved, a myCare account will be created for proxy use.
4. The Authorization for Release of Protected Health Information for myCare proxy access is valid until revoked by the patient or El Camino Hospital

D. **Patients Requesting a Password Reset or Re-activation of their myCare Account:**

1. Patients will undergo the same verification process as a new patient requesting access.
2. Once the patients identity has been verified, a temporary password will be generated and provided to patient and/or account will be re-activated.

E. **Patients Requesting a Deactivation of their myCare Account:**

1. Patients will undergo the same verification process as a new patient Requesting access.
2. Once patient's identity has been verified, the account will be deactivated and a notation entered regarding the deactivation request.

F. **Expired Patients**

1. Once a patient medical record is marked as expired/deceased, the patient's myCare account access will be de-activated.
2. Any active proxy user access will remain active for 30 days post patient expiratiion in a read-only format
3. Users with proxy access can request deactivation prior to the 30 days by calling the HIM Department for assistance
4. No additional proxy accounts will be created once patient has expired.

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Approval Signatures

Step Description	Approver	Date
MEC	Michelle Nelmida: Administrative Coord	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	02/2023
HIM Leadership	Kristina Underhill: Manager HIM Ops	02/2023
	Kristina Underhill: Manager HIM Ops	02/2023

AB18k14. Medication Administration in the Neonatal Intensive Care Unit -NICU

Status **Pending** PolicyStat ID **12721537**

Origination	06/2009	Owner	Melinda Porter: CNS/NP
Last Approved	N/A	Area	NICU
Effective	Upon Approval	Document Types	Policy
Last Revised	04/2023		
Next Review	2 years after approval		

Medication Administration in the Neonatal Intensive Care Unit (NICU)

COVERAGE:

All El Camino Hospital Neonatal Intensive Care Unit (NICU) Staff

PURPOSE:

The purpose of this policy is to provide guidance to the NICU for the safe handling, checking, and administration of all medications to prevent patient injury.

POLICY STATEMENT:

El Camino Hospital and the NICU identifies High Risk / High Alert (HR/HA) medications and develops special safeguarding procedures to manage these medications to reduce medication errors. The list of identified HR/HA medications used in the NICU is periodically reviewed, revised, and published by the Pharmacy and Therapeutic (P&T) Committee to all patient care areas.

PROCEDURE:

A. Low risk medications: The administrating Registered Nurse (RN) is responsible for verifying the correct medication, dose, route, patient and time against the Electronic Health Record (EHR). The administering RN confirms the patient using two patient identifiers and administers the medication. Medications that fall under this category include:
    - Acetaminophen
    - Ferrous Sulfate

- Multivitamins
- Sodium Chloride
- Phytonadione
- Erythromycin Ointment
- Cyclomydril Opthalmic Solution
- Proparacaine Opthalmic Solution
- Gentamicin Ointment
- Hepatitis Vaccine
- Hepatitis B Immune Globulin
- Bacitracin Ointment
- A&D Ointment
- Glycerin Suppository
- Hyaluronidase

B. HR/HA Medications: require an "independent double check" by two registered nurses.
    1. Two RNs verify the correct medication by independently calculating, dose, route, patient, and time.
    2. The checking RN must witness medication preparation steps.
    3. If dosage calculation is involved:
        a. The checking RN must independently repeat all calculations without prior knowledge of the administering RN's calculation result.
        b. The two RNs compare the final calculation results each RN has independently derived. The results must concur.
    4. If infusion pump programming is involved:
        a. The checking RN must independently verify the accuracy of each pump setting as ordered per the EHR.
    5. When the above steps have been verified an "independent double-check" is said to be completed.
    6. The administering RN administers the drug after confirming the correct patient using two patient identifiers.

C. Medication requiring mandatory independent double-checks:
    1. Anti-arrhythmic drips (all concentrations):
        - Amiodarone
        - Lidocaine
        - Digoxin
    2. Vasoactive drips (all concentrations):

- Epinephrine
- Dopamine
- Dobutamine
- Phenylephrine
- Norepinephrine
- Nitroprusside
- Nitroglycerine

3. Narcotic analgesics (all concentrations):
    - Morphine
    - Morphine drips
    - Fentanyl
    - Fentanyl drips
4. Sedatives/nondepolarizing neuromuscular blockers (all concentrations):
    - Chloral hydrate
    - Midazolam drips
    - Lorazepam drips
    - Vecuronium drips
    - Vecuronium
    - Pancuronium drips
    - Pancuronium
    - Rocuronium
5. Other agents:
    - Insulin drips
    - Heparin drips
    - Prostaglandins
    - Adenosine
    - Indomethacin

****A physician is required to be present at the bedside during administration of Adenosine.**

D. All medications used in the NICU that are not listed under the low risk or HR/HA categories will require a double check by two nurses verifying the correct medication, dose, route, patient and time against the EHR. The administering RN is then responsible for confirming the patient using two patient identifiers before administering the medication.
    1. The P&T Committee defines a current list of HR/HA medications through periodic reviews of medication errors and those medications used in the organization.

2. The organization develops protocols and procedures for the safe procuring, storing, ordering, transcribing, preparing, dispensing and administering of HR/HA medications.
3. The P&T Committee establishes standardized concentrations, where applicable, for HR/HA medications.
4. The organization reduces or eliminates HR/HA medications from floor-stocks whenever possible. Bulk quantities of HR/HA medications are only allowed in the pharmacy.
5. The organization incorporates mandatory double-check or independent double-check procedures for HR/HA medications.

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	04/2023
P & T	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	03/2023
MCH Exec	Nikki Le Bautista: Medical Staff Coord	02/2023
Peds. Dept.	Melinda Porter: CNS/NP	01/2023
UPC	Melinda Porter: CNS/NP	12/2022
	Melinda Porter: CNS/NP	11/2022

AB18k15. Neonatal Screening for Critical Congenital Heart Disease -CCHD- Using Pulse Oximetry-Changes

Status Active PolicyStat ID 11072077

Origination	02/2013	Owner	Melinda Porter: CNS/NP
Last Approved	08/2022	Area	Maternal Child Health (MCH)
Effective	08/2022	Document Types	Policy
Last Revised	08/2022		
Next Review	08/2024		

Neonatal Screening for Critical Congenital Heart Disease (CCHD) Using Pulse Oximetry

COVERAGE:

~~All El Camino Hospital Staff~~

All Maternal Child Health Staff

PURPOSE:

- ~~Babies with a critical congenital heart defect (CCHD) are at significant risk for death or disability if their condition is not diagnosed soon after birth.~~
- ~~CCHDs can potentially be detected using pulse oximetry screening, which is a test to determine the amount of oxygen in the blood and pulse rate.~~

A. Babies with a critical congenital heart defect (CCHD) are at significant risk for death or disability if their condition is not diagnosed soon after birth.

B. CCHDs can potentially be detected using pulse oximetry screening, which is a test to determine the amount of oxygen in the blood and pulse rate.

POLICY STATEMENT:

It is the policy of El Camino Hospital to ensure patient safety. All babies in the Mother Baby Unit (MBU) and Neonatal Intensive Care Unit (NICU) will have a CCHD screening done before discharge, except babies who have been evaluated by a diagnostic echocardiogram.

REFERENCES:

~~1. State of California - Health and Human Services Agency, Department of Health Care Services.~~

(2014). Guidelines for Critical Congenital Heart Disease Screening Services. https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl040314.pdf

2. Knapp, AA, Metterville, DR, Kemper, AR, Prosser, L, Perrin, JM. (2010) Evidence review: Critical congenital cyanotic heart disease. Prepared for the Maternal and Child Health Bureau, Health Resources and Services Administration.
3. Kemper AR, Mahle WT, Martin GR, Cooley WC, Kumar P, Morrow WR, Kelm K, Pearson GD, Glidewell J, Grosse SD, Lloyd-Puryear M, Howell RR. (2011). Strategies for Implementing Screening for Critical Congenital Heart Disease. Pediatrics; 128:e1-e8.

- State of California - Health and Human Services Agency, Department of Health Care Services. (2014). Guidelines for Critical Congenital Heart Disease Screening Services. https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl040314.pdf
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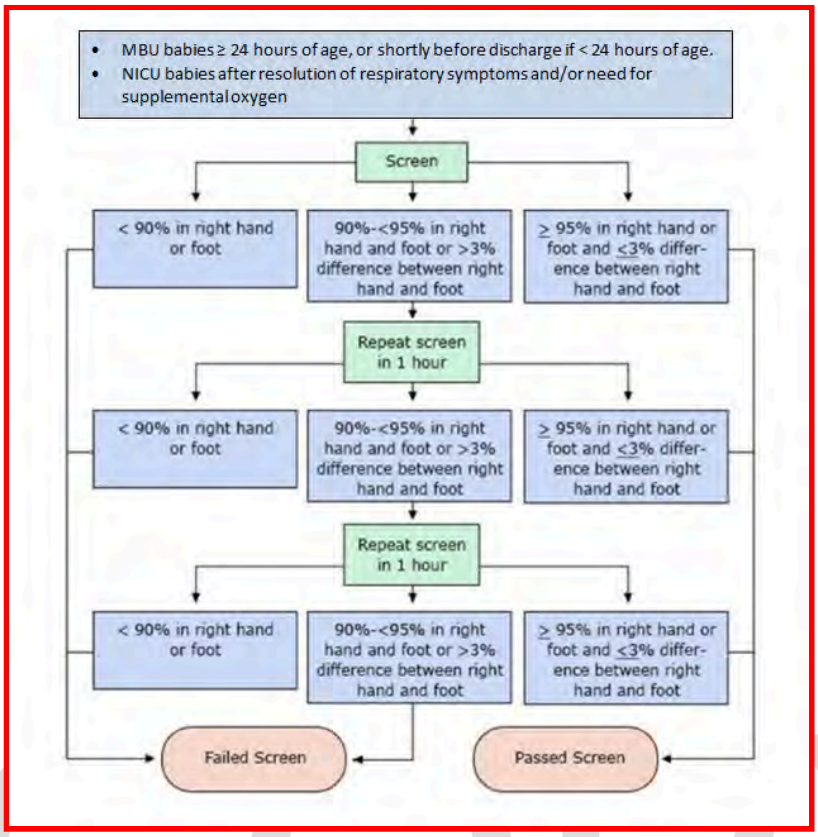
- Kemper AR, Mahle WT, Martin GR, Cooley WC, Kumar P, Morrow WR, Kelm K, Pearson GD, Glidewell J, Grosse SD, Lloyd-Puryear M, Howell RR. (2011). Strategies for Implementing Screening for Critical Congenital Heart Disease. Pediatrics; 128:e1-e8.

PROCEDURE:

1. Gather Equipment:
    - Portable Pulse Oximetry Monitor
    - Infant Pulse Oximetry Sensor
    - Alcohol wipes
    - Instruction sheet for parents: "When Babies are Screened" (See Attachment A)
2. Place sensor on infant's right hand, followed by right foot and obtain readings. Ascertain readings are accurate by observing pulse wave form and correlating pulse rate if necessary. If infant is active or fussy, wait until infant calms to obtain readings.
3. For passed screen: (see chart below) record results of testing on patient in Electronic Health Record (EHR) and indicate that testing is complete.
4. For failed screen: document result (less than 90% in right hand or foot) and notify infant's pediatrician for additional treatment. Record results of testing on patient in EHR.
5. For equivocal screen: document result and repeat testing (see chart) in one hour intervals, two times, to determine if result is negative or positive result. If positive notify infant's pediatrician for additional treatment. Record results of testing on patient in EHR.
6. Once testing and documentation complete; inform parents of result, remove infant sensor, clean and return pulse oximetry monitor to designated holding area and return sensor to recycling area. Wash hands.



A. Gather Equipment:
   1. Portable Pulse Oximetry Monitor
   2. Infant Pulse Oximetry Sensor
   3. Alcohol wipes
   4. Instruction sheet for parents: "When Babies are Screened" (See Attachment A)

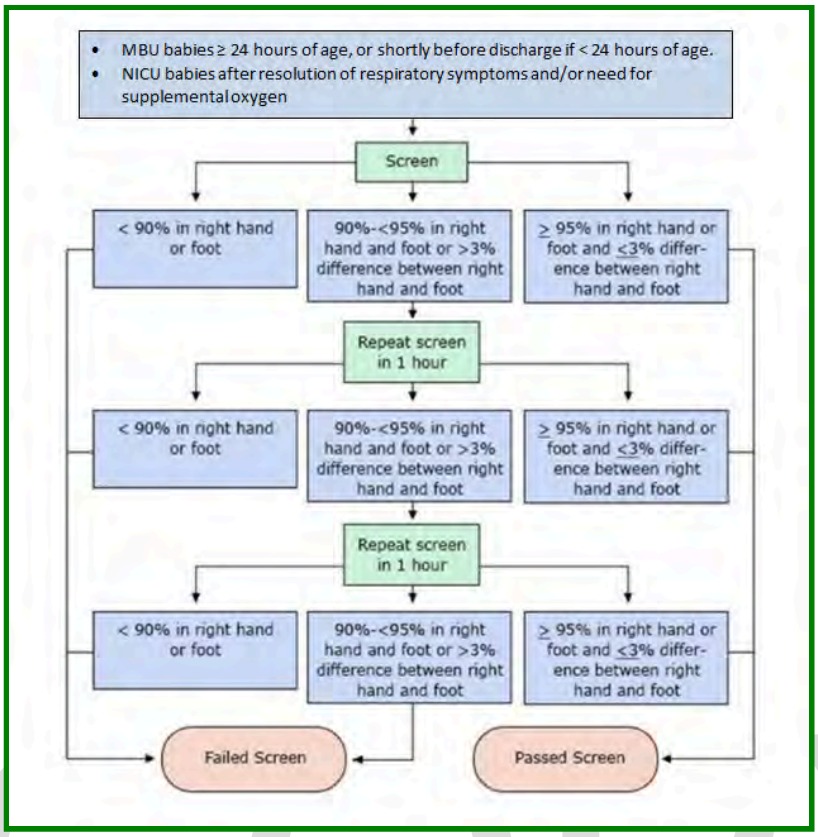
B. Place sensor on infant's right hand/wrist, followed by right foot and obtain readings. Ascertain readings are accurate by observing pulse wave form and correlating pulse rate if necessary. If infant is active or fussy, wait until infant calms to obtain readings.

C. For passed screen: (see chart below) record results of testing on patient in Electronic Health Record (EHR) and indicate that testing is complete.

D. For failed screen: document result (less than 90% in right hand or foot) and notify infant's pediatrician for additional treatment. Record results of testing on patient in EHR.

E. For equivocal screen: document result and repeat testing (see chart) in one hour intervals, two times, to determine if result is negative or positive result. If positive notify infant's pediatrician for additional treatment. Record results of testing on patient in EHR.

F. Once testing and documentation complete; inform parents of result, remove infant sensor, clean and return pulse oximetry monitor to designated holding area and return sensor to recycling area. Wash hands.



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Attachments

A: Instruction Sheet for Parents

Image 1

Approval Signatures

Step Description	Approver	Date
Publish	Patrick Santos: Policy and Procedure Coordinator	08/2022
MEC	Franz Encisa: Director Quality and Public Reporting [PS]	08/2022

ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	08/2022
MCH Exec	Nikki Le Bautista: Medical Staff Coord	06/2022
Peds. Dept.	Melinda Porter: CNS/NP	05/2022
UPC	Melinda Porter: CNS/NP	04/2022
	Melinda Porter: CNS/NP	01/2022

AB18k16. Mountain View and Los Gatos Arterial Blood Gas Laboratory Director Responsibilities and Delegations

Status **Pending** PolicyStat ID **13307525**

Origination	N/A	Owner	James Canfield: Manager Diagnostic Respiratory Care
Last Approved	N/A	Area	Respiratory Care Services
Effective	Upon Approval	Document Types	Policy
Last Revised	N/A		
Next Review	3 years after approval		

Mountain View and Los Gatos Arterial Blood Gas Laboratory Director Responsibilities and Delegations

COVERAGE:

Arterial Blood Gas Laboratory Core Staff and Respiratory Therapist

PURPOSE:

To establish the appropriate standards for the Mountain View and Los Gatos Arterial Blood Gas Laboratory Director Responsibilities and Delegations

POLICY STATEMENT:

The Medical Director is responsible for the technical and scientific oversight of the Blood Gas Laboratory as well as compliance with all regulatory standards, including The Joint Commission, State & Federal laws. To ensure complete coverage of the Laboratory, some responsibilities will be delegated to other members of the administrative personnel or technical personnel.

PROCEDURE:

The Blood gas Laboratory Medical Director Responsibilities include:

A. Involvement in the design, implementation and oversight of the lab's Quality Management program, including selection of quality indicators, review of complaints and incidents and corrective action plans.

    1. Ensuring that proficiency testing, alternative assessment, and QC procedures are

sufficient for the extent of testing performed in the laboratory.

2. Ensuring adequacy of laboratory services including Point of Care Testing according to medical staff and institutional needs, and fiscal/budgetary considerations.
3. Consulting on selection of laboratory equipment, supplies and services with respect to quality
4. Ensuring sufficient number of personnel with appropriate educational qualifications, documented training and competency to meet the needs of the laboratory.
5. Ensuring a safe environment in compliance with applicable regulations
6. Ensuring communication of laboratory data and appropriate patient result reporting
7. Providing consultations regarding medical significance and appropriateness of laboratory tests
8. Supporting education programs and strategic planning
9. Interacting with government and other agencies as appropriate
10. Ensure that delegated functions are carried out and that persons performing delegated functions are qualified to do so.

The Medical Director delegates some responsibilities to the Technical Director and Lead Technologist and Supervisors in the following manner:

Position	Organization, Authority and Responsibility
Section Technical Director	A. Responsible for overall operation, administration and compliance of the laboratory section. B. Ensures section compliance with regulatory and accreditation standards. C. Must be accessible to provide onsite, phone, or electronic consultation as needed. D. Provides clinical consultation for test appropriateness and interpretation. E. Reviews monthly QC/QA summary report with Lead Techs. F. Defines critical values, after consultation with clinicians and approval from Medical Executive Committee. G. Authorizes test menu. Assess and approve proposals for test changes. H. Assures representation on appropriate hospital committees. I. Approves requirements to ensure competency of testing personnel. J. Reviews proficiency testing results and approves corrective actions. K. Approves all new and significantly revised Policies and

	Procedures.
Lead Technologist and Supervisors	A. Compile and submit monthly quality summary reports to Technical Director. Report at Pulmonary Committee meeting. B. Implement test methods with approval from Technical Director C. Coordinate training and competency testing of testing personnel. Ensure testing is performed by qualified testing personnel. Train and authorize testing personnel as appropriate. D. Troubleshoot, resolve and document technical problems. E. Review and maintain records of instrument maintenance. F. Review technical policies and procedures biennially and submit documents with significant revisions to Technical Director or designee for approval. G. Verify testing methods and procedures and establish testing performance characteristics with approval from the Section Director. H. Together with the Technical Director evaluate change proposals for feasibility, compliance needs, and test methodology. Communicate changes and effective date. Ensure testing personnel are trained prior to test changes. I. Coordinate proficiency survey testing, sign attestation, report results and investigate any unacceptable responses. Review proficiency survey results with Technical Director. J. Perform and/or evaluate analytical measurement range validation, calibration verification and correlation studies. K. Together with Technical Director develop and implement staff competency assessments L. Leads perform technical and general supervisor duties.

Oversight:

The Medical Director will ensure all delegated director duties are properly performed through weekly meetings with the Technical Director, and quality assurance meetings as well as other communications and meetings with the Lead Technologist and Supervisors as required.

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	03/2023
Medical Director Respiratory Care Services	James Canfield: Manager Diagnostic Respiratory Care	03/2023
Director Respiratory Care Services	Jolie Fournet: Dir Resp Care & Min Inv Prog	03/2023
	James Canfield: Manager Diagnostic Respiratory Care	03/2023

AB18k17. Individualized Quality Control Plan Respiratory Care Blood Gas Laboratories

Status **Pending** PolicyStat ID **11858124**

Origination	01/2016	Owner	James Canfield
Last Approved	N/A	Area	Respiratory Care Services
Effective	Upon Approval	Document Types	Plan
Last Revised	09/2019		
Next Review	3 years after approval		

Individualized Quality Control Plan Respiratory Care Blood Gas Laboratories

I. COVERAGE:

Pulmonary Diagnostics Laboratories Core Staff and Respiratory Therapists MV and LG Campuses

II. PURPOSE:

The purpose of this Standardized Process/Procedure is to provide guidelines for an effective individualized quality control plan (IQCP). The steps help determine if the current quality procedures are adequate or if additional or different activities are needed to reduce potential failures and errors.

I. DEFINITIONS:

1. **Risk Assessment:** this is the means of identifying and evaluating the risk of potential problems or errors that may occur in our testing process. The testing process encompasses all phases of testing: beginning with the specimen collection (pre analytic) and continues through the analysis of the specimen (analytic) until the final test result is reported (post analytic).
2. **Quality Control Plan:** QC Plan will establish control procedures that reduce the likelihood of providing an inaccurate patient test result in our laboratory.
3. **Quality Assessment**: regular, documented reviews of each of your IQCPs to your existing Quality Assessment Plan. The monitoring must include, but is not limited to, each required component of IQCP (testing personnel, environment, specimens, reagents, and test system).
4. **Pre-Analytic Phase:** Pre-analytic is a part of the total testing process referring to all steps taken prior to the actual testing of a patient specimen from the test request to the actual

testing of the specimen.

5. **Post-Analytic Phase:** Post-analytic is a part of the total testing process occurring after analysis. It includes but is not limited to data entry; follow-up plan; and reporting results to the healthcare provider.
6. **Analytic Phase:** A part of the total testing process involving workflows related to preparation and processing of patient specimens, analysis of specimens, and interpretation of test results.

II. REFERENCES:

1. CDC CLIA Website, http://wwwn.cdc.gov/clia/default.aspx, retrieved January 2016
2. CLIA Federal Regulations, http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/CLIA_Regulations_and_Federal_Register_Documents.html, retrieved January 2016
3. CDC IQCP Workbook and Resources, http://wwwn.cdc.gov/CLIA/Resources/IQCP/, retrieved January 2016

III. PROCEDURE:

A. The IQCP process includes: Risk Assessment, Quality Control Plan (QCP), and Quality Assessment (QA). An IQCP must address the potential failures and errors identified in the entire testing process: pre-analytic, analytic and post-analytic phases of testing. At regular intervals there will be a review of each of the elements that the plan incorporates to prevent errors and ensure accurate results, including review of:

   1. QC results and graphs
   2. other quality measures we have implemented
   3. proficiency testing results
   4. incidence of specimen rejection
   5. concerns or complaints from providers
   6. any incidents related to this test

B. The Diagnostic Services Manager and the Diagnostic Laboratory leads are responsible for implementing and reviewing QA processing on an ongoing basis. Quarterly reports are to be given to the Pulmonary Committee and the Director of Respiratory Care Services.

C. **A risk assessment** is performed annually. The process is for identifying and evaluating the potential failures and errors that could occur during the **pre-analytical** (before testing), **analytical** (testing), and **post-analytical** (after testing) phases of testing. At a minimum, evaluate the following six components of the testing process for potential failures and errors:

   1. specimen
   2. test system
   3. Previous year's CVM, QC and PT results
   4. reagent
   5. environment

6. testing personnel

D. **The Quality Control Plan (QCP)** describes practices, procedures and resources needed by your laboratory to ensure the quality of a testing process. The QCP includes measures to assure the accuracy and reliability of test results, and that the quality of testing is adequate for patient care. The QCP provides for immediate detection of errors that occur due to test system failure, adverse environmental conditions, and operator performance. It also monitors, over time, the accuracy and precision of test performance that may be influenced by changes in the specimen, test system, reagent, environment, or variance in operator performance. The following are performed as part of the plan:

1. Document temperatures for the refrigerator and freezer each day of patient testing.
2. Document the room temperature, morning and afternoon, each day of patient testing. The acceptable criteria for temperature ranges must be included in the temperature logs.
3. Verify specimen collection syringes for acceptability upon receipt in the laboratory.
4. Document improperly collected specimens following established Specimen Rejection Policy.
5. Verify specimen collection and receipt times
6. Test and document reagent stability by running external normal and abnormal controls per manufacturer's instructions.
7. Verify and document Internal QC as "acceptable" for each patient test performed before patient results are reported.
8. Document the date and time when reagent cartridges are removed from the refrigerator.
9. Verify that training of testing personnel, upon hire and when indicated, documents successful demonstration of competency as indicated by laboratory policy and regulations. The Manager will insure that 100% of all new employees' orientation will include specific job duties and responsibilities. All policies have been modified to include job specific orientation processes. In addition, all employee training files will be audited bi-monthly and calendar alerts have been established. Therefore, all paperwork required for annual recertification will occur on the staff member's employment anniversary date and each employee will received automated reminders monthly three months prior to recertification date. This process is monitored on an ongoing basis by the Manager and or the lab lead with quarterly reports to the Department Director
10. Each employee will received automated reminders monthly three months prior to recertification date. The Manager will audit the process for compliance quarterly and report the results at the quarterly Pulmonary Committee meeting.

E. **Quality Assessment (QA)**: All IQCP QA monitoring is part of the lab's overall QA plan and is an ongoing review process for the IQCP. The lab has a review system for the ongoing monitoring of the effectiveness of the lab's IQCP. The monitoring includes, but not limited to specimen, environment, testing personnel, reagent, and test system.

Proficiency results are examined for discrepancy. Method history is reviewed (QC, maintenance, lot number, staff competency, and policy and procedure). Survey material problem are investigated (handling, reconstitution, storage, analysis sequence, matrix effects, etc.).

When the laboratory discovers a testing process failure, the laboratory will conduct an investigation to identify the cause of the failure and its impact on patient care. The investigation will include documentation of all corrections, corresponding corrective action(s) for all patient results affected by the testing process failure, and evaluation of the effectiveness of the corrective action(s) taken. The laboratory will implement the correction(s) and corresponding corrective action(s) necessary to resolve the failure and reduce the risk of recurrence in the future. If necessary, the laboratory will update the risk assessment with the new information and modify the QCP, as needed. In addition, if there is a complaint on a test result and or unacceptable QC and proficiency test result, the lab investigates and takes corrective action. It may be necessary to change the IQCP as identified and required by on-going monitoring.
The following documents will be reviewed:

1. QC data sheets **analytical**
2. PT records (scores, testing failures, trends) **analytical**
3. CVM records **analytical**
4. Complaint reports (QRR) **pre-analytical**
5. Patient results review **analytical**
6. Appropriateness of specimen, specimen collection, specimen handling and transportation **pre-analytical**
7. Critical results call logs**post-analytical**
8. Turnaround time reports **post-analytical**
9. Records of preventive measures, corrective actions, & follow-up **post-analytical**
10. Personnel training and competency assessment **post-analytical**

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	09/2022

Medical Director Respiratory Care Services	James Canfield: Manager Diagnostic Respiratory Care	07/2022
Director Respiratory Care Services	Jolie Fournet: Dir Resp Care & Min Inv Prog	07/2022
	James Canfield: Manager Diagnostic Respiratory Care	06/2022

AB18k18. Donor Gift Acceptance Policy

Status **Active** PolicyStat ID **14885331**

Origination	01/2024
Last Approved	01/2024
Effective	01/2024
Last Revised	01/2024
Next Review	01/2027
Owner	Dakota Atley: Dir Foundation Operations
Area	Foundation
Document Types	Policy

Donor Gift Acceptance Policy

COVERAGE:

All El Camino Health and El Camino Health Foundation Staff.

PURPOSE:

The purpose of this policy is to govern the acceptance of gifts, provide guidance to donors and their professional advisors in completing gifts, protect the best interests of those who make voluntary contributions to support the mission of El Camino Health, and protect the interests of El Camino Health and El Camino Health Foundation. This policy is intended only as a guide. Flexibility within this policy is permitted in situations where it is considered by El Camino Health Foundation to be appropriate and in the best interests of the organization.

DEFINITIONS:

- El Camino Health and its Subsidiaries (ECH) – A health system and includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and urgent care, providing multi-specialty care and primary care.
- El Camino Health Foundation (ECHF) – is a not-for-profit corporation under the laws of the State of California and a tax-exempt organization under section 501(c)(3) organization of the Internal Revenue Code that receives substantial support from the public. Contributions to ECHF are tax deductible as provided by law. ECH is the sole beneficiary of ECHF.

PROCEDURE:

ECHF is a supporting organization of ECH. Its policies, procedures and programs must be consistent with the mission and programs of ECH and ECHF. Except as specifically described, the provisions of this policy shall be binding on both ECH and ECHF.

All gifts to ECH and ECHF shall be received by ECHF, which will record the terms, restrictions and conditions of the gift. The ECHF office will deposit all gift monies to the appropriate bank accounts and provide information to ECH accounting department and send the acknowledgment to donor(s). Pledges and gifts will be recorded and a pledge payment reminder system will be maintained by ECHF.

Recordings shall be made in a manner that provides appropriate tax acknowledgement to the donor. All contributions shall be made and accepted in conformity with the provisions of Federal and State laws, as well as the Internal Revenue Code and regulations that are in effect at the time of the gift transaction.

ECHF shall seek the advice of legal counsel when appropriate to accept a gift. ECHF will strongly encourage donor(s) to seek independent professional counsel prior to making a gift. ECHF will not give tax or legal advice to any donor under any circumstances.

A. Gift Designation

1. Unrestricted Gifts – ECHF encourages donations to be made without restrictions as to the application of the gift. To this end:
    a. ECHF will maintain an unrestricted fund to receive and account for such unrestricted gifts, commonly known as the “El Camino Health Fund”, "El Camino Fund", “Greatest Need Fund” or “Where the Need is Greatest”.
    b. Two to three cycles per year, ECH service lines and/or departments submit requests for funding which are reviewed and approved by ECHF Allocations Committee and then the ECHF Board.
    c. Unrestricted funds will be released to ECH in support of ECHF’s operating expenses (salaries, benefits and rent are currently covered by ECH).
2. ECHF also accepts gifts restricted to established funds, newly donor named restricted funds or high priority program areas of ECH, as designated by ECHF.
3. Other gifts restricted by the donor to specific departments or activities of ECH or ECHF may be accepted as follows:
    a. Gifts may be accepted with the understanding that the money may be disbursed into the annual budget of the appropriate operating department in order to satisfy the restriction while helping the department address its greatest needs. Through annual review of fund activity, departments will be held accountable to ensure funds are used within five years, unless an extension is granted, of the gift or as designated by the donor with ECHF agreement.
4. Gifts to ECHF cannot be restricted to the benefit of a specific individual (example: for an employee or for payment of a specific individual’s hospital bill).
5. No restricted fund will be established that requires approval for expenditure by anyone other than the President of the Foundation for requests of $5,000 or more and the Director of Foundation Operations for requests below $5,000.
6. If a donor provides funds before a designation is established or agreed upon, the funds will be held in the Holding Account until the designation is made and/or agreed upon and then the funds will move to the appropriate fund no later than the

following month end close.

7. Any income that is earned on restricted fund balances may be placed in the unrestricted fund.

B. Endowed Gifts

1. Please see the Endowment Spending Policy

C. Form of Gifts

1. OUTRIGHT GIFTS

a. Gifts by cash, check or credit card shall be accepted by ECHF regardless of the amount.

i. When the purpose of the payment is to make a charitable gift; checks may be made payable to “El Camino Health”, “ECH”, “El Camino Health Foundation”, “El Camino Hospital Foundation”, “ECHF” and/or to a particular program or service line of ECH or ECHF.

ii. Currency shall be receipted at the point of reception by two employees representing ECHF.

iii. Payment by credit card may be accepted through the secure website for on-line giving to ECHF, by telephone, at an event or in person and subject to credit card company authorization requirements. Credit card payments shall be receipted by email or mailing proof of electronic execution of the charges if on-site presentation of electronic receipt is not feasible. After processing, credit card numbers are destroyed; no credit card numbers are held on file for future payments.

b. Publicly traded securities will be accepted by ECHF and will be sold within 24 business hours upon notification of receipt.

i. For ECHF gift crediting and accounting purposes, reasonable efforts will be made to determine and record the gift date as the date the securities are surrendered by the donor. The assigned value of the gift shall be the average of the high and low public trades of the security on the gift date.

c. Closely held securities, or securities not traded publicly, will not be accepted. In this circumstance, the donor will need to liquidate the asset and provide a cash gift or utilize another organization to pass the funds through. Some circumstances may be considered after consultation with ECHF Finance Committee and approval from ECHF Board.

i. Prior to acceptance, ECHF shall establish the method of liquidation of the securities through redemption or sale. In so doing, the donor shall pay a third party to estimate the fair market value and determine whether there are any restrictions on transfer.

ii. No commitment for the redemption or sale of such securities shall be made prior to completion of the gift.

2. REAL ESTATE
    a. Before acceptance, gifts of real estate must be reviewed and approved by ECHF Executive Committee and ECHF Board. Among the factors to be considered are:
        i. Value of the property
        ii. Any donor restrictions
        iii. The marketability of the property
        iv. Any liens or mortgages
        v. Transaction costs in accepting or selling the property
        vi. Maintenance cost
        vii. Environmental risks
        viii. Additional liabilities
    b. Prior to presentation of a proposed real estate gift to the Executive Committee, an El Camino Health Staff member must inspect the property, get a third-party professional evaluation, particularly in regard to potential environmental liability.
    c. The following documents must be provided by the donor prior to Executive Committee review:
        i. Deed to property
        ii. Real estate tax documentation
        iii. Plot plan
        iv. Substantiation of zoning status
    d. The donor may be expected to pay for all or a portion of the following costs until the property has been sold:
        i. Maintenance
        ii. Real estate taxes
        iii. Insurance
        iv. Brokerage commission and other costs of sale
        v. Appraisal
        vi. Third-party professional evaluation
    e. For ECHF's gift crediting and accounting purposes, the assigned value of the gift is the appraised value of the property.
3. LIFE INSURANCE
    a. ECHF will accept life insurance policies as gifts only when it is named as

the owner and beneficiary of 100% of the policy.

b. If it is a paid-up policy, the assigned value of the gift for ECHF's gift crediting and accounting purposes is the policy's replacement cost.

c. If the policy is partially paid-up, the assigned value is its cash surrender value. (Note: The IRS's allowed charitable income tax deduction is equal to the interpolated terminal reserve, which is an amount slightly in excess of the cash surrender value.)

d. If ECHF is the recipient of a life insurance policy and the policy owner no longer pays the premium, ECHF may choose to pay the annual premium.

4. GIFTS OF TANGIBLE PERSONAL PROPERTY

a. Property donated for use by ECHF should, in their sole judgement, have an application related to ECHF's exempt purposes. Depending on the value of the gift, ECHF may require an outside appraisal of the property paid for by the donor before accepting it.

b. Other donated property may be accepted upon approval by the ECHF Executive Committee and ECHF Board. Such gifts shall be sold for the benefit of ECHF. For ECHF's gift crediting and accounting purposes, the assigned value of the gift will be its realized sales price.

c. No property which requires special display facilities or security measures shall be accepted without consultation with the El Camino Hospital CAO (Chief Administrative Officer) and ECHF Executive Committee and ECHF Board.

d. ECHF adheres to all IRS requirements related to the disposal of gifts of tangible personal property and the filing of appropriate forms.

5. PLEDGES AND PROMISES TO GIVE

a. A promise to give, or a pledge, is a written or oral promise to make a contribution in the future. It is recorded as a contribution when there is verifiable evidence that such a promise has been conveyed.

b. ECHF will record pledges in its financial statement in accordance with generally accepted accounting principles.

c. Pledges may be payable in single or annual installments. Pledges greater than $10,000 may not exceed 7 years.

d. As a general rule, ECHF's public recognition of contributions will be based on gifts actually received, not on promised donations, especially in regard to amount-based recognition.

6. PLANNED GIFTS

a. ECHF accepts donations in the form of various planned gift vehicles including but not limited to bequests, charitable remainder trusts, charitable lead trusts and charitable gift annuities. Donors and their legal advisors are encouraged to reference the doing business as El Camino Health Foundation or its legal name, El Camino Hospital Foundation.

b. Donors who have indicated that they have established a planned gift may, depending on the individual situation, be asked to disclose written evidence of such gift for the benefit of ECHF. Such information is for internal financial purposes and is not binding on the donor.

c. Mature planned gifts, unless otherwise designated by the donor, will be directed into the ECHF unrestricted fund, "El Camino Fund", to provide support where the need is greatest.

d. Generally, ECHF will not pay for the drafting of legal documents for a charitable remainder trust or charitable lead trust. The Executive Committee may approve such a request if circumstances warrant and if ECHF is named as sole beneficiary and the gift is irrevocable. The donor's own counsel must review the documents at donor's cost.

e. ECHF does not currently offer itself as trustee, but should the request arise with ECHF named as sole beneficiary, ECHF will appoint a third party as trustee. ECHF Executive Committee must approve such a relationship.

f. Management fees for the administration of these trusts when ECHF has agreed to serve as trustee or co-trustee shall be paid from the income of the trust.

g. In the event ECHF agrees to serve as trustee, the trust's payout rate to the donor shall be negotiated between the donor and ECHF and shall reflect the number of beneficiaries, their ages and the size of the trust. The payout rate must be such that ECHF agrees that the trust reflects donative or charitable intent on the part of the donor. By current law, this payout rate cannot be lower than 5%.

h. Charitable Gift Annuities:

    i. A donor may give a charity set assets by which the charity contracts to pay an annuity to a designated beneficiary while the beneficiary is living. ECHF follows the American Council on Gift Annuities suggested rates. In addition, the following conditions must be met:

        - Administrative fees shall be paid from the income earned by the annuity.
        - There shall be no more than two beneficiaries on an annuity.
        - The minimum gift to establish a charitable gift annuity is $10,000.

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

Approval Signatures

Step Description	Approver	Date
Publish	Patrick Santos: Policy and Procedure Coordinator	01/2024
ePolicy	Patrick Santos: Policy and Procedure Coordinator	01/2024
Foundation Board	Dakota Atley: Dir Foundation Operations	12/2023
Executive Committee	Dakota Atley: Dir Foundation Operations	12/2023
Finance Committee	Dakota Atley: Dir Foundation Operations	12/2023
	Dakota Atley: Dir Foundation Operations	12/2023

AB18k19. Restricted Fund Policy

Status Active PolicyStat ID 13952204

Origination	07/2023
Last Approved	07/2023
Effective	07/2023
Last Revised	07/2023
Next Review	07/2026
Owner	Dakota Atley: Dir Foundation Operations
Area	Foundation
Document Types	Policy

Restricted Fund Policy

COVERAGE:

All El Camino Health Staff.

PURPOSE:

The purpose of this policy is to state that all restricted gifts are to be spent in accordance with the donor's intent and to define the process for creating, spending, and managing El Camino Health Foundation's restricted funds (also known as Special Purpose Funds). The primary objective of a restricted fund is to provide current cash flow for designated projects, programs, patient care, etc. These are considered current use funds and the goal is to expedite the spending in accordance with the donor's intention so that the Foundation may report to the donor the impact of their gift in order to steward them to continue giving additional support. When a donor restricts El Camino Health Foundation to allocate funds to a specific purpose, El Camino Health and El Camino Health Foundation are required to do so by law and policy. Failure to comply with restrictions or unauthorized use of restricted funds may result in legal action. If a donor choses no restriction on their donation, the gift will be placed in the El Camino Fund (also known as Where the Need is Greatest Fund or Unrestricted Fund).

DEFINITIONS:

- El Camino Health and its Subsidiaries (ECH) – A health system and includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and urgent care, providing multi-specialty care and primary care.
- El Camino Health Foundation (ECHF) – is a not-for-profit corporation under the laws of the State of California and a tax-exempt organization under section 501(c)(3) organization of the Internal Revenue Code that receives substantial support from the public. Contributions to ECHF are tax deductible as provided by law. ECH is the sole beneficiary of ECHF.

- Restricted Fund – A restricted fund is any **donation made and earmarked for a specific purpose by the donor.** The donor has the legal right to restrict the donations they contribute to ECHF and require that their gifts be used only for limited and specific purposes. Restricted funds provide reassurance to donors that their contributions are used in a manner that they have chosen.
- Service Line Manager – Primary contact assigned by the business line to work with ECHF to manage the restricted fund(s) expenditures in a timely manner.

PROCEDURE:

A. REQUIRED GIFT AMOUNT TO ESTABLISH A RESTRICTED FUND

1. Restricted Funds

   a. The donor who makes a gift of $25,000 or more is afforded the right to name a restricted fund (Example: The Atkins Fund for Nursing Excellence) if a restricted fund does not exist for the donor's restrictions. Proceeds from that fund will be used as the donor designates.

   b. The donor who makes a gift of any amount may restrict that gift and assign it to a previously established restricted fund. If no fund exists for the intended purpose, the donor may assign the gift to another fund or increase the gift amount to the $25,000 threshold and name a new restricted fund.

B. RESTRICTIONS ON SPENDING BASED ON FUND VALUE
If the restricted fund balance is below $0.00, ECH Finance will cease all spending from the fund until the fund value returns to a balance above $0.00. New added revenue in any given month is reported once month end close is completed by ECH Finance and reports are released for the previous month's activities, typically15-20 business days after the close of the previous month. If a restricted fund balance is still below $0.00 at each fiscal year end, 06/30, the restricted fund will be adjusted to $0.00 and the adjusted value will be charged back to the cost center as a reduction of reimbursements.

C. FUND MANAGEMENT GENERAL POLICY
It is the policy of ECHF that all gifts, pledges and private grants from individuals, corporations, foundations, and organizations made to ECHF for restricted funds are recorded and monitored by the ECHF's donor management system. All qualifying restricted funds are to be spent in accordance with the donor's intent. If at some future time the use of this fund is not possible due to a change in ECH's programs or the healthcare environment; the ECHF Board, according to its policies and applicable law, and in consultation with the original donor if available; reserves the right to adjust the usage of the fund towards a purpose that most closely meets the donor's original intent.

D. INTERNAL PROCESS

1. Setting Up Restricted Fund Internally
   To set-up a new restricted fund, a minimum amount of $25,000 or a balance less than $25,000 plus irrevocable pledged commitments to reach the $25,000 is required. Contributions are grouped together by their restrictions and are recorded in ECH's Activities Module of the ECH accounting system as Foundation Funds or Grants. ECHF funds in the Activities module are monitored by both the ECH

Controller and ECHF President. If the gift has no donor-placed restrictions, then the gift will go toward the El Camino Fund (also known as Where the Need is Greatest or Unrestricted Fund).

2. Procedure to Ensure Funds Will Be Used
    a. Donations that are restricted by the donor for a specific area or program will be placed in an appropriate restricted fund.
    b. If a restricted fund does not exist for the donor's restrictions, the donation will be placed in the holding account until a new restricted fund is created.
    c. ECHF staff responsible for securing the gift will submit a "New Fund Set-up Request Form" to the ECHF Program Manager, Gift Accounting.
    d. The ECHF Program Manager, Gift Accounting will submit a request to ECH Finance to set-up the new restricted fund.
    e. The ECHF staff responsible for securing the gift are responsible for alerting the Service Line Manager when a restricted fund has been assigned to them and what restrictions are on the activity.
    f. Once created, the restricted fund will be assigned by ECH Finance, who will notify ECHF. ECHF will then notify the appropriate Service Line Manager and ECHF staff responsible for securing the gift.
    g. ECH Finance Department will provide a Monthly Activity Report (MAR) of ECHF's restricted funds that summarizes fund activity to ECHF. ECHF will then share with the assigned Service Line Manager.
    h. Any discrepancies on the restricted fund MAR needs to be reported to the ECH Chief Accountant for oversight, who will make any necessary changes.
    i. Discrepancies must be reported to ECH Finance and ECHF within thirty (30) days. Any requests for modifications to the MAR post-30 days will require the ECHF President's approval. Any approved changes will be reflected on the following month's MAR.
    j. The Service Line Manager will be responsible for administering the allocated spend amount from the restricted fund and will have the authority and responsibility to request expenses/purchases of their respective assigned restricted funds expenditures with the exceptions in sections, p, q and r listed below.
    k. It is the responsibility of the Service Line Manager to ensure that the expenditure is in keeping with the restrictions of the fund. Questions regarding appropriate use should be directed to ECHF.
    l. All relevant ECH policies must be adhered to (catering, mileage reimbursement, etc.). All item purchases must follow ECH's procurement policies.
    m. At the close of the second quarter of each fiscal year, all funds with no expenditures in the last six (6) months will be reviewed by the ECHF President, ECH Chief Financial Officer, ECH Controller and ECHF Director of

Foundation Operations. The appropriate Service Line Manager will be alerted and asked to provide an update on expected expenditures for the remainder of the fiscal year.

n. At the end of each fiscal year, if monies are still available, the ECHF President and ECH Chief Financial Officer will review those funds with relevant members of ECH Executive Management who will then discuss with their respective Service Line Manager(s) regarding any funds lacking activity to ensure the timely and responsible use of the funds.

o. If after the end of fiscal year review, there remains unspent monies in a restricted spendable fund account the fund will be reviewed by the ECHF President and the ECHF Finance Committee to determine if funds should carry over to the next fiscal year for future expenditures or used to offset expenses charged incorrectly to an operational budget.

p. All expenditures or restricted funds used to fund a full-time, part-time, hourly or contract employee require the ECH Chief Operating Officer's pre-approval and HR's normal process to request a new employee or contractor.

q. All expenditures from restricted funds used for Capital equipment (as defined in the Asset Capitalization Policy) requires the ECH Chief Operating Officer's pre-approval.

r. After Service Line Manager(s) and their appropriate ECH Executive Team member(s) approvals, all expenditures must also be approved by the ECHF President or ECHF Director of Foundation Operations through ECH's financial management tracking system.

E. Minimum Information Required to Establish a New Restricted Fund

1. Restricted Name (Short Description)
2. Program Name or Funding Description (Long Description)
3. Fund Class (Research, Care or Education)
4. Fund Category (Restricted or Unrestricted)
5. Assigned Service Line Manager Name
6. 2nd Person's Name to Receive Copy of Reports (if applicable)
7. Grant/Gift Start Date
8. Division/Department Name/Program Area
9. Division/Department Head Name
10. Executive Manager Reporting to
11. Single Donor (Donor's Name) or Multiple Donors
12. Donors Intent Restrictions
13. Key Words for Searches

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Approval Signatures

Step Description	Approver	Date
Publish	Patrick Santos: Policy and Procedure Coordinator	07/2023
ePolicy	Patrick Santos: Policy and Procedure Coordinator	07/2023
Foundation Board	Dakota Atley: Dir Foundation Operations	07/2023
Executive Committee	Dakota Atley: Dir Foundation Operations	07/2023
Finance Committee	Dakota Atley: Dir Foundation Operations	07/2023
	Dakota Atley: Dir Foundation Operations	07/2023

AB18k20. Tribute Gifts Policy

Status **Active** PolicyStat ID **12435565**

Origination	10/2022
Last Approved	10/2022
Effective	10/2022
Last Revised	10/2022
Next Review	10/2025
Owner	Dakota Atley: Dir Foundation Operations
Area	Foundation
Document Types	Policy

Tribute Gifts Policy

COVERAGE:

El Camino Hospital Staff and Affiliates.

POLICY STATEMENT:

It is the policy of El Camino Health Foundation that all tribute gifts made to El Camino Health are recorded and tracked via the Foundation's donor management system. All tribute gifts are to be spent in accordance with the donor's intent.

PROCEDURE:

The donor who gave the gift will choose the fund designation. If the donor does not designate a fund, the gift will support the unrestricted El Camino Fund.

A. When a family member of the tribute notifies the Foundation and requests for the gift to be re-designated to a different fund, ECHF will inform the family member that only the donor may make the fund change request.

B. ECHF will notify the designated contact to receive the notification that a tribute donation has been made with the name of donor(s) and mailing address (unless they wish to be anonymous). The dollar amount of each donor will remain confidential.

    1. When the designated contact requests for a report of how much was received, we will honor the request and disclose the total amount and count of how many gifts were received.
    2. Notifications will be sent to the designated contact on a per gift basis unless requested differently by the designated contact. (Example: once a week, every 5 gifts received, etc).

3. For Circle of Caring Program honorees, the designated individual or group will be notified of their outstanding care. This will include the donor's name (unless they wish to be anonymous) and message (if any).
    a. When the honoree is a physician, the physician will be notified directly.

C. When ECHF receives notification that a tribute gift is coming, the Program Manager, Gift Accounting staff will be notified to make the necessary updates to ensure timely tribute notifications are satisfied.

D. ECHF will not take further action when a tribute gift does not have a designated contact. The gift will still be linked to the tribute name.

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Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2022
	Dakota Atley: Dir Foundation Operations	09/2022

AB18k21. Medical Staff Services - Credentialing Quality Process Improvement-Changes

Status **Pending** PolicyStat ID **14315677**

Origination	01/2023	Owner	Raquel Barnett: Sr. Director Medical Staff Services
Last Approved	N/A	Area	Medical Staff
Effective	Upon Approval	Document Types	Plan
Last Revised	12/2023		
Next Review	1 year after approval		

Medical Staff Services - Credentialing Quality Process Improvement

PURPOSE:

El Camino Hospital (ECH) Medical Staff Services Credentialing Quality Improvement Process describes the internal quality improvement framework utilized to continuously improve the credentialing process.

CREDENTIALING QUALITY IMPROVEMENT PROGRAM STRUCTURE:

A. The scope of activities covered by the Medical Staff Services Credentialing Quality Improvement Program (Program) include but are not limited to the following:
    1. Data integrity
    2. Timeliness of practitioner onboarding
    3. Credential file audit process (prior to Department Chair, Interdisciplinary Practice Committee, Credentials Committee, Medical Executive Committee review and recommendation)

B. Medical Staff Services maintains credentialing data and documents in a secure electronic and paperless environment which is the system of truth across health system. The goals and objectives of the Program for each quality indicator, A.1-3 are as follows:
    1. Ongoing oversight of credentialing related data to ensure accuracy of practitioner data internally and to downstream systems (e.g. Epic, Find a Doc, Pharmacy).
    2. Timely practitioner onboarding includes an initial application turn-around time within

120 days of receipt of a completed application. The objective is to support specialty and patient needs across the health system.

3. Credential file audit is to ensure all required elements are obtained as defined by ECH, California State, and Regulatory bodies (e.g. TJC, NCQA, CDPH, CMS). The objective is to ensure file completeness and regulatory compliance prior to a credentialing decision.

C. Performance Assessment for the Program indicators and analysis is defined as follows:

1. Credentialing data is evaluated on an ongoing basis using routine reports from the credentialing database-(e.g. practitioners by alarm, reappointment, temporary privileges, expirables).
2. Credentialing Quality Improvement Dashboard
    a. Applicant Preapplication Turn Around Time
    b. Preapplication Received to Application Sent
    c. Onboarding Turn Around Time
    d. Monthly Application Volume
    e. FPPE Status
    f. Expirables
    g. Denials
3. Credentials file audit is the systematic review of credentials files undergoing initial credentialing, recredentialing, return from leave of absence, change of practitioner status and/or privileges mid-cycle, temporary/expedited privileges. The analysis is conducted by Medical Staff Services Department leadership and is defined in the Medical Staff Services Department Credential and Privileging Procedure, credentialing system controls, virtual committee process, and checklists.
    a. 100% of credentials files are screened for completeness and accuracy prior to review and recommendation by committees.

D. Process for resolving client complaints

1. Complaint is received from client and reviewed within 30 days of receipt.
2. Investigate and review by appropriate personnel for additional information and/or follow-up (as needed).
3. Appropriate action plan is developed and implemented within 30 days in accordance with client.
4. Action plan is monitored for ongoing compliance.
5. Track and trend as appropriate.

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Approval Signatures

Step Description	Approver	Date
MEC	Michael Coston: Interim Regulatory Accreditation and Licensing Con	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	12/2023
Credentialing Committee	Raquel Barnett: Sr. Director Medical Staff Services	11/2023
IDPC	Raquel Barnett: Sr. Director Medical Staff Services	09/2023
	Raquel Barnett: Sr. Director Medical Staff Services	09/2023

AB18k22. Medical Staff Services - Protecting Credentialing Information and System Controls-Changes

Status **Pending** PolicyStat ID **14307938**

Origination	01/2023	Owner	Raquel Barnett: Sr. Director Medical Staff Services
Last Approved	N/A	Area	Medical Staff
Effective	Upon Approval	Document Types	Policy
Last Revised	09/2023		
Next Review	3 years after approval		

Medical Staff Services - Protecting Credentialing Information and System Controls

COVERAGE:

Medical Staff Services Department, Administration and Medical Staff Leadership.

PURPOSE:

To ensure the employees of El Camino Hospital (ECH) Medical Staff Services Department (MSSD) and those with business requirements comply with all hospital policies and procedures, State and Federal laws governing confidentiality of credentialing and peer review information. All MSSD staff and those with business requirements are responsible for safeguarding the security of credentialing and peer review information while performing their duties.

POLICY STATEMENT:

It is the policy of ECH Medical Staff Services to ensure all practitioner data obtained, stored and/or shared in relation to credentialing and peer review is held as confidential and privileged information.

DEFINITION:

- Practitioner – the word Practitioner used throughout this policy means both Licensed Independent Practitioner (LIP) and Allied Health Practitioner (AHP).

PROCEDURE:

A. **Practitioner Credentialing Guidelines**

1. Specific statements about confidentiality.
    a. ECH deems all credentialing and peer review documents as protected. MSSD staff, physician leaders, department chairs and members of hospital committees follow hospital polices as they relate to confidentiality. The following agreements are obtained, as applicable:
        i. Medical Staff Services Department Employee Confidentiality and Nondiscriminatory Agreement
        ii. Medical Staff and Committee Members Confidentiality and Nondiscriminatory Agreement
2. Release of credentialing information.
    a. Documentation submitted by the practitioner as part of the application process may be released upon receipt of an acceptable release of information signed and dated within 180 days of receipt.
    b. Primary source verification obtained as part of the application process is confidential and shall not be released, unless otherwise permitted or required by law and instructed by Hospital Legal Counsel.
3. Provisions for electronic information.
    a. MSSD is responsible for management, security, and oversight of credentialing and peer review-related information.
    b. All data and documentation are stored in a secure electronic environment.
    c. MSSD database administrator (DBA) has oversight to grant system access based on individual business needs. Security access is assigned based on role and responsibility.
    d. Accuracy of electronic information gathered is defined in the Medical Staff Services Credentialing Quality Process Improvement Policy.
    e. ECH uses an electronic signature or unique electronic identifier of staff to document verification.
    f. MSSD uses an electronic checklist through the automated credentialing system.
    g. The unique identifier requires a password to confirm user identity.
    h. ECH use web crawlers to verify credentialing information from approved sources.
        i. Web crawlers are structured by the DBA to only utilize primary source verifications that are acceptable to The Joint Commission (TJC), California Department of Public Health (CDPH), entries for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NQCA).

ii. MSSD reviews primary source verifications and documents any findings.

- MSSD attests to the review of the credentialing information in the checklist.

4. Employee Orientation and Confidentiality Agreements
    a. MSSD orients new staff to their roles in securing credentialing and peer review information, and explains the rationale for security and confidentiality of credentialing and peer review information, security policies, password protection, and authorization levels.
        i. New staff attend a hospital orientation and department-specific orientation. The department-specific orientation includes but is not limited to the following:
            - Introduction to MSSD, its mission, functions and culture.
            - MSSD organizational chart.
            - Medical Staff Officers, Executive Leadership, and Medical Directors
            - Medical Staff Bylaws
            - Medical Staff Services Department Credentialing and Privileging Procedure
            - Corporate Compliance Confidentiality Policy
            - Protecting Credentialing Information and System Controls Policy

5. Employee confidentiality agreements
    a. All staff sign a Medical Staff Services Department Confidentiality and Nondiscriminatory Agreement (Attachment 1) stating that they will not share credentialing and peer review information, that they will follow confidentiality and security procedure, and that they will protect, during and after employment with ECH, any confidential information they handle.
6. Disposal of confidential credential information
    a. The MSSD has secure shred bins located within the department. All confidential information in printed form is required to be disposed of using these bins.
    b. Documents discarded in secure shred bins are only accessible to the vendor who collects and shreds the documents.

B. **Personnel Management**

1. MSSD orientation regarding security roles
    a. MSSD obtains and manages confidential and peer review protected information that, whether oral, written or electronic, will be maintained in

manner that ensures its confidentiality. Confidentiality is required of all persons covered by this policy when accessing, using, disclosing, or transmitting sensitive information.

i. Refer to MSSD Orientation Manual

ii. Refer to policy 7580848, Information Security - Acceptable Use Workforce Communication.

2. Confidentiality agreements

a. Medical Staff Services Department staff sign a confidentiality agreement, which is kept in their MSSD employee file.

C. **System Confidentiality, Data Recovery, and Back-Up**

1. ECH Information Technology conducts assessments for all applicable software systems as part of the organization's vendor review and assessment process. This includes, but is not limited to, mutual non-disclosure agreement, security risk assessment, data flow, business continuity, information security policy, and data process discovery.

2. The following controls are in place to ensure successful completion of back-ups.

a. Refer to policy 7552129, Information Systems – Information Back-Up.

b. Refer to ASM Information Security Policy Manual

3. Back-ups occur at predetermined intervals.

a. Refer to policy 7552129, Information Systems – Information Back-Up.

b. Refer to ASM Information Security Policy Manual

c. Refer to Database Backup Report in MD-Staff

4. Archived data is held in a secured location.

a. Refer to policy 11439962, Retention and Destruction of Organization Records

b. Refer to ASM Information Security Policy Manual

c. Refer to ASM Master Agreement

D. **Practitioner Credentialing Guidelines**

1. 1. Ensuring confidentiality

a. All new employees must complete an orientation at onboarding Refer to section 13 of the Medical Staff Services Department Orientation Manual. MSSD utilizes a secured electronic credentialing database as a start to finish process to ensure confidentiality of credentialing documents and information. Practitioners and their authorized agents use passwords they choose to log into an electronic portal to complete and upload documents.

E. **Practitioner Directory**

1. ECH utilizes the Find a Doctor website for practitioner directory purposes.

2. Primary source verified information is relayed daily from the MSSD credentialing software database to the Find a Doctor website. Information includes but is not limited to practitioner name, degree, education and training, primary specialty, and group practice address information.
3. Discrepancies in information are shared between MSSD, Marketing Operations, and Information Technology to ensure ongoing accuracy of the directory information.
4. Audits are conducted by the MSSD.

F. **Credentialing System Controls**

1. MSSD obtains primary source verification information in the following manner.
    a. Credentialing information is received via electronic portal, electronic facsimile, email, web crawls and primary source websites.
    b. Data and primary source documents are stored and labeled with a date-stamp and assigned user (Medical Staff Coordinator) in the credentialing database.
    c. Primary source verifications are reviewed and attested to by the Medical Staff Coordinator prior to audit process.
    d. System approved web crawls upload documents and/or comments to the credentialing database (e.g. State License, OIG, SAM).
2. Tracking modifications
    a. Credentialing database tracks modifications, including but not limited to; when information was modified, how the information was modified, the staff who made the modification and why the information was modified.
3. Authorization to modify information
    a. MSSD staff including Director, Manager, Supervisor, Business Systems Analyst, Medical Staff Coordinator, Administrative Assistant, Administrative Coordinator, Professional Practice Evaluation Manager, Professional Practice Evaluation Coordinator is granted access and security levels to modify and delete as required by their role and secured by the database administrator.
    b. Modification or deletion of information is acceptable under the following circumstances:
        i. Credentialing information is updated to maintain accuracy (examples, expirables, group practice and address change, appointment and privileging information due to reappointment).
        ii. To correct a data entry error made by applicant or Medical Staff Coordinator.
4. Authorization to view information and/or make credentialing recommendations and decisions
    a. System access is defined in the System Controls and Security Access Grid (Attachment 2).

5. Securing information
    a. Access to the credentialing database is controlled by the MSSD database administrator (DBA) and policy 7552117, Information Systems – Equipment Security.
    b. Credentialing database and hospital network are password protected. Access is approved by MSSD leadership. All access is granted on business need. (also note A3-c)
    c. The hospital follows the National Institute of Standards and Technology guideline per policy 7552132, Information Systems – Information Classifications
    d. Employees who leave the organization or department have their access disabled by Information Technology and MSSD database administrator.
6. Building security
    a. Building security is maintained by ECH Security Department. Access is granted to the office (e.g. department staff, custodial staff) based on job description and business need. Refer to policies 9121448 Security Services Scope of Service and 9121598 Physical Access Controls and Photo ID Badge Issuance. Refer to System Controls and Security Access Grid (Attachment 2).
7. Annually monitoring the credentialing process
    a. MSSD annually monitors the credentialing process by evaluating the following:
        i. Primary source verification information, tracking modifications, authorization to modify information, securing information, and building security.
    b. The annual monitoring process includes but is not limited to:
        i. Security policies
        ii. Audit Change Log
        iii. Review of automatic system alerts and flags
        iv. Modifications since previous audit
8. Credentialing Systems Controls Oversight
    a. At least annually, a monitoring report is completed regarding compliance with Credentialing Systems Controls policies and procedures, utilizing–Credentialing System Controls Audit Report (Attachment 3). The annual report is submitted to the Credentials Committee and Medical Executive Committee.
    b. In the event the annual monitoring identifies items not meeting policy and procedure guidelines, the following will be conducted:
        i. A qualitative and quantitative analysis for all modifications that did not meet policies.

ii. Modifications that did not meet policy guidelines will be addressed, and an action plan established.

iii. Quarterly monitoring will be implemented and written follow-up provided to the Credentials Committee.

iv. Monitoring of Inappropriate Modifications Report will be included in the request for documents at the time of the annual oversight assessment. ECH would only need to submit this report if it identified inappropriate modifications. MSSD will perform ongoing monitoring of the report until improvement is demonstrated for three consecutive quarters. If there is no demonstrated improvement for at least one finding, all quarterly reports will be submitted to the MSSD Director.

9. MSSD reviews policies at least every three (3) years to ensure accuracy and alignment of processes.

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Attachments

Credentialing System Controls Audit Report

Protecting Credentialing Information and System Controls Access Grid

Approval Signatures

Step Description	Approver	Date
MEC	Heidi Yamat: Director AR&L and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	10/2023
Credentialing Committee	Raquel Barnett: Sr. Director Medical Staff Services	09/2023
IDPC	Raquel Barnett: Sr. Director Medical Staff Services	09/2023
	Raquel Barnett: Sr. Director Medical Staff Services	09/2023

AB18k23. Medical Staff Services - Ongoing Monitoring and Interventions

Status **Pending** PolicyStat ID **12940604**

Origination	N/A	Owner	Raquel Barnett: Director Medical Staff Services
Last Approved	N/A	Area	Medical Staff
Effective	Upon Approval	Document Types	Policy
Last Revised	N/A		
Next Review	3 years after approval		

Medical Staff Services - Ongoing Monitoring and Interventions

COVERAGE:

Medical Staff Services Department, Administration and Medical Staff Leadership

PURPOSE:

To ensure the employees of the El Camino Hospital (ECH) Medical Staff Services Department (MSSD) and those with business requirements comply with all hospital policies and procedures, State and Federal laws governing confidentiality of credentialing and peer review information. All MSSD staff and those with business requirements are responsible for safeguarding the security of credentialing and peer review information while performing their duties.

POLICY STATEMENT:

It is the policy of medical staff services to ensure ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

DEFINITION:

- Practitioner – the word Practitioner used throughout this policy means both licensed independent practitioner (LIP) and allied health practitioner (AHP).

PROCEDURE:

Ongoing Monitoring and Interventions

A. MSSD collects and reviews sanctions, from the following primary sources within 30 calendar days of release by the reporting entity:
    1. MediCal, Medicare, Office of Inspector General (OIG), System for Award Management (SAM), and National Practitioner Databank (NPDB)
        a. All findings are reported to MSSD leaders for review.
    2. MSSD collects and reviews sanctions and limitations on licensure by use of the NPDB On-going Monitoring/Continuous Query.

B. MSSD collect and reviews practitioner specific patient complaints and evaluates the practitioners history of complaints for all practitioners' every 6 months

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2023
Credentialing Committee	Vivian Dang: Supv Medical Staff Svcs	01/2023
IDPC	Ryan Nhan: Medical Staff Coord	01/2023
	Raquel Barnett: Director Medical Staff Services	01/2023

AB18k24. Medical Staff Services - Electronic Signatures

Status **Pending** PolicyStat ID **12940914**

Origination	N/A	Owner	Raquel Barnett: Director Medical Staff Services
Last Approved	N/A	Area	Medical Staff
Effective	Upon Approval	Document Types	Policy
Last Revised	N/A		
Next Review	3 years after approval		

Medical Staff Services - Electronic Signatures

COVERAGE:

El Camino Hospital Administration and Medical Staff Leadership (“Leader”)

PURPOSE:

To establish guidelines regarding electronic signatures and streamline the process for communicating to Medical Staff and Allied Health Practitioners regarding matters including but not limited to: medical staff membership/privileges and allied health practitioner status/privileges, Peer Review matters, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

STATEMENT:

Medical Staff Services Department (“MSSD”) operates within an electronic, confidential, and peer review protected environment. Electronic signature is used by the MSSD as a means of attestation and approval of notification to Medical Staff and Allied Health Practitioners regarding membership, status, and privileges, Peer Review, FPPE, and OPPE.

Electronic signatures are considered legally binding as a means to identify the approval of letters and form contents, confirm content accuracy and completeness as intended by the approver and to ensure e-signature integrity. It is the policy of El Camino Health to accept electronic signatures as defined within this policy for author and/or approver validation of documentation, content accuracy and completeness with all the associated ethical, business, and legal implications.

DEFINITIONS:

Practitioner: Medical Staff and Allied Health Practitioners as defined in ECH Medical Staff Bylaws.

REQUIREMENTS:

Electronic signature is the standard method in the preparation and dissemination of information to El Camino Health practitioners. Communication sent on behalf of a Leader is vetted and approved by the applicable Leader, prior to the electronic signature addition to the document and dissemination to the practitioner.

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Approval Signatures

Step Description	Approver	Date
MEC	Franz Encisa: Director Quality and Public Reporting	Pending
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	01/2023
Credentialing Committee	Vivian Dang: Supv Medical Staff Svcs	01/2023
IDPC	Ryan Nhan: Medical Staff Coord	01/2023
	Raquel Barnett: Director Medical Staff Services	01/2023