El Camino Health

AGENDA
REGULAR MEETING OF THE
EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, August 13, 2025 – 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: **1-669-444-9171, MEETING CODE: 952 7295 1940# 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: If 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 people 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	**RECOGNITION OF FORMER EXECUTIVE COMPENSATION COMMITTEE CHAIR BOB MILLER** - Approve Resolution 2025-03	Bob Rebitzer, Board Chair	**Motion Required**	**5:30 – 5:35**
6	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**5:35**
7	**CEO STRATEGIC REPORT** - **FY25 YEAR IN REVIEW** - **FY26 EXTERNAL FACTORS** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Dan Woods, CEO Lanhee Chen, Director	Discussion	**5:35 – 6:20**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
8	**CAPITAL REQUEST: PROPERTY ACQUISITION: 399 EL CAMINO REAL, MOUNTAIN VIEW; APN# 193-04-040** *Gov't Code Section 54956.8 – for a report and discussion involving negotiations prior to purchase, sale, exchange, or lease of real property.*	Ken King, CASO Peter Goll, CAO of ECHMN	Discussion	**6:20 – 6:30**
9	**LOS GATOS REDEVELOPMENT UPDATE – DRAFT – PROJECT GOVERNANCE STRUCTURE** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Carlos Bohorquez, CFO Tracey Lewis-Taylor, COO Ken King, CAO	Discussion	**6:30 – 6:45**
10	**CAPITAL REQUEST: MOUNTAIN VIEW CAMPUS COMPLETION - WING J PROJECT** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets regarding new services or programs.*	Don Watters, Finance Committee Chair Tracey Lewis-Taylor, COO Ken King, CASO	Discussion	**6:45 – 6:55**
11	**VERBAL LEGAL UPDATE** *Report involving Gov't Code Section 54956.9(d)(2) – conference with legal counsel – pending or threatened litigation:* *- SEIU v. Silicon Valley Medical Development and El Camino Hospital* *- CMS Regulatory Update*	 Theresa Fuentes, CLO Deanna Dudley, CHRO Theresa Fuentes, CLO Mark Adams, MD, CMO Shreyas Mallur, MD, CQO	Discussion	**6:55 – 7:15**
12	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *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.*	Mark Adams, MD, CMO	**Motion Required**	**7:15 – 7:20**
13	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (06/11/25) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Bob Rebitzer, Board Chair	**Motion Required**	**7:20 – 7:25**
14	**EXECUTIVE SESSION** *Gov't Code Section 54957(b) for discussion and report on personnel performance matters – Senior Management.*	Bob Rebitzer, Board Chair	Discussion	**7:25 – 7:30**
15	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**7:30**
16	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Gabe Fernandez, Governance Services Coordinator	Information	**7:30**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
17	**APPROVAL OF PROPERTY ACQUISITION: 399 EL CAMINO REAL, MOUNTAIN VIEW; APN# 193-04-040**	Bob Rebitzer, Board Chair	**Motion Required**	**7:30 – 7:35**
18	**APPROVAL OF CAPITAL REQUEST: MOUNTAIN VIEW CAMPUS COMPLETION - WING J PROJECT**	Bob Rebitzer, Board Chair	**Motion Required**	**7:35 – 7:40**
19	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (06/11/25) b. Approve Policies, Plans, and Scope of Services as Reviewed and Recommended for Approval by the Medical Executive Committee c. Approve FY26 Compliance and Audit Committee Goals d. Approve Closure and Removal from License of Senior Health Clinic e. Approve Resolution 2025-04 - Recognition of Former Quality Committee Vice Chair Melora Simon f. Approve FY26 ECHB Pacing Plan g. Receive Period 11 Financials h. Receive Informational Item from Finance Committee Chair Regarding Appointment of Christina Lai to Finance Committee	Bob Rebitzer, Board Chair	**Motion Required**	**7:40 – 7:45**
20	**CEO REPORT**	Dan Woods, CEO	Information	**7:45 – 7:50**
21	**BOARD ANNOUNCEMENTS**	Bob Rebitzer, Board Chair	Information	**7:50 – 7:55**
22	**ADJOURNMENT** **POLICIES APPENDIX**	Bob Rebitzer, Board Chair	**Motion Required**	**7:55**

NEXT MEETINGS: September 17, 2025; October 8, 2025; November 12, 2025; December 10, 2025; February 11, 2025; March 18, 2025; May 13, 2025; June 17, 2025

El Camino Hospital Board

RESOLUTION 2025 – 03

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE AND SUPPORT

WHEREAS, the Board of Directors of El Camino Hospital values and wishes to recognize the extraordinary service of individuals who demonstrate visionary leadership, steadfast commitment, and an enduring impact on the health and well-being of our patients, staff, and community.

WHEREAS, the Board honors and recognizes Bob Miller for his dedicated service as Chair of the Executive Compensation Committee from 2012 to 2025, providing thoughtful oversight, deep expertise, and a values-driven approach to executive compensation and leadership strategy.

WHEREAS, the Board acknowledges Bob Miller's consistent focus on aligning executive performance with organizational goals and community expectations, and his legacy of strengthening governance through collaboration, accountability, and integrity.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously recognize, thank, and pay tribute to:

BOB MILLER

FOR YOUR EXEMPLARY LEADERSHIP, YOUR STRATEGIC GUIDANCE, AND YOUR LASTING CONTRIBUTION TO EL CAMINO HOSPITAL'S MISSION TO HEAL, RELIEVE SUFFERING, AND ADVANCE WELLNESS.

IN WITNESS THEREOF, I have hereunto set my hand this **13TH DAY OF AUGUST 2025.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee J. Chen, JD
Wayne Doiguchi
Peter C. Fung, MD, MBA
Julia E. Miller
Jack Po, MD
Bob Rebitzer
Carol A. Somersille, MD, FACOG
George O. Ting, MD
Don Watters
John Zoglin

Bob Rebitzer
Board Chair
El Camino Hospital Board of Directors

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Ken King, CAO
Date: August 13, 2025
Subject: Property Acquisition – APN # 193-04-040

Recommendation:

Management recommends Board approval of the purchase of a property located at 399 W. El Camino Real in Mountain View at a cost not to exceed $22.2 million as reviewed and recommended for Board approval by the Finance Committee on July 30, 2025.

Summary:

1. Situation: We have the opportunity to purchase a Class A general office building in a prominent location on El Camino Real in Mountain View.

2. Authority: The Finance Committee recommends Board Approval of real estate transactions exceeding $5 million.

3. Background: This particular property is located at 399 W. El Camino Real, Mountain View.

4. Assessment: The property at 399 W. El Camino Real is a three-story +/- 32,000 square foot building with below grade parking, sitting on approximately 0.64 acres of land. It is at the corner of El Camino Real and Bonita, between Castro Street and Phyllis Ave. It is easily accessible from both Northbound and Southbound lanes on El Camino Real. The building is Class A General Office Building originally constructed in 2004 and has been well maintained. The purchase and sale agreement is conditioned upon Board approval and the price is $22.2 million or approximately $688 per square foot.

5. Outcomes: We anticipate closing escrow no later than October 31st, allowing time for the seller to execute a 1031 Exchange.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Ken King, CAO
Tracey Lewis Taylor, COO
Date: August 13, 2025
Subject: MV Campus Completion Project – Funding Request

Recommendation:

To request Board approval for the funding not to exceed $80.5 million for Phase 3B (Wing J) of the Mountain View (MV) Campus Completion Project as reviewed and recommended for approval by the Finance Committee on July 30, 2025.

Summary:

This is the final funding request for the MV Campus Completion Project which upon completion will represent the completion of the Master Facilities Plan for the MV Campus approved by both the Hospital and District Boards in June 2016. The project will provide increased capacity and access for patients at the Mountain View Campus.

1. Situation:

The final phase Wing J Expansion is needed to support the volume growth in the Emergency Department, the Procedural Environments and the Inpatient Units.

The Medical Observation Unit will serve to improve patient throughput and safety by having a dedicated Unit for patients who are currently cared for in the Emergency Department and on Inpatient Units.

2. Authority: Capital Expenditures exceeding $5 million require approval by the Board of Directors as recommended by the Finance Committee.

3. Background: The Master Facilities Plan for the MV Campus was approved in June 2016 by the El Camino Health Board of Directors, the El Camino Healthcare District Board of Directors and the City of Mountain View. Demolition of Old Main Hospital and **MV Campus Completion**

4. Assessment: The first three phases of the MV 2016 Facilities Master Plan have been completed (see below). The final phase has received preliminary funding, but the request today will allow for completion of the project.

The **MV Campus Completion** Project Consists of the following elements:

1.	Phase 1.	Temporary Service Yard	Completed
2.	Phase 2.	Demolition of the Old Main Hospital	Completed
3.	Phase 3A.	New Service Yard Construction	Completed
4.	Phase 3B.	Wing J Expansion	Current Funding Requested

This final funding request for Phase 3B is not to exceed $80.5 million. This funding is needed to construct the units outlined above for a 42,838 square foot hospital building expansion on 3 floors, with a connecting corridor and all related site work.

5. Other Reviews: The Financial Analysis shows a positive financial return due to growth and retention of approximately 10,000 emergency patients and 1,500 elective procedural patients in the 10-year period between FY2027 and FY2037. The analysis indicates a ROI of between 17-20% over ten years with a NPV between $1.1M - $3.4M with a 7.5% discount rate.

6. Outcomes: The 22-month construction schedule will begin in mid-August, with a target date for completion in June 2027.

El Camino Health

Minutes of the Open Session of the
El Camino Hospital Board of Directors
Wednesday, June 11, 2025

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

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

Board Members Absent
Jack Po, Vice-Chair
Lanhee Chen

Staff Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Mark Adams, CMO
Omar Chughtai, CGO
Deanna Dudley, CHRO
Theresa Fuentes, CLO
Peter Goll, CAO, ECHMN
Mark Klein, CCMO
Tracey Lewis Taylor, COO
Shreyas Mallur, MD, CQO
Andreu Reall, VP of Strategy
Diane Wiggelsworth, VP of Compliance

Staff Present (cont.)
Jon Cowan, Executive Director, Government Relations and Community Partnerships
Anne Yang, Executive Director, Governance Services
Gabe Fernandez, Governance Services Coordinator
Tracy Fowler, Director, Governance Services**
Brian Richards, Information Technology**

***via teleconference*

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 5:30 p.m. Roll call was taken and Directors Chen, Doiguchi and Po were absent at roll call. A quorum was present. Director Doiguchi arrived at 5:58pm.	***The meeting was called to order at 5:30 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 noted.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. No members of the public were present and no written correspondence was received.	
5. MEDICAL STAFF VERBAL REPORT	Chair Rebitzer invited Dr. Xanthopoulos to present the verbal medical staff report. Dr. Xanthopoulos provided updates on partnering with Administration on physician retention and recruitment as well as an update on specialists. Regarding anesthesia, the medical staff started a CRNA program (certified registered nurse anesthetists). CRNAs are like physician assistants or nurse practitioner equivalent, and they provide some of the services of anesthesiologists. ECH has a relationship with Samuel Merritt nursing students. Shortly after rolling out the CRNA program, the medical staff looked to create a pipeline of nursing students from the program, and it has been very successful. He then spoke about the Los Gatos ICU, which has been a challenge for some time, and now there is a solid plan going forward. Director Miller commented that the physicians have everything they need to do their job. Dr. Xanthopoulos stated that the physicians are very well supported.	

6. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 5:38 p.m. **Movant**: Miller **Second**: Watters **Ayes**: Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Doiguchi, Po **Recused**: None	***Recessed to closed session at 5:38 p.m.***
7. AGENDA ITEM 18: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:33 p.m., and Agenda Items 7-16 were addressed in the closed session. Chair Rebitzer stated for the public that there were technical difficulties and requested Mr. Fernandez to read out the Zoom teleconference number. Mr. Fernandez stated the number is 1-669-444-9171. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report and Closed Session Minutes were approved by a unanimous vote of all Directors present.	***Reconvened Open Session at 7:33 p.m.***
8. AGENDA ITEM 19: APPROVE FY26 OPERATING AND CAPITAL BUDGET AND CONTINGENCY FUND	**Motion:** To approve the FY26 Operating and Capital Budget and Contingency Fund **Movant**: Watters **Second**: Miller **Ayes**: Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters **Nays**: Zoglin **Abstentions**: None **Absent**: Chen, Po **Recused**: None	
9. AGENDA ITEM 20: PROPERTY PURCHASE: 1533 CALIFORNIA CIRCLE, MILPITAS, CA 95035 (APN 022-37-045)	**Motion:** To approve the property purchase at 1533 California Circle, Milpitas. **Movant**: Fung **Second**: Doiguchi **Ayes**: Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Po **Recused**: None	
10. AGENDA ITEM 21: ACQUISITION OF ADVANCED CARDIOVASCULAR SPECIALISTS, INC. (ACS)	**Motion:** To approve Resolution 2025-02 regarding acquisition of Advanced Cardiovascular Specialists, Inc. (ACS) **Movant**: Ting **Second**: Watters **Ayes**: Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Po	

	Recused: None	
11. AGENDA ITEM 22: APPROVE MEDICAL STAFF DEVELOPMENT PLAN	**Motion:** To approve Medical Staff Development Plan **Movant**: Fung **Second**: Miller **Ayes**: Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Po **Recused**: None	
12. AGENDA ITEM 23: CONSENT CALENDAR ITEMS	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. Items d and i were removed for discussion. Director Zoglin asked about the FY25 pacing plan Strategy Update sequencing followed by the Strategy Deep Dive in April on page 162 of the packet. Director Zoglin requested to look at the pacing for FY26 to look at the strategy sequencing. Chair Rebitzer asked about the FY26 pacing plan approval. Ms. Yang confirmed that there is no FY26 pacing plan for approval for this time. Director Zoglin inquired about whether for Committees the Chair or Vice Chair should be a board member. Ms. Yang confirmed this is accurate and in the Committee Governance Policy. Director Somersille requested to add Dr. Sharma as Vice Chair of the Quality Committee for the Committee Assignments and Liaisons document for FY26. She also inquired about the language of the Committee Chair appointing and removing the Vice Chair and whether this was taken out of the charters. Ms. Fuentes clarified that this language was taken out of the charters and captured in the Committee Governance Policy. Director Miller asked for item i: the Compliance and Audit Committee Goals to be revised and brought back to the Board. **Motion:** To approve the consent calendar **Movant**: Zoglin **Second**: Watters **Ayes**: Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Po **Recused**: None	***Consent calendar items were approved except for item i: Compliance and Audit Committee Goals, which Staff will revise.*** - ***Consent calendar items g and h were received.*** ***ACTION: Compliance and Audit Committee Goals to be revised for Committee and return back to ECHB*** ***ACTION: FY26 ECHB Pacing Plan to ensure Strategy topics are sequenced appropriately with next year preview ahead of Deep Dive and current year updates clearly labeled.***

13. AGENDA ITEM 24: CEO REPORT	Mr. Woods provided an update on the organization with the recognition of ECH by Newsweek as one of the Best Maternity Hospitals for the fourth consecutive year. ECH recognized Dr. Alan Merchant on May 2, 2025, who is a pioneering orthopedic surgeon, with a long career at ECH with decades of innovation and excellence in orthopedic care. Mr. Woods highlighted Ms. Dudley as YWCA Golden Gate Silicon Valley's 2025 Tribute to Women Awards. The ECH Marketing team campaign "El Camino Health Strong" received three national Telly Awards for compelling stories of trust, recovery, ECH medical expertise and caring. ECH hosted a HIMSS Northern California Chapter for "Innovations in Digitally Enabled Care" event. From Corporate Health Services, the Chinese Health Initiative and South Asian Heart Center continue to engage with emotion health and heart screenings for the community. Mr. Woods mentioned that the Foundation continues to do well in their fundraising goal. He highlighted Board Chair Rebitzer hosted a successful event The Longevity Revolution: Living Longer Better with Dr. Peter Attia on May 13. The Auxiliary donated over 4000 hours in April.	
14. AGENDA ITEM 25: BOARD ANNOUNCEMENTS	Chair Rebitzer commented that Director Somersille has recruited three excellent candidates for the Quality Committee. Director Somersille acknowledged the team effort of the ad hoc Committee in selecting three excellent candidates.	
15. AGENDA ITEM 26: ADJOURNMENT	**Motion:** To adjourn at 7:49 p.m. **Movant**: Watters **Second**: Miller **Ayes**: Doiguchi, Fung, Miller, Rebitzer, Somersille, Ting, Watters, Zoglin **Nays**: None **Abstentions**: None **Absent**: Chen, Po **Recused**: None	***Meeting adjourned at 7:49 p.m.***

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

_____
John Zoglin, Secretary/Treasurer

Prepared by: Anne Yang, Executive Director, Governance Services
Reviewed by Legal: Theresa Fuentes, Chief Legal Officer, Tracy Fowler, Director, Governance Services

El Camino Health

BOARD OF DIRECTORS
Documents for Review
August 13, 2025

Department	Document Name	Origin Date	Last Reviewed	Revised?	Doc Type	Document Details | Approval Workflow
Risk Mgmt	A20b1. Alleged Assault or Abuse of Patients Receiving Care at ECH	N/A	N/A	**New**	Policy	• ePolicy > MEC > Board New document and new process.
Board	A20b2. Board of Director Approval of Hospital Policies	2-1-17	N/A	**Major**	Policy	• ePolicy > Board
Health Equity	A20b3. Healthy Equity – Cultural Competency	N/A	N/A	**New**	Policy	• Cultural Competency > ePolicy > Board New document
Respiratory Care	A20b4. Scope of Service: Respiratory Care Services	2-1-18	6-8-22	**Major**	Scope of Service	• Med Dir | Dept Dir > ePolicy > MEC > Board Majority of sections were updated
Imaging Services	A20b5. Radiation Safety – Radiation Protection Program	7-1-14	2-5-25	Minor	Policy	• Radiation Safety > ePolicy > MEC > Board Updated Pediatric definition/reference, per CDPH
Foundation	A20b6. Quasi-Endowment Fund Policy	N/A	N/A	**New**	Policy	• Finance Committee > Executive Committee > Foundation Board > ePolicy > Board New document

Updated Procedure section to include ability for CEO or AOC to put a policy into effect via executive directive until the formal process is complete.

El Camino Health

EL CAMINO HOSPITAL
BOARD OF DIRECTORS MEMO

To: El Camino Hospital Board of Directors
From: Anne Yang, Executive Director, Governance Services
Date: August 13, 2025
Subject: Revised FY26 Compliance and Audit Committee Goals

Recommendation: Review and approve the revised FY26 Compliance and Audit Committee Goals.

Authority: The Board reviews and approves the FY26 Advisory Committee Goals and Pacing Plans at the June ECHB meeting, and prior to that, the Governance Committee provides review and recommendation for Board approval.

Summary: At the June 2, 2025 Governance Committee meeting, the Governance Committee did not approve the Compliance and Audit Committee Goals, and requested a revision before sending back to the Board for approval. The Governance Committee recognized that the Compliance and Audit Committee covers many significant topics throughout the fiscal year, and requested the Committee to rewrite their goals to align more closely with the pacing plan for FY26.

At the June 25, 2025 Compliance and Audit Committee meeting, the Committee reviewed and approved the revised set of FY26 Compliance and Audit Committee Goals. The goals were re-written to reflect

List of Attachments:

1. Revised Proposed FY26 Compliance & Audit Committee Goals

El Camino Health

FY26 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 VP, 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	STATUS	METRICS
1. Review Enterprise Risk Management (ERM) metrics and assess if any modifications are needed to current domains monitored or individual metrics to align with enterprise risk tolerance.	Q2 FY26	0%	Committee reviews and provides feedback regarding ERM domains or metrics.
2. Evaluate potential revisions to the Committee Charter and Code of Conduct to foster continuous improvement within the Compliance Committee.	Q3 FY26	0 %	Committee provides recommendations for revisions and monitors impact to committee self-assessment results.
3. Review 2027 Strategic Plan, Goals and Joint Ventures/Business Affiliates for potential impact on Compliance Program.	Q3 FY26	0%	Committee provides recommendations if compliance assessments or modifications to Compliance Program are needed for strategies the organization is undertaking.

SUBMITTED BY:

Chair: Lica Hartman
Executive Sponsor: Diane Wigglesworth

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Diane Wigglesworth, VP of Compliance
Date: August 13, 2025
Subject: Closure and Removal from Hospital License of Senior Health Center

Recommendation:

To request Board approval of Senior Health Clinic closure and removal from hospital license.

Summary:

In June 2018, El Camino Hospital (ECH) closed its outpatient geriatric primary care services at the Senior Health Center, located in Suite 5, 2600 Grant Road, Mountain View, California (the "Center"). This action was taken in part because there are similar services offered through the El Camino Health Medical Network.

At the time of closure, ECH did not seek to remove the services from the hospital license. This was recently discovered in connection with an overall effort to bring hospital clinics and locations up-to-date with the hospital license.

In order to facilitate closure and removal of the Center from the hospital license, the California Department of Public Health (CDPH) is requesting documentation of Board of Directors approval of the closure and the removal from the hospital license. We have been unable to locate documentation of Board approval from 2018, and as a result we are seeking approval now.

In addition, Health and Safety Code section 1255.25 requires that prior to eliminating a service provided in a hospital, the hospital must comply with certain public notice requirements, including publication and posting of a closure notice, as well as written notice to CDPH, the city council of the city in which the hospital is located, and the County Board of Supervisors. ECH is working with CDPH and taking the necessary steps to comply with these requirements.

Authority: The Board has the authority to close and remove a clinic or facility from the hospital license, subject to the requirements of Health and Safety Code section 1255.25.

With the Board's approval, ECH can proceed with removal of the Center from the license.

List of Attachments:

1. Hospital License – applicable services highlighted
2. Senior Health Clinic closure notice

License: 070000660
Effective: 12/31/2024
Expires: 12/30/2025
Licensed Capacity: 466

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

El Camino Hospital

to operate and maintain the following **General Acute Care Hospital**

El Camino Health

El Camino Health Los Gatos

El Camino Health
2500 Grant Rd
Mountain View, CA 94040-4302

Bed Classifications/Services/Stations

287 General Acute Care
52 Perinatal
24 Intensive Care
24 Intensive Care Newborn Nursery
7 Pediatric
180 Unspecified General Acute Care

Other Approved Services

Basic Emergency Medical
Cardiac Catheterization Laboratory Services
Cardiovascular Surgery
Dental Services
Mobile Unit - Magnetic Resonance Imaging (MRI) - Outpatient
Nuclear Medicine
Occupational Therapy
Outpatient Services - Behavioral Health at Outpatient Behavioral Health Clinic, 2400 Grant Road, G101, Mountain View
Outpatient Services - Breast Care - Breast Health Center at Sobrato Pavilion, 2495 Hospital Drive, 1st Floor, Suite 1F63, Mountain View
Outpatient Services - Cancer Center at Medical Oncology Clinic, 2505 Hospital Drive, Suite 102, Mountain View
Outpatient Services - Endoscopy at Sobrato Pavilion, 2495 Hospital Drive, 2nd Floor, Suite 2F60, Mountain View
Outpatient Services - General Laboratory at Sobrato Pavilion, 2495 Hospital Drive, 1st Floor, Suite 1F61, Mountain View

(Additional Information Listed on License Addendum)

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, San Jose District Office, 1741 Technology Drive, Suites 130/160, San Jose, CA 95110, (408) 277-1784

POST IN A PROMINENT PLACE

State of California
Department of Public Health
License Addendum

License: 070000660
Effective: 12/31/2024
Expires: 12/30/2025
Licensed Capacity: 466

El Camino Health (Continued)
2500 Grant Rd
Mountain View, CA 94040-4302

Other Approved Services (cont'd)

Outpatient Services - General Practice at Senior Health Center, 2660 Grant Road, Suite F, Mountain View
Outpatient Services - Infusion Services at Infusion Center, 2505 Hospital Drive, Suite 101, Mountain View
Outpatient Services - Multispecialty - Advanced Care & Diagnostics Center at Sobrato Pavilion, 2495 Hospital Drive, 1st Floor, Suite 1F60, Mountain View
Outpatient Services - Perinatal Testing - Perinatal Diagnostic Center at Sobrato Pavilion, 2495 Hospital Drive, 5th Floor, Suite 550, Mountain View
Outpatient Services - Radiation Oncology at Radiation Oncology Services, 125 South Drive, Mountain View
Outpatient Services - Rehabiliation Services at 2400 Grant Road, 2nd Floor, Mountain View
Outpatient Services - Respiratory Care at Sobrato Pavilion, 2495 Hospital Drive, 2nd Floor, Suite 2F60, Mountain View
Outpatient Services - Surgery at 2480 Grant Road, Mountain View
Outpatient Services - Wound Care at Senior Health Center, 2660 Grant Road, Suite F, Mountain View
Physical Therapy
Podiatry Service
Radiation Therapy
Respiratory Care Services
Speech Pathology

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, San Jose District Office, 1741 Technology Drive, Suites 130/160, San Jose, CA 95110, (408) 277-1784

POST IN A PROMINENT PLACE

State of California
Department of Public Health
License Addendum

License: 070000660
Effective: 12/31/2024
Expires: 12/30/2025
Licensed Capacity: 466

El Camino Health (Continued)
2500 Grant Rd
Mountain View, CA 94040-4302

El Camino Health Los Gatos
815 Pollard Rd
Los Gatos, CA 95032-1438

Bed Classifications/Services/Stations
143 General Acute Care
30 Rehabilitation
14 Perinatal
8 Coronary Care
7 Intensive Care
2 Intensive Care Newborn Nursery
82 Unspecified General Acute Care

Other Approved Services
Basic Emergency Medical
Mobile Unit - Magnetic Resonance Imaging (MRI)
Mobile Unit - Other - CT Scanner
Nuclear Medicine
Occupational Therapy
Outpatient Services - Behavioral Services at 825 Pollard Road, Suite 201, Los Gatos
Outpatient Services - Infusion - Oncology at Oncology Clinic and Infusion Center, 815 Pollard Road, Los Gatos
Outpatient Services - Rehabilitation Clinic at 555 Knowles Dr. #100, Los Gatos
Physical Therapy
Respiratory Care Services
Speech Pathology

EL CAMINO HOSPITAL D/P APH
2590 Grant Rd
Mountain View, CA 94040-4302

Bed Classifications/Services/Stations
36 Acute Psychiatric
36 Acute Psychiatric Care

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
Consolidated license
The 30 Rehabilitation Center beds are located at 355 Dardanelli Lane, Los Gatos, CA 95032.

TOMÁS J. ARAGÓN, MD, DrPH
Director and State Public Health Officer

Joshua Williams
Joshua Williams, Staff Services Manager I

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, San Jose District Office, 1741 Technology Drive, Suites 130/160, San Jose, CA 95110, (408) 277-1784

POST IN A PROMINENT PLACE

Public Notice

December XX, 2024

The Senior Health Program, located at 2660 Grant Road (Suite F) in Mountain View, closed its doors permanently in June 2018.

While the 2660 Grant Road facility no longer offers geriatric primary care provider (PCP) services, similar type services are offered through the El Camino Health Medical Network at the following primary care locations in Mountain View:

- 2660 Grant Road, Suite E
- 2495 Hospital Drive, Suite 460
- 2204 Grant Road, Suite 203

Additionally, El Camino Health provides Wound Care services at the 2660 Grant Road (Suite F) location. Please call 650-940-7003 for more information.

For any questions or concerns about this closure, please contact our Patient Experience Team for assistance at patient_experience@elcaminohealth.org or by calling **650-962-5836.**

Dan Woods
Chief Executive Officer
El Camino Health
650-940-7000

El Camino Health®

El Camino Hospital Board

RESOLUTION 2025 – 04

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE AND SUPPORT

WHEREAS, the Board of Directors of El Camino Hospital values and wishes to recognize individuals who demonstrate enduring commitment, thoughtful leadership, and a passion for continuous improvement in healthcare quality and patient safety.

WHEREAS, the Board honors and recognizes Melora Simon for her decade of dedicated service on the Quality, Patient Care, and Patient Experience Committee from 2015 to 2025, including three years as Vice Chair, during which she brought insight, compassion, and accountability to the Hospital's efforts to advance clinical excellence.

WHEREAS, the Board acknowledges Melora Simon's steadfast advocacy for patient-centered care, her collaborative approach to complex challenges, and her contributions to building a culture of transparency, learning, and trust across the organization.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously recognize, thank, and pay tribute to:

MELORA SIMON

FOR YOUR TEN YEARS OF OUTSTANDING SERVICE, YOUR DEDICATION TO QUALITY AND SAFETY, AND YOUR UNWAVERING COMMITMENT TO EL CAMINO HOSPITAL'S MISSION TO HEAL, RELIEVE SUFFERING, AND ADVANCE WELLNESS.

IN WITNESS THEREOF, I have hereunto set my hand this **13TH DAY OF AUGUST 2025.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee J. Chen, JD
Wayne Doiguchi
Peter C. Fung, MD, MBA
Julia E. Miller
Jack Po, MD
Bob Rebitzer
Carol A. Somersille, MD, FACOG
George O. Ting, MD
Don Watters
John Zoglin

Bob Rebitzer
Board Chair
El Camino Hospital Board of Directors

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD
FY2026 PACING PLAN / MASTER CALENDAR

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
APPROVALS AND CONSENT CALENDAR												
Board Minutes		✓	✓	✓	✓	✓		✓	✓		✓	✓
Committee Reports and Recommendations		✓	✓	✓	✓	✓		✓	✓		✓	✓
Community Benefit Plan												✓
Credentialing and Privileges Report		✓	✓	✓	✓	✓		✓	✓		✓	✓
Physician Agreements		✓	✓	✓	✓	✓		✓	✓		✓	✓
Policies		✓	✓	✓	✓	✓		✓	✓		✓	✓
FINANCE												
Audited Financial Report				✓								
Budget (Preview)											✓	
Budget Approval												✓
Period Financials (Consent)		✓	✓	✓	✓	✓		✓	✓		✓	✓
Quarterly Financials (Focus)					✓			✓			✓	
PHYSICIANS AND MEDICAL NETWORK												
ECHMN Report			✓								✓	
Medical Staff Report			✓		✓			✓			✓	
QUALITY												
Quality STEEEP Dashboard			✓		✓			✓			✓	
Quality Committee Report				✓					✓			
STRATEGY												
Los Gatos Redevelopment		✓	✓			✓			✓		✓	
Strategic Plan Metrics (FY25)		✓	✓									
Strategic Plan Update (FY26)					✓			✓			✓	
Preliminary Strategy Implications (FY27)									✓			
Strategic Goals Preview (FY27)											✓	
Strategic Goals Approval (FY27)												✓
EXECUTIVE PERFORMANCE												
CEO Update (Year in Review)		✓										
CEO Assessment (Board Executive Session)			✓									
Organizational Performance Goal Score (Prior Year)				✓								
Executive Base Salaries and Salary Ranges				✓								
CEO Compensation				✓								
COMPLIANCE AND GOVERNANCE												
Annual Compliance Program Report Out				✓								
Enterprise Risk Management						✓						✓
Board Assessment Results			✓		✓							
Board Officer Elections (*Even Years*)												✓
Board Calendar									✓			
Committee Goals												✓

Updated 07/10/2025

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: August 13, 2025
Subject: Financials: FY2025 – Period 11 (May 2025) & YTD - Consent Calendar

Purpose:

To provide the Board an update on financial results for FY2025 Period 11 (May 2025) & YTD.

Executive Summary – Period 11 (May 2025):

Patient activity / volumes were consistent with budget.

- **Average Daily Census:** 314 is (1) / (0.2%) unfavorable to budget and 7 / 2.1% higher than the same period last year.
- **Adjusted Discharges:** 3,928 are 65 / 1.7% favorable to budget and 156 / 4.1% higher than the same period last year.
- **Emergency Room Visits:** 7,150 are 184 / 2.7% unfavorable to budget, but 753 / 9.5% lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 13,811 are 2,024 / 17.2% favorable to budget and 1,632 / 13.4% higher than the same period last fiscal year.

Financial performance for Period 11 was favorable to budget. This is attributed to strong procedural volume and favorable management of variable expenses across the enterprise.

Total Operating Revenue ($):	$149M is $6M / 4.0% favorable to budget and $9M / 6.5% higher than the same period last fiscal year.
Operating EBIDA ($):	$23M is $3M / 16.2% favorable to budget and $3M / 14.0% higher than the same period last fiscal year.
Net Income ($):	$33M is $16M / 88.6% favorable to budget, but $0.5M / 1.4% lower than the same period last fiscal year.
Operating Margin (%):	10.1% (actual) vs. 8.5% (budget)
Operating EBIDA Margin (%):	15.8% (actual) vs. 14.1% (budget)
Net Days in A/R (days):	50.3 days are favorable to budget by 3.7 days / 6.9% and 0.1 days / 0.2% higher than the same period last year.

Executive Summary – YTD FY2025 (as of 5/31/2025):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 313 is 0 / 0.1% favorable to budget and 5 / 1.6% higher than the same period last year.
- **Adjusted Discharges:** 41,253 are 192 / 0.5% favorable to budget and 992 / 2.5% higher than the same period last year.
- **Emergency Room Visits:** 75,251 are 1,020 / 1.4% favorable to budget and 91 / 0.0% higher than the same period last fiscal year.

- **Outpatient Visits / Procedures:** 142,327 are 16,552 / 13.2% favorable to budget and 15,649 / 12.4% higher than the same period last fiscal year.

Total Operating Revenue ($):	$1,572M is $60M / 4.0% favorable to budget and $138M / 9.6% higher than the same period last fiscal year.
Operating EBIDA ($):	$251 is $37M / 17.1% favorable to budget and $24M / 10.7% higher than the same period last fiscal year.
Net Income ($):	$254M is $76M / 42.9% favorable to budget, but $15M / 5.5% lower than the same period last fiscal year. Lower year-over-year net income is attributed to unstable capital markets.
Operating Margin (%):	10.0% (actual) vs. 8.0% (budget)
Operating EBIDA Margin (%):	15.9% (actual) vs. 15.8% (budget)

Recommendation:

- Recommend Board approval of FY2025 – Period 11 & YTD financials

List of Attachments:

- Financial Report: FY2025 Period 11 & YTD

El Camino Health

Summary of Financial Operations

Fiscal Year 2025 – Period 11

7/1/2024 to 05/31/2025

Operational / Financial Results: Period 11 – May 2025 (as of 05/31/2025)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Year over Year change	YoY % Change	Moody's 'Aa3'	S&P 'AA'	Fitch 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	314	315	(1)	(0.2%)	307	7	2.1%	---	---	---	---
	Adjusted Discharges	3,928	3,863	65	1.7%	3,773	156	4.1%	---	---	---	---
	OP Visits / OP Procedural Cases	13,811	11,787	2,024	17.2%	12,179	1,632	13.4%	---	---	---	---
	Percent Government (%)	59.9%	59.2%	0.7%	1.2%	58.4%	1.5%	2.5%	---	---	---	---
	Gross Charges ($)	628,681	605,093	23,588	3.9%	556,558	72,123	13.0%	---	---	---	---
Operations	Cost Per CMI AD	22,308	20,032	2,275	11.4%	19,328	2,980	15.4%	---	---	---	---
	Net Days in A/R	50.3	54.0	(3.7)	(6.9%)	50.2	0.1	0.2%	48.1	49.7	47.5	
Financial Performance	Net Patient Revenue ($)	141,903	137,531	4,372	3.2%	129,632	12,271	9.5%	297,558	564,735	---	
	Total Operating Revenue ($)	148,568	142,843	5,725	4.0%	139,437	9,131	6.5%	389,498	610,593	268,739	
	Operating Margin ($)	**15,061**	**12,138**	**2,923**	24.1%	**11,894**	**3,167**	26.6%	**7,400**	**11,601**	**8,331**	
	Operating EBIDA ($)	**23,435**	**20,168**	**3,267**	16.2%	**20,564**	**2,871**	14.0%	**26,400**	**39,689**	**22,574**	
	Net Income ($)	33,312	17,662	15,650	88.6%	33,771	(459)	(1.4%)	19,085	20,150	15,049	
	Operating Margin (%)	**10.1%**	**8.5%**	**1.6%**	19.3%	**8.5%**	**1.6%**	18.8%	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**15.8%**	**14.1%**	**1.7%**	11.7%	**14.7%**	**1.0%**	7.0%	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	287	275	12	4.2%	266	20	7.7%	258	304	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2024. 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 2024. 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 2024. 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 < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

Operational / Financial Results: YTD FY2025 (as of 05/31/2025)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Year over Year change	YoY % Change	Moody's 'Aa3'	S&P 'AA'	Fitch 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	313	312	0	0.1%	308	5	1.6%	---	---	---	---
	Adjusted Discharges	41,253	41,061	192	0.5%	40,261	992	2.5%	---	---	---	---
	OP Visits / OP Procedural Cases	142,327	125,775	16,552	13.2%	126,678	15,649	12.4%	---	---	---	---
	Percent Government (%)	59.5%	58.7%	0.8%	1.3%	59.2%	0.3%	0.5%	---	---	---	---
	Gross Charges ($)	6,700,320	6,353,067	347,254	5.5%	5,818,841	881,479	15.1%	---	---	---	---
Operations	Cost Per CMI AD	20,403	20,032	371	1.9%	18,834	1,569	8.3%	---	---	---	---
	Net Days in A/R	50.3	54.0	(3.7)	(6.9%)	50.2	0.1	0.2%	48.1	48.1	47.5	
Financial Performance	Net Patient Revenue ($)	1,500,850	1,450,005	50,846	3.5%	1,359,667	141,184	10.4%	3,273,141	6,212,080	---	
	Total Operating Revenue ($)	1,572,185	1,512,125	60,059	4.0%	1,434,165	138,019	9.6%	4,284,479	6,716,521	3,224,864	
	Operating Margin ($)	**157,180**	**121,715**	**35,465**	29.1%	**134,173**	**23,007**	17.1%	**81,405**	**127,614**	**99,971**	
	Operating EBIDA ($)	**250,753**	**214,153**	**36,600**	17.1%	**226,582**	**24,171**	10.7%	**290,404**	**436,574**	**270,889**	
	Net Income ($)	254,231	177,966	76,264	42.9%	268,998	(14,768)	(5.5%)	209,939	382,842	180,592	
	Operating Margin (%)	**10.0%**	**8.0%**	**1.9%**	24.2%	**9.4%**	**0.6%**	6.9%	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**15.9%**	**14.2%**	**1.8%**	12.6%	**15.8%**	**0.2%**	1.0%	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	287	275	12	4.2%	266	20	7.7%	258	304	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2024. 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 2024. 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 2024. 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 < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

Consolidated Balance Sheet (as of 05/31/2025)

($000s)

ASSETS

CURRENT ASSETS	May 31, 2025	Audited June 30, 2024
Cash	294,722	202,980
Short Term Investments	94,242	100,316
Patient Accounts Receivable, net	229,428	211,960
Other Accounts and Notes Receivable	23,546	25,065
Intercompany Receivables	25,385	17,770
Inventories and Prepaids	46,537	55,556
Total Current Assets	**713,860**	**613,647**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	17,385	23,309
Plant & Equipment Fund	540,429	503,081
Women's Hospital Expansion	45,669	31,740
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	17,470	17,561
Workers Compensation Reserve Fund	13,086	12,811
Postretirement Health/Life Reserve Fund	23,009	22,737
PTO Liability Fund	41,477	37,646
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	38,354	33,030
Total Board Designated Assets	**949,285**	**894,322**
FUNDS HELD BY TRUSTEE	**18**	**18**
LONG TERM INVESTMENTS	**707,920**	**665,759**
CHARITABLE GIFT ANNUITY INVESTMENTS	**1,276**	**965**
INVESTMENTS IN AFFILIATES	**49,100**	**36,663**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,063,738	2,016,992
Less: Accumulated Depreciation	(952,820)	(874,767)
Construction in Progress	219,374	173,449
Property, Plant & Equipment - Net	**1,330,292**	**1,315,675**
DEFERRED OUTFLOWS	42,431	41,550
RESTRICTED ASSETS	51,106	32,166
OTHER ASSETS	205,717	195,447
TOTAL ASSETS	**4,051,005**	**3,796,213**

LIABILITIES AND FUND BALANCE

CURRENT LIABILITIES	May 31, 2025	Audited June 30, 2024
Accounts Payable	49,859	71,017
Salaries and Related Liabilities	35,325	35,693
Accrued PTO	42,745	38,634
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	6,991	13,419
Intercompany Payables	17,638	13,907
Malpractice Reserves	1,830	1,830
Bonds Payable - Current	11,360	10,820
Bond Interest Payable	5,958	7,673
Other Liabilities	19,385	12,261
Total Current Liabilities	**193,391**	**207,554**
LONG TERM LIABILITIES		
Post Retirement Benefits	22,403	22,737
Worker's Comp Reserve	13,086	12,811
Other L/T Obligation (Asbestos)	27,709	27,707
Bond Payable	427,662	441,105
Total Long Term Liabilities	**490,860**	**504,360**
DEFERRED REVENUE-UNRESTRICTED	**1,632**	**1,038**
DEFERRED INFLOW OF RESOURCES	**89,101**	**92,261**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,986,575	2,731,120
Minority Interest	-	(1,114)
Board Designated	225,529	216,378
Restricted	63,917	44,616
Total Fund Bal & Capital Accts	**3,276,021**	**2,991,001**
TOTAL LIABILITIES AND FUND BALANCE	**4,051,005**	**3,796,213**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Don Watters, Chair, Finance Committee
Date: August 13, 2025
Subject: Appointment of Community Member to the Finance Committee

Purpose:

To inform the Board that the Finance Committee approved Christina Lai as a community member of the Finance Committee (FC) at their July 30, 2025, Special Meeting.

Summary:

1. Situation: Due to a Committee Position vacancy. Per the Board's Charter, the FC shall be comprised of two (2) or more Hospital Board members. The Committee may also include 2-4 Community[1] members with knowledge of finance committee practices, executive leadership and/or Financial Management.

2. Authority: Per the Charter, new Community members shall be appointed by the Committee and approved by the Board. All community committee appointments shall be for a term of three years expiring on June 30th.

3. Background: Given the need to add a community member to the Finance Committee, the Hospital Board Chair in consultation with the Finance Committee Chair and ECH CEO, recommended to the Hospital Board that Christina Lai transition from the Governance to the Finance Committee effective FY2026. Ms. Lai's appointment to the FC was approved by the Board, contingent on FC approval, at the June 2025 ECHB meeting.

4. Outcome: This is an informational item to inform the Board that the Finance Committee approval was received.

[1] Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT | August 13, 2025

CLINICAL SERVICES

Norma Melchor Heart & Vascular Institute

El Camino Health and Norma Melchor Heart & Vascular Institute were **named one of the best hospitals in the country for heart surgery and treating heart failure**. HVI has also won a **Platinum Award from the American College of Cardiology for 8 years in a row** for giving excellent care to people having heart attacks. They also **earned top 3-star ratings (highest achievement) for two big surgeries: replacing heart valves and doing bypass surgery**.

HVI was again named a National Center of Excellence, meaning they are a leader in heart care, always improving and helping people in the community learn how to stay heart-healthy.

HVI continues to innovate and lead with the adoption of new treatments including:

- A new heart treatment called **Pulsed Field Ablation (PFA)** to help people with irregular heartbeats (called atrial fibrillation).
- Our heart center also launched a new **advanced imaging program** in its first year. This program uses special machines like CT scans, PET scans, and MRI to get very detailed pictures of the heart.
- We also use a smart computer tool called **HeartFlow RoadMap** that helps doctors read heart scans more accurately. It uses artificial intelligence (AI) to find blockages in heart arteries better and faster.

Cancer

Dr. Tran Ho, Co-Director of Breast Cancer Program and a fellowship trained breast surgeon, **is selected as Silicon Valley Business Journal as one of the 40 under 40 stars.**

MARKETING

In July 2025, El Camino Health's marketing and communications team achieved several key milestones in brand growth, service line marketing, and engagement across digital and traditional channels. **The team met its annual goal for unaided brand awareness**, **with the strongest gains in the Mountain View and secondary service areas. Service line marketing delivered measurable results, including an increase in urgent care appointments scheduled through SEM campaigns**, which achieved click-through rates well above industry averages. **New digital content and campaigns were launched for mother-baby, cancer, and mental health programs.**

Additionally, **a successful Men's Health Fair held at the Los Gatos campus on July 19, increased attendance by 24 percent over the prior year's event, featured more than 20 physicians hosting specialty tables, and included well-attended lectures on prostate cancer and heart health.** On social media, Instagram saw a 5.4 percent increase in reach and a 31.6 percent rise in profile visits, while LinkedIn engagement rates outperformed competitors. Internal communications remained strong, with high open and click-through rates across

executive and employee newsletters, ongoing support for major organizational initiatives, and continued enhancements to the Engage intranet platform.

INFORMATION SERVICES

El Camino Health received the "Partnership and Innovation Award" at the Solventum National Conference for successful outcomes and adoption related to the Ambient Listening project.

Social Determinants of Health compliance is now tracked via a new dashboard to support targeted quality improvement efforts.

Deb Muro was recognized by Becker's Healthcare as one of their top CIO's To Know for 2025. The IT Leaders featured are driving forward thinking strategies that create meaningful improvements for both patients and providers.

CORPORATE HEALTH SERVICES

Concern Health has won a large multi-hospital system in Southern California and has a number of other healthcare systems in the pipeline. This is a major focus area for growth. There are several high profile benefit consultants that identify Concern as an ideal partner for healthcare institutions.

The **Chinese Health Initiative (CHI) established a new partnership with the prestigious Taipei First Girls' High School alumni association and delivered a diabetes prevention webinar to 70+ participants**. In addition, CHI participated in the annual Men's Health Fair held at the Los Gatos campus, engaging with 200+ community members during the event.

The **South Asian Heart Center engaged 249 participants in screening, education, and coaching programs to prevent heart disease and diabetes and completed 499 consultations and coaching sessions.** We hosted 15 lifestyle workshops and health information events attended by 250 participants and community members.

Separator Page

A19b1. Alleged Assault or Abuse of Patients Receiving Care at ECH

Status **Pending** PolicyStat ID **18630078**

Origination	N/A	Owner	Sheetal Shah: Sr Director Risk Management and Patient Safety
Last Approved	N/A	Area	Risk Management & Patient Safety
Effective	Upon Approval	Document Types	Policy
Last Revised	N/A		
Next Review	3 years after approval		

Alleged Assault or Abuse of Patients Receiving Care at ECH

COVERAGE:

All El Camino Hospital (ECH) Staff and Medical Staff

PURPOSE:

To provide appropriate management (identification, assessment, safeguarding of evidence, referral, reporting, ongoing screening and documentation) of all instances of alleged assault or abuse reported by a patient or anyone on behalf of a patient who is receiving or has received care while at El Camino Hospital.

STATEMENT:

ECH will ensure the patient care environment is conducive to the improvement of patient outcomes, by respecting each patient's rights and honoring their dignity. ECH patients have the right to considerate and respectful care in a safe environment, free from abuse, assault, or harassment. All ECH staff and medical staff will be aware and considerate of how their actions affect patients.

All staff and medical staff who suspect or receive information concerning alleged assault or abuse of a patient when receiving care at ECH are responsible for promptly communicating their observations, information, or suspicions to their immediate supervisor, Assistant Hospital Manager, or Administrator on Call.

Alleged patient assault or abuse is taken seriously, and it is of the utmost importance to provide prompt intervention as outlined in the procedure below. Staff and medical staff must maintain confidentiality and not discuss the matter with any other person except as required for reporting and investigation,

Alleged Assault or Abuse of Patients Receiving Care at ECH

must not retaliate against any individual for raising concerns, and must cooperate with any investigation.

Any allegations of assault or abuse must be investigated and handled as indicated in the procedure below.

Any allegations of abuse or assault of a patient by staff or employed allied health practitioner should be handled through the HR process. Any allegations of abuse or assault of a patient by a physician or non-employed allied health practitioner shall be immediately referred to the Chief of Staff or designee for appropriate action and investigation, including as appropriate the corrective actions, or summary suspension, identified in Article 7 of the Medical Staff Bylaws. The Chief of Staff, the Medical Staff Executive Committee, or the department head, or designee, or the governing body or designee may summarily restrict, suspend, or remove a physician or allied health professional from providing care to a patient if that practitioner's conduct appears to require immediate action be taken to protect the life or well-being of a patient, or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person.

Any allegations of abuse or assault by a contractor shall be handled as indicated in the procedure below. In addition, notification to the contractor's employer may be necessary as per contractual requirements.

DEFINITIONS:

- **Abuse or Assault** - The willful infliction of injury (physical or mental), unreasonable confinement, unwanted touching, intimidation, or punishment, with resulting physical or mental harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
- **Assault Response Team** (**ART**) – Includes representatives from Risk Management, AOC of the day, COO, AR&L, CQO, Nursing, Department Head, Patient Experience, Care Coordination, HR, Legal, Security, Medical Staff Services

REFERENCES:

- Reporting of Abuse, Elder or Dependent Adult
- Discrimination and Harassment
- Discipline and Discharge
- Adverse Event Reporting to Regulatory or State Licensing Agencies
- Reporting of Child Abuse
- Medical Staff Code of Conduct and Professional Behavior
- Medical Staff Bylaws

PROCEDURE:

When a report is made by staff, patients, patient representatives, family members or visitors who allege

abuse or assault by staff or medical staff, follow Attachment A Worksheet for Responding to Allegations of Patient Assault or Abuse.

ATTACHMENTS:

- Attachment A – Steps to Responding to Allegations of Assault or Abuse of Patients Receiving Care at ECH
- Attachment B – Procedure for Allegations Involving Staff
- Attachment C – Minimum Components of Investigation

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

Attachment A - Steps to Responding to Allegations of Assault or Abuse of Patients Receiving Care at ECH.pdf

Attachment B - Procedure for Allegations Involving Staff.pdf

Attachment C - Minimum Components of Investigation.pdf

Approval Signatures

Step Description	Approver	Date
	Sheetal Shah: Sr Director Risk Management and Patient Safety	Pending

Separator Page

A19b2. Board of Director Approval of Hospital Policies-Changes

Status **Pending** PolicyStat ID **18617314**

Origination	02/2017	Owner	Diane Wigglesworth: VP, Compliance
Last Approved	N/A	Area	Board
Effective	Upon Approval	Document Types	Policy
Last Revised	07/2025		
Next Review	3 years after approval		

Board of Director Approval of Hospital Policies

COVERAGE:

All El Camino Hospital Employees, Medical Staff and Volunteers

PURPOSE:

To define which hospital policies require approval by the Board of Directors of El Camino Hospital ("the Board").

POLICY STATEMENT:

This Board policy describes the criteria for determining when documents, as defined below, require approval by the Board. All policies, plans and scopes of services of El Camino Hospital will be approved by the Board a minimum of every 3 years or as required by regulation.

DEFINITIONS:

A. ~~**Policy**: A policy is defined as a brief written statement of intent or principle that determines actions or decisions. Generally, a policy is based on law, regulations, accreditation standards, or leadership decisions.~~

B. ~~**Plan:** A single document that provides detailed description of provision of a particular program or scope of service, often required by regulation. Ex. Disaster Plan, Pandemic Plan, Plan for Provision of Care.~~

C. ~~**Procedure**: A step-by-step written outline detailing how something is to be accomplished. Procedures answer the "what" and "How do I do it" questions. Ex: Chemotherapy,~~

Board of Director Approval of Hospital Policies

~~Administration of.~~

~~D. **Protocol**: Defines care and management of a broad patient care issue. A prescriptive, detailed definition of what is to be implemented using precise, sequential steps, preferably evidenced based. Examples include Alcohol Withdrawal, Management of.~~

~~E. **Guideline**. Guidelines describe the recommended care approach for a given diagnosis or condition. Guidelines must be evidenced based and are often listed in evidence based databases.~~

~~F. **Standardized Procedure**. The legal mechanism for nurses and nurse practitioners to perform specific functions which would otherwise be considered the practice of medicine. Physician Leadership at El Camino Hospital (ECH) has agreed to allow specific functions to be performed by specific nurses in specific circumstances in accordance with standardized procedures.~~

~~G. **Scope of Service**: A document that describes the provision of service of a particular program or department of the hospital.~~

- **Policy**: A policy is defined as a brief written statement of intent or principle that determines actions or decisions. Generally, a policy is based on law, regulations, accreditation standards, or leadership decisions.
- **Plan:** A single document that provides detailed description of provision of a particular program or scope of service, often required by regulation. Ex. Disaster Plan, Pandemic Plan, Plan for Provision of Care.
- **Procedure**: A step-by-step written outline detailing how something is to be accomplished. Procedures answer the "what" and "How do I do it" questions. Ex: Chemotherapy, Administration of.
- **Protocol**: Defines care and management of a broad patient care issue. A prescriptive, detailed definition of what is to be implemented using precise, sequential steps, preferably evidenced based. Examples include Alcohol Withdrawal, Management of.
- **Guideline**. Guidelines describe the recommended care approach for a given diagnosis or condition. Guidelines must be evidenced based and are often listed in evidence based databases.
- **Standardized Procedure**. The legal mechanism for nurses and nurse practitioners to perform specific functions which would otherwise be considered the practice of medicine. Physician Leadership at El Camino Hospital (ECH) has agreed to allow specific functions to be performed by specific nurses in specific circumstances in accordance with standardized procedures.
- **Scope of Service**: A document that describes the provision of service of a particular program or department of the hospital.

PROCEDURE:

A. All patient care policies, all plans and scopes of services requiring Board approval will be reviewed and approved by the appropriate hospital committee prior to coming to the Board. Dates for hospital committee approvals shall be reflected in documents. ~~For clinical~~Clinical policies~~/~~, plans~~/~~, and scopes of service~~,~~ require approval by the Medical Executive Committee

Board of Director Approval of Hospital Policies

~~and the e-Policy~~(MEC) and ePolicy Committee ~~shall approve prior to~~before being submitted for Board approval. ~~For non~~Non-clinical ~~or~~and administrative ~~policies, the~~documents may be approved by ePolicy and management unless specifically designated for Board ~~delegates authority to approve through the e-Policy Committee and Management~~approval.

B. Policies/Plans/Scopes of Service requiring Board approval shall be sent to the MEC or to the designated advisory committee of the Board (e.g. Quality/Finance/Compliance) for review and recommendation prior to final ~~Hospital~~ Board approval.

C. Procedures, protocols, standardized procedures and guidelines as defined above are reviewed by designated hospital committees identified in the Policy & Procedure Formulation, Approval and Distribution policy, and do not require Board approval.

D. The Board retains the rights to specify policies that require Board approval. All poicies, plans and scope of service must be reviewed and updated at least every three years or more frequestly as required by regulations or internal policy.

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Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	Pending
	Diane Wigglesworth: VP, Compliance	07/2025

Separator Page

A19b3. Health Equity - Cultural Competency-New Policy

Status **Pending** PolicyStat ID **18169088**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	3 years after approval
Owner	Najwa Mojaddadi: Manager, Health Equity
Area	Health Equity
Document Types	Policy

Health Equity - Cultural Competency

COVERAGE:

All El Camino Hospital (ECH) inpatient and outpatient staff

PURPOSE:

El Camino Hospital is committed to adhering to guidelines and procedures that promote and maintain care that is competent, sensitive and embodies humility towards our patients in operations by providing the highest quality of care and access to every patient, regardless of race, ethnicity, cultural background, age, socioeconomic status, sexual orientation, gender identity, ability status, and English proficiency or literacy.

This policy seeks to enhance communication and improve patient satisfaction, safety, and quality of care, to foster an inclusive environment for patients and their families.

POLICY STATEMENT:

This policy is written to ensure compliance with the laws, regulations and best clinical practices that align with key regulatory and certifying bodies including:

- The Joint Commission Standards: RI.01.01.01, RI.01.01.03 and PC.02.01.21
- American Nurses Association (ANA) Standard 8
- National Culturally and Linguistically Appropriate Services Standards 1, 2, 4, and 5

Health Equity - Cultural Competency

DEFINITIONS:

- **Cultural Competency** - Cultural competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs. A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. (American Hospital Association, 2013)
- **Cultural Humility** - Cultural humility is a reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them. Strategies for practicing cultural humility include: Practicing self-reflection, including awareness of your beliefs, values, and implicit biases / Recognizing what you don't know and being open to learning as much as you can /Being open to other people's identities and empathizing with their life experiences/ Acknowledging that the patient is their own best authority, not you / Learning and growing from people whose beliefs, values, and worldviews differ from yours. (U.S. Department of Health and Human Services, n.d.)
- **Cultural Sensitivity** - Awareness and appreciation of the values, norms, and beliefs characteristic of a cultural, ethnic, racial, or other group that is not one's own, accompanied by a willingness to adapt one's behavior accordingly. (American Psychological Association, n.d.)

REFERENCES:

- American Hospital Association. (2013, June 18). *Becoming a culturally competent health care organization*. https://www.aha.org/ahahret-guides/2013-06-18-becoming-culturally-competent-health-care-organization
- U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *CLAS, cultural competency, and cultural humility*. https://thinkculturalhealth.hhs.gov/assets/pdfs/resource-library/clas-clc-ch.pdf
- American Psychological Association. (n.d.). *Cultural sensitivity*. In *APA Dictionary of Psychology*. https://dictionary.apa.org/cultural-sensitivity
- U.S. Department of Health and Human Services, Office of Minority Health. (n.d.). *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. Think Cultural Health. Retrieved May 14, 2025, from https://thinkculturalhealth.hhs.gov/clas/standards
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- The Joint Commission. (2021, November 29). *Language access and interpreter services – Understanding the requirements*. Hospital and Hospital Clinics: Rights and Responsibilities of the Individual (RI). https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/rights-and-responsibilities-of-the-individual-ri/000002120/

Health Equity - Cultural Competency

PROCEDURE:

At ECH, strategies that ensure culturally competent, sensitive and humble care include:

A. Providing interpreter services
B. Providing training to staff to increase cultural awareness, sensitivity, humility, knowledge, and skills
C. Coordinating with culturally congruent care providers
D. Incorporating culture-specific attitudes and values into health promotion tools and patient education materials
E. Including patients, family/partners, and community members in health care decision making
F. Locating healthcare services and clinics in geographic areas that are easily accessible

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Attachments

R3 Report: Patient-Centered Communication Standards for Hospitals

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy	Patrick Santos: Policy and Procedure Coordinator	06/2025
Cultural Competency Committee	Najwa Mojaddadi: Manager, Health Equity	05/2025
	Najwa Mojaddadi: Manager, Health Equity	05/2025

History

Created by Mojaddadi, Najwa: Manager, Health Equity on 5/14/2025, 5:16PM EDT

Health Equity - Cultural Competency

Last Approved by Mojaddadi, Najwa: Manager, Health Equity on 5/14/2025, 5:16PM EDT

Last Approved by Mojaddadi, Najwa: Manager, Health Equity on 5/14/2025, 5:21PM EDT

Comment by Santos, Patrick: Policy and Procedure Coordinator on 5/14/2025, 5:23PM EDT

> Cultural Competency Cmte 4/9/25

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/13/2025, 3:49PM EDT

> ePolicy 6/13/25

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A19b4. Scope of Service- Respiratory Care Services- Redline

Status **Pending** PolicyStat ID **18289813**

Origination	02/2018	Owner	Jolie Fournet: Dir Resp Care & Min Inv Prog
Last Approved	N/A	Area	Respiratory Care Services
Effective	Upon Approval	Document Types	Scope of Service
Last Revised	06/2025		
Next Review	3 years after approval		

Scope of Service: Respiratory Care Services

Types and Ages of Patients Served

The department of Respiratory Care Services, which includes Respiratory Therapy, Interventional ~~Bronchoscopy~~Pulmonary Team, Pulmonary Health (Diagnostics Lab), Respiratory ~~Care~~Disease Specialists, Plerual Prgram, Lung Nodule Program, Tobacco Cessation Program, Chronic Respiratory Disease Program and CLIA licensed POCT Blood Gas Lab, is organized as a treatment and diagnostic service for the needs of both Inpatients and Outpatients at both the Mountain View and Los Gatos campuses.

Respiratory Care Services serves all patient ages from Neonatal to Geriatric with the exception of a Pediatric Intensive Care. Those pediatric patients whose condition is beyond the scope of care at ECH are stabilized and transferred to an appropriate facility.

NOTE: Per California Department of Health pediatric service means the observation, diagnosis and treatment (including preventive treatment) of children and their illnesses, injuries, diseases and disorders by appropriate staff, space, equipment and supplies. Pediatric services apply to patients less than 14 years of age. The California Department of Health definition of Pediatrics is used at ECH (California Code of Regulations: Title 22, Division 5, Chapter 1, Article 6, section 70537).

Assessment Methods

Diagnostic and therapeutic respiratory services provided to patients are assessed by physicians, NP, and respiratory care practitioners who monitor patient's response to treatment, progress with treatment, validity of arterial blood gas and pulmonary function testing based on internal quality controls, external proficiency testing as well as pre-established protocols for patients on mechanical, noninvasive

ventilation and oxygen therapy.

Scope and Complexity of Services Offered

A full complement of core treatment services is available to all service lines within the hospital on a 24-hour basis. An extensive array of diagnostic services is available to all patients and clients in the system Monday-Friday, from 7:00 a.m. to 4:30p.m. Selected tests and services are available to specific service lines.

Services provided, classified as therapeutic and diagnostic, are described below.

A. Therapeutic Services: include, but are not limited to:

1. Adult, pediatric (for stabilization only) and neonatal mechanical ventilation
2. Adult and Neonatal high frequency oscillatory ventilation
3. Adult Inhaled Nitric Oxide Administration
4. Neonatal Inhaled Nitric Oxide Administration (MV campus only)
5. Surfactant Administration
6. Attendance at High Risk Deliveries
7. Adult, pediatric (for stabilization only) and Neonatal Noninvasive ventilation
8. Long term ventilation
9. Cardiopulmonary resuscitation / member of Code Blue team
10. Adult, Pediatric, and Neonatal Intubation
11. Oxygen therapy – Low flow & High flow therapies
12. Small volume nebulizer treatments, Continuous Nebulizer treatments (ED)
13. Chest Physiotherapy via different methods such as chest vest, Aerobika (PEP device), or ~~Metaneb~~Volara
14. Oximetry
15. ETCO2 monitoring (Capnography)
16. Medication Administration via HHN or MDI
17. Tracheostomy Care, which could include but are not limited to: changing trach, suctioning, weaning and Passy Muir Valve application
18. Adult, Pediatric & Neonatal transport assistance
19. Therapeutic and Diagnostic bronchoscopy
20. Patient & Family education and discharge teaching
21. MRI transport and MRI ventilator support
22. Rapid Response Team
23. ~~Sepsis Alerts~~
24. ~~OSA consults~~

Scope of Service: Respiratory Care Services

25. ~~COPD consults~~
26. ~~Asthma consults~~
27. ~~Pneumonia consults~~
28. OSA evaluation and education
29. COPD evaluation and education
30. Asthma evaluation and education
31. Pneumonia evaluation and education
32. Tobacco Cessation Program
33. Pleural program consults
34. Interventional Pulmonary Consults

B. **Diagnostic Services:** include but are not limited to:

1. Blood gas analysis including co-oximetry and EPOC electrolyte and metabolic panels
2. ~~Home Sleep Tests~~
3. Complete pulmonary function studies
4. Bedside spirometry/flow volume loops
5. Body plethysmography
6. Calorimetry Studies
7. 6 Minute Walk Test
8. Pulmonary Exercise Studies
9. Cardiopulmonary stress testing
10. Peak flow and vital capacity measurement
11. NIF, MVV, MIF/NIF
12. High altitude simulation studies
13. Bronchoprovocation studies
14. Capnography and oximetry studies
15. Nocturnal saturation studies
16. Sputum induction for AFB, PCP, TB
17. Lung Nodule Surveillance Program
18. Diagnostic video bronchoscopy
19. Interventional Bronchoscopy: including but not limited to:
    a. Robotic Bronchoscopy with Cone Beam CT
    b. Narrow Band Imaging
    c. Argon/Cryo Airway Recannulization
    d. Fiducial Placements

e. Electromagnetic Navigational Bronchoscopy
f. Rigid Bronchoscopy/Thoracoscopy
g. Ultrasound thoracentesis with chest tube placement
h. Endobronchial Ultrasound
i. Pulmonary Dilation/Stent Placement
j. Bronchial Valve Placement
k. Bronchial Thermoplasty
l. Confocal Laser Microscopy

Appropriateness, Necessity and Timeliness of Services

The Respiratory Care Services Department assesses the appropriateness and necessity of diagnostic and therapeutic procedures by evaluating the patient's clinical history against pre-established criteria for individual therapies and by assessment of the patient's condition prior to the initiation of treatment and at regular intervals thereafter, as described in the policies and procedures of the department.

Timeliness of services is addressed in departmental policies and procedures, which describe the hours of operation as well as performance of routine and stat procedures.

Documentation of assessments of patients on adult, pediatric, and neonatal mechanical ventilation is completed within one hours of initiation and stabilization of the patient and every four hours thereafter. Documentation of blood gas results are with 20 minutes of receipt ~~for~~of analysis. All other routine assessments are documented within two hours of initiation if appropriate and should be completed by end of the shift.

Staffing Plan/Staff Mix

Staffing is maintained according to an expected standard of ~~50-60~~60-65 work units per therapist with limited exceptions, especially at LG campus. On day shift at MV, a flex therapist is assigned for emergency and unplanned procedure volume. The Lead therapist or Charge therapist carries a half workload or ~~takes Emergency Department cases and new patient starts if~~less at both campuses. At times there is ~~no flex~~an ED therapist at MV campus. Assignments are established by points where one point is equal to ten minutes. Sixty points is equal to ten hours' worth of assigned work in a twelve hour shift.

Minimum Staffing levels are established as:

1. MV Day shift:	Minimum of ~~7~~9 at all times; ~~8-10~~10-14 during peak census
2. MV Night shift:	Minimum of ~~5~~8 at all times; ~~6-9~~10 - 12 during peak census
3. LG Day Shift:	Minimum of 2 at all times, with exceptions; ~~3~~4 during peak census
4. LG Night Shift:	Minimum of 2 at all times, with exceptions; ~~3~~4 during peak census
5. Respiratory	Minimum or ~~2~~3 at all times; ~~RCS~~RDS cover both MV and LG campuses

Scope of Service: Respiratory Care Services

~~Care~~Disease Spec.	
6. Pulmonary Lab:	Monday- Friday, 7:00a.m. – 4:30p.m; Minimum of 2 Mon-Fri; staff cover both MV and LG campuses
7. Interventional Pulm. Team	Monday – Friday – 7A – 5P; 4 therapists at all times to cover MV and LG campuses

Staffing is assessed every four hours for current and subsequent shift with staffing increased with the use of per diem staff or with pre-approval, the use of outside labor / contract therapists. Staffing is adjusted downward through the use of daily cancellation, (DC SEIU) as outlined in departmental staffing guidelines and CBA (SEIU).

At Mountain View Campus, minimum core staffing of ~~two~~four trained therapists per shift is always maintained for NICU, CCU, ~~Pulmonary Lab~~, Charge, and ~~main~~two trained therapists for Pulmonary Health (during open hours) at hospital 24 hours/day. Included in the minimum core ~~for day shift,~~ are ~~2~~two therapists trained in Bronchoscopy. At Los Gatos Campus, staff is trained in all areas which include but not limited to ICU, NICU, L&D, ER, and bronchoscopies.

In the event workload exceeds staffing levels and the need to implement the Therapy Prioritization Policy may be deemed necessary, the Lead or Charge therapist contacts the Director, Manager, Asst Manager or designee, to determine the need to initiate Respiratory Care Therapy Prioritization System (as defined in Therapy Prioritization Policy).

Professional medical services for Respiratory Care Services are directed by Medical Directors in which there are (3) three. Administrative direction of Respiratory Care Services is provided by a Registered Respiratory Therapist. Pulmonary Diagnostic Services are supported by ~~a Manager~~an Asst. manager, who oversees Respiratory ~~Care~~Disease Specialists, Interventional ~~Bronchoscopy~~Pulmonary team & procedures, blood gas and Pulmonary Labs who is a Registered Pulmonary Function Technologist. Administrative Director & ~~Diagnostics~~ Manager have Asst Manager handling some of the operational oversight of department. Asst. ~~Manager is a~~Managers are Registered Respiratory ~~Therapist~~Therapists. Lung Nodule Program has NP as navigator and reports to Administrative Director and (1) Medical Director. NP has oversight of Pulmonary Health programs (excluding diagnostics and ABG labs) and performs pleural procedures.

Respiratory Care Services Staff providing care and services are all California licensed respiratory care practitioners (RCPs). NP is licensed and credentialed by ECH Medical Staff Office.

Level of Service Provided

The levels of services provided by the department are consistent with the diagnostic and therapeutic needs of the patients as determined by the Medical Directors.

Respiratory Care services are designed to meet patient needs by accurately performing and interpreting diagnostic and therapeutic procedures in a timely manner. Performance improvement and quality control activities are in place to measure and assess the degree to which the Respiratory Care Services Department meets patients' needs.

Scope of Service: Respiratory Care Services

Standards of Practice

Respiratory Care Services is governed by California state and federal regulations as outlined in Title 22, CMS Conditions of Participation 482.57, and standards established by The Joint Commission. The Blood Gas Labs comply with CLIA standards and is surveyed by CAP (College of American Pathologists) in addition to the above. The department also follows guidelines set forth by the American Association for Respiratory Care. Additional practices are described in department policies and procedures.

Organization, Chain of Command, Level of Supervision

A. The purpose is to ensure the availability of Lead Therapists and management personnel oversight of staff to ensure minimal errors in patient care. When an error occurs during patient care:
    1. Complete electronic event report (iSAFE)
    2. Email Director or designee to notify of iSAFE
    3. Address error correction with staff ensuring both patient and employee satisfaction when appropriate

B. Organization
    1. Respiratory Care Services is an enterprise department comprised of Respiratory Therapy, Pulmonary ~~Diagnostics Lab~~Health, Respiratory ~~Care~~Disease Specialists, and Interventional ~~Bronchoscopy~~Pulmonary, organized as a diagnostic and treatment service reporting to the Chief Nursing Officer.

C. Medical Direction
    1. The Medical Direction of the enterprise department is provided by an active and Emeritus El Camino Hospital physician specializing in Pulmonary Medicine, who is accountable to the Chief Medical Officer and managed through the medical staff office. There is a Medical Director at both the Mountain View and Los Gatos campuses. Interventional Pulmonary Team and NP has a Medical Director board certified in Interventional Pulmonary and Pulmonary medicine.

D. Technical Direction
    1. The Technical Direction of the enterprise department is provided by a Registered Respiratory Care Practitioner, who has the responsibility for operation of the department and is accountable to the Chief Nursing Officer.

E. Chain of Command Medical Problems
    1. When a Respiratory Care Practitioner encounters a medical problem that may cause serious complications to a patient the therapist shall contact the Lead or Charge Therapist if the Lead is not available, to inform and discuss the circumstances.
    2. The Lead or Charge Therapist will evaluate the situation and make recommendations for the therapist to discuss with the attending physician or will

Scope of Service: Respiratory Care Services

contact the Medical Director if appropriate. Director or designee is also notified and they determine escalation to Risk Managment.

3. In the event of high census or staffing shortages the Lead Therapist or Charge Therapist shall contact the department Director or Department designee of any need to initiate department's prioritization policy.

F. Chain of Command Technical Problems

1. All technical problems, errors, occurrences, equipment failures should be brought to the attention of the Lead Therapist and Department Director or designee as soon as possible prior to end of shift.
2. The Lead shall take corrective actions as necessary and inform the Director or designee of actions taken.
3. Director will ensure appropriate corrective actions have been taken, the necessary individuals have been involved or informed and the necessary documentation has been completed.

G. Levels of Supervision

1. All licensed Respiratory Care Practitioners work under the Direction of the Medical Directors and all applicable Federal and State regulations covering the practice of Respiratory Therapy. Staff is under the direct supervision of the Lead Therapist or Charge Therapist. Additionally, the Medical Directors have an interactive relationship with the staff therapists acting as clinical advisors and active consultants. The Medical Directors participate actively in the performance, quality, improvement process and other regulations of the department.
2. All Respiratory Therapy Students on Clinical affiliations at the hospital shall have supervision by a designated therapist preceptor, or college instructor in the immediate area.

H. Applicable Regulations

1. Title 22

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Approval Signatures

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

Scope of Service: Respiratory Care Services

MEC	Michael Coston: Director Quality and Public Reporting [PS]	06/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2025
Department Medical Director or Director for non-clinical Departments	Jolie Fournet: Dir Resp Care & Min Inv Prog [PS]	06/2025
	Jolie Fournet: Dir Resp Care & Min Inv Prog	06/2025

History

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 6/3/2025, 12:52PM EDT

Draft saved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/3/2025, 1:57PM EDT

Edited by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/3/2025, 1:59PM EDT

> Minor working changes; added new services

Last Approved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/3/2025, 1:59PM EDT

Draft saved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/9/2025, 3:59PM EDT

Edited by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/9/2025, 4:01PM EDT

> Dr. Saw had me change some of the wording from consults to evaluation and education. With these changes both Drs. Tseng and Saw approve the policy - June 9, 2025

Last Approved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/9/2025, 4:01PM EDT

Last Approved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/9/2025, 4:02PM EDT

> Medical Directors approve.

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 6/13/2025, 1:25PM EDT

Draft saved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/13/2025, 2:08PM EDT

Comment by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/13/2025, 2:10PM EDT

> California Code of Regulations: Title 22, Division 5, Chapter 1, Article 6, section 70537 - definition of pediatrics added to scope.

Scope of Service: Respiratory Care Services

Edited by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/13/2025, 2:12PM EDT

> ePolicy approval granted given added definition of pediatrics.

Last Approved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/13/2025, 2:12PM EDT

Last Approved by Fournet, Jolie: Dir Resp Care & Min Inv Prog on 6/13/2025, 3:27PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 6/13/2025, 3:30PM EDT

> ePolicy 6/13/25

Administrator override by Santos, Patrick: Policy and Procedure Coordinator on 6/13/2025, 4:36PM EDT

> Included cite to definition.

Last Approved by Coston, Michael: Director Quality and Public Reporting on 6/26/2025, 1:58PM EDT

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A19b5. Radiation Safety - Radiation Protection Program-Redline

Status **Pending** PolicyStat ID **18076052**

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Last Revised	04/2025
Next Review	1 year after approval
Owner	Aletha Fulgham: Dir Diagnostic Imaging Svcs
Area	Imaging Services
Document Types	Policy

Radiation Safety - Radiation Protection Program

COVERAGE:

All El Camino Hospital staff, medical staff, and volunteers

PURPOSE:

To provide standards for proper radiation protection at El Camino Hospital

POLICY STATEMENT:

This policy describes the ECH Radiation Protection Program, the reporting structure and program oversight. It is the hospital guidance document for occupational and public radiation safety/exposure.

DEFINITIONS:

- ALARA: an acronym for "as low as (is) reasonably achievable," which means making every reasonable effort to maintain **exposures** to **ionizing radiation** as far below the dose limits as practical.
- RSO: Radiation Safety Officer
- RSC: Radiation Safety Committee
- RPP: Radiation Protection Plan
- RPA: Radiation Protection Apparel
- Per California Department of Health, pediatric service means the observation, diagnosis and treatment (including preventive treatment) of children and their illnesses, injuries, diseases and disorders by appropriate staff, space, equipment and supplies.

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- Pediatric services apply to patients less than 14 years of age.
- The California Department of Health definition of Pediatrics is used at ECH.

REFERENCES:

- American College of Radiology – Radiation Safety
- California Department of Public Health- Radiologic Health Branch
- California State Bill 1237
- Title 17, the California Code of Regulations, Title 10, Code of Federal Regulations, Part 20
- NCRP Recommendations for Ending Routine Gonadal Shielding During Abdominal and Pelvic Radiography
- RSO Delegation of Authority: http://policies.elcaminohospital.org/dotNet/documents/?docid=9828https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8243IR1.pdf
- California Code of Regulations: Title 22, Division 5, Chapter 1, Article 6, section 70537

PROCEDURE:

A. **Program Structure and Oversight**

1. **Radiation Safety Officer (RSO) -** The RSO is qualified by the California Department of Health Services, Radiologic Health Branch (CDPH) and is responsible for the Radiation Protection Program (RPP.)
    a. The duties and responsibilities of the RSO and governance of the RSO and organization are addressed in the Delegation of Authority document.
    b. The RSO is responsible to report annually the activities of the RPP to the hospital medical staff.

2. **Radiation Safety Committee-** The Radiation Safety committee reports to the Hospital Safety Committee and meets quarterly. A quorum for any meeting is three of the four core members.
    a. Membership
        i. Core Members of the RSC are:
            - RSO
            - The Chairman
            - A representative from hospital administration
            - A representative from nursing administration
        ii. Represented members are required from each department that utilizes ionizing radiation and may include members of the Medical Staff.
        iii. Appointment to the RSC is made through recommendation and approval by the RSO.

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b. Radiation Safety Committee has the following responsibilities:
    i. To review proposals for diagnostic and therapeutic uses of radionuclides.
    ii. To review regulations for the use, transport, storage and disposal of radioactive materials.
    iii. In concert with the RSO, analyze technical data regarding the use of ionizing radiation for the ECH Enterprise, and make recommendations to ensure best institutional safety practices, and review regulatory requirements for compliance.
    iv. To review rules and guidelines for nursing and other individuals who are in contact with patients receiving therapeutic amounts of unsealed radionuclides; rules relating to the discharge of such patients; and rules to protect personnel involved when such patients undergo procedures or autopsy.
    v. To assure the provision of radiation safety training suitable to the needs of the hospital.
    vi. Annual review of equipment records to ensure physics surveys are within limits.
    vii. Review the Radiation Protection Plan annually.
    viii. Review quarterly Quality Control records from all areas where radiation is used.
    ix. Maintains policies on the following topics for guidance.
        - Radiation Protection
        - Inspection and maintenance of Radiation Protective Apparel (RPA)
        - Dosimetry monitoring
        - CT radiation dose documentation
        - Declared pregnant radiation workers
        - Pregnancy screening and patient management
        - Portable radiography guidelines
        - Fluoroscopy exposure regulatory guidance
        - Radiation exposure events; wrong patient or body part imaged
        - Radionuclide delivery and storage
        - Radioactive spills and emergencies
        - Radiopharmaceuticals safety
        - Radioactive waste management
    x. Annual review of RPA inspection report.

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c. Radiation Areas
    i. A current copy of department form RH-2364 (notice to employees) is posted. Title 17 is available on-line.
    ii. All radiation areas are identified as hazardous via the posting of a radiation sign or placard.
    iii. Emergency procedures applicable to working with sources of radiation are available.

d. Occupational Exposure
    i. The hospital will issue a dosimeter to any individual whose anticipated dose is expected to exceed 10% of the annual dose limit while at the facility.
    ii. Dosimeters must be worn appropriately by all radiation workers at all times, if likely to receive 5mSv per year according to the Nuclear Regulatory Commission.
    iii. Dosimeter reports are reviewed by the RSO monthly and reported quarterly to the RSC. Reports are available for review by radiation workers on-line at www.myldr.com
    iv. At no time will a dosimeter be exposed to radiation unless worn by the individual to whom it is issued. Any infraction of this rule may result in the loss of that person's privilege to work with radioactive material and/or ionizing radiation. Flagrant violations of this policy may result in discipline up to and including termination.

3. **Radiation Safety of Pregnant Radiation Workers**
Radiation workers may declare their pregnancy in writing to the Radiation Safety Officer. Upon declaration, the Radiation Safety Officer or designee will order a fetal dosimeter, provide a spare as needed, and provide specific precautions and policies relating to radiation safety during their pregnancy. If the pregnancy is not declared, the individual is not considered to be pregnant. See policy **Declared Pregnant Radiation Worker**

4. **Education**
    a. It is an El Camino Hospital requirement that all staff working in a radiation environment be provided with radiation safety training as part of their orientation prior to assumption of duties.
    b. All staff members meet continuing education in radiation safety through current licensure and/or HealthStream.

5. **Investigational Levels for ALARA:**
    a. El Camino Hospital has established investigational levels for occupational doses in conjunction with 10 CFR 20.1201 significantly lower than the annual Nuclear Regulatory Commission ALARA levels. Individuals exceeding ALARA exposure limits will receive notification from Landauer,

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reviewed by the RSO. The RSO conducts an investigation and maintains records of all occurrences and findings. Should any worker exceed NRC limits, an immediate review by the RSO and RSC will occur. A report of the investigation, any actions taken, and a copy of the individual's exposure records will be presented to the RSC at its first meeting following completion of the investigation.

b. Licensees Investigational Level Thresholds- All Sub-accounts

Badge Exposure Diagnostic Radiology Nuclear Medicine Radiation Oncology Interventional Cardiology Fluoroscopy Supervisor	**Monthly**	**Quarterly**	**Yearly**	**% NRC**
DDE/TEDE	>125 mrem	>375 mrem	>1500 mrem	30%
LDE	>375 mrem	>1125 mrem	>4500 mrem	30%
SDE	>1250 mrem	>3750 mrem	> 15000 mrem	30%
Ring	>750 mrem	>2250 mrem	> 9000 mrem	18%

c. The Committee will review each dose in comparison with those of others performing similar tasks as an index of ALARA program quality and will record the review in the Committee minutes.

6. **Reestablishment of Investigational Levels**:
    a. In cases where a worker's, or a group of workers' doses, need to exceed an investigation level, a new, higher investigational level may be established for that individual or group on the basis that it is consistent with good ALARA practices.
    b. Justification for new investigational levels will be documented.
    c. The RSC will review the justification, and must approve or disapprove all revisions of investigational levels.

B. **Public (patient) Safety Radiation Exposure -** It is the policy of El Camino Hospital to keep the radiation exposure to all patients at the lowest possible levels.
    1. No imaging study will be performed without a valid physician order and corresponding requisition from a licensed medical practitioner.
    2. Technique charts and modality protocols are available to assist technologist in maintaining ALARA while still producing diagnostic quality images for interpretation.
    3. The Technologist will use ALARA based principles, optimize technical factors for image acquisition, and maintain best practices in order to reduce patient dose while

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maintaining diagnostic image quality.

a. The technologist will use lead or lead equivalent shielding during radiographic procedures where shield placement is appropriate and aligned with minimizing patient radiation exposure. Gonadal and fetal shielding should not be used during abdominal and pelvic radiography when it could interfere with the automatic exposure control or obscure the anatomy of interest.

b. All female patients of child-bearing age will be screened for pregnancy.

c. Student Radiologic Technologists work under the direct supervision of a licensed radiographer until they receive competency. For the studies they have received competency on, they may work under indirect supervision.

4. During the use of portable fluoroscopy (C-arms), the technologist will delineate the area of radiation exposure or risk during the procedure unless otherwise directed or changed by the supervising physician.
5. Relatives of the patient or other healthcare workers wearing protective apparel may hold the patient in position if other methods fail. Technologists are to hold patients only in an emergency.
6. Any event where a patient is unnecessarily or incorrectly exposed to ionizing radiation will be reviewed, e.g. wrong patient, wrong body part.

C. **Pediatric Patients**

1. In an effort to reduce patient radiation dose, all pediatric patients should have proper techniques and immobilization devices used while undergoing imaging procedures.
2. When performing CT Scans on pediatric patients, the technologist should significantly reduce technique by using appropriate pediatric protocol.

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]	06/2025
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	06/2025

Radiation Safety - Radiation Protection Program

Radiation Safety	Aletha Fulgham: Dir Diagnostic Imaging Svcs	04/2025
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> Added Pediatric patient definition.

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> Paula presented Pediatric Definition at ePolicy 5/9/25; finalizing list to submit to MEC. Once acknowledged, content will be transferred to active version.

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Separator Page

A19b6. Quasi-Endowment Fund Policy-New Policy

Status **Pending** PolicyStat ID **18432940**

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Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	3 years after approval
Owner	Dakota Atley: Dir Foundation Operations
Area	Foundation
Document Types	Policy

Quasi-Endowment Fund Policy

COVERAGE:

El Camino Health, El Camino Health Foundation, El Camino Health Foundation Board, El Camino Health Foundation Executive Committee, El Camino Health Foundation Finance Committee and All El Camino Health Staff & Volunteers.

PURPOSE:

This Policy sets forth the standards for the establishment of a Quasi-Endowment Fund and the procedures for the accounting, reporting, and distribution of such funds. From time to time, the El Camino Health Foundation Board's Finance Committee may recommend to the El Camino Health Foundation Board's Executive Committee and El Camino Health Foundation Board designating certain otherwise unrestricted funds as a Quasi-Endowment Fund.

POLICY STATEMENT:

In order to support the mission of ECH, external donors provide certain gifts to ECHF, some of which contain no restrictions (i.e., Unrestricted Gifts) and some of which may only be used for a specific service line, program, activity, or purpose (i.e., Temporarily Restricted Gifts). In some cases, external donors establish a fund whereby the donor stipulates, as a condition of the gift, that the principal be maintained for a specified period of time or until a specific event occurs, or that the principal be maintained in perpetuity, and only the earnings of the fund may be spent by ECHF (i.e., Endowed Fund). Both unrestricted and temporarily restricted gift funds may be designated as Quasi-Endowment Funds. However, if a Temporarily Restricted Gift or other restricted fund is designated as a Quasi-Endowment Fund, the donor-imposed restrictions, or other restrictions applicable to the original funds will apply to

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the Quasi-Endowment Fund. Once a fund has been designated as a Quasi-Endowment Fund, the ECHF Finance Committee with approval by the ECHF Executive Committee and Foundation Board may be held in cash, cash-equivalent and/or invested consistently with ECHF's investment policy. Accordingly, only the fund's earnings may be expended in accordance with ECHF's Endowment Spending Policy during the time it may be invested in the pooled fund; the principal may not be expended unless specifically recommended by the ECHF Finance Committee, then endorsed by the ECHF Executive Committee and with the ECHF Board's approval through its governance procedures.

DEFINITIONS:

- El Camino Health and its Subsidiaries (ECH) – A health system that includes two not-for-profit acute care hospitals in Los Gatos and Mountain View and regional urgent care centers, 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) 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.
- Quasi-Endowment Fund – is an Unrestricted Fund that is not limited to cash or cash equivalent investment, and its Investment and Spend Policy is recommended by the ECHF Finance Committee and then endorsed by the ECHF Executive Committee and then approved by the ECHF Board. This policy stipulates that any newly established Quasi-Endowment Fund will have a minimum starting balance of $500,000. As an example, when the Foundation Board establishes a Quasi-Endowment Fund the source of the funds for the Unrestricted Fund may be the overflow of excess cash raised beyond the needs of strategic projects. A purpose of the Quasi-Endowment Fund is to allow funds raised to be reinvested in investment vehicles other than cash or cash equivalents.

  Statement of Financial Accounting Standards (SFAS) 117 Definition: An organization's governing board may earmark a portion of its unrestricted new assets as a board-designated quasi-endowment fund (sometimes called "funds functioning as endowment" or "quasi-endowment fund") to be invested to provide income for a long but unspecified period. The principal of a board-designated endowment, which results from a Foundation Board driven internal designation, is not donor-restricted and is classified as unrestricted net assets. Accounting standards established by the Financial Accounting Standards Board (FASB) require nonprofits to report quasi-endowment funds as unrestricted funds. Quasi-endowment funds are reported on Form 990, Part X, Line 27 (unrestricted net assets). They are also reported on Part V (Endowment Funds) of Schedule D (Supplemental Financial Statements).
- Planned Gift – a gift wherein ECHF received the contribution arrangement in the present but realized in some future date(s). This is usually associated with estate planning and the settlement of an estate.
- Corpus – The original gift amount that funded the Quasi-Endowment Fund.
- Pooled Fund – A collection of funds in ECHF's investment portfolio where the balances are being invested in ECH's portfolio of assets.
- Spendable Fund – The portion of the gift that holds investment earnings that are available for expenditure. Every Quasi-Endowment Fund will have both a quasi-endowment fund and a

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corresponding "spendable" fund assigned to assist with the management of funds.

- Spend Rate – The rate set annually by the ECHF Board, with the recommendation of the ECHF Finance and ECHF Executive Committees, which is used to determine what portion of the earnings will be made available for spending.
- Service Line Manager – Primary contact assigned by the business line to work with ECHF to manage the Quasi-Endowment Fund expenditures.

PROCEDURE:

Authorization: Only with the ECHF Finance Committee's recommendation and the ECHF Executive Committee and ECHF Board's approval may establish, alter (including increasing or decreasing the funding amount), or terminate a Quasi-Endowment Fund. Such actions are taken by the ECHF Finance Committee based on the written recommendation of the ECHF President.

Establishment of a Quasi-Endowment Fund: Service Lines desiring to establish a Quasi-Endowment Fund should forward the following information to ECHF President:

- The amount of initial funding recommended for the Quasi-Endowment Fund
- The funds that will fund the Quasi-Endowment Fund
- The purpose or intention of the fund
- Any restrictions imposed by the donor or source of the original funds
- Authorization (signature) of ECHF President and ECH CEO or ECH CFO confirming the recommendation to establish the Quasi-Endowment Fund. After ECHF and ECH Finance have received and verified this information, they will share the information with the ECHF Finance Committee Chair and together they will determine whether to recommend that they request approval from the ECHF Finance Committee to establish the Quasi-Endowment Fund with both the ECHF Executive Committee and ECHF Board approvals. Accounting Treatment: Quasi-Endowment Funds are classified in the general ledger as Board-designated endowments and are included within unrestricted net assets for financial reporting purposes. All Quasi-Endowment Funds are classified, reported, and managed in accordance with the standards prescribed by the Uniform Prudent Management of Institutional Funds Act.

A. REQUIRED GIFT AMOUNT TO ESTABLISH A QUASI-ENDOWMENT FUND
    1. Restricted or Unrestricted Quasi-Endowment Funds
        a. $500,000 or more to set up a new Quasi-Endowment Fund.
        b. $100,000 or more to add to an existing Quasi-Endowment Fund.
    2. Use of Planned Gift
        a. A Planned Gift or a portion thereof may be used to fund either a Restricted or Unrestricted Quasi-Endowment Fund if the gift is irrevocable, meets the criteria of establishing a Quasi-Endowment Fund, and a notarized instrument of the gift is on record with ECHF.

B. INVESTMENT OF FUNDS
    1. When Quasi-Endowment Fund gifts to ECHF are combined with ECH's accounts for

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investment and oversight. The investment results and expenses of the pool are allocated to all the accounts proportionately – based on the percent each fund represents of the total fund.

C. ESTABLISHING THE SPENDABLE FUND AMOUNT WHEN FUND(S) ARE INVESTED

1. Please refer to the Endowment Spending Policy.

D. ONE-TIME ALLOWANCE

1. If, prior to the adoption of this policy, the current Operational Quasi-Endowment Fund value is more than the original donated corpus, that excess may be placed into a spendable fund. The excess can be spent pursuant to the previously established policies. Post December 31, 2025, any monies remaining in the Operational Quasi-Endowment Fund will be added to the funds Quasi-Endowment Fund balance; yet, will not change the original Quasi-Endowment Fund Corpus.

E. FUND MANAGEMENT GENERAL POLICY

1. It is the policy of ECHF that all quasi-endowments set-up is recorded and monitored by the ECHF's donor management system and ECH Finance's fund management system. All qualifying Quasi-Endowment Funds are to be spent in accordance with the fund's intent and within policy guidelines for types of spending purposes. If at some future time the use of this fund is not possible due to a change in priorities of the ECHF Board Finance Committee and with its approval, ECH's programs or the healthcare environment, the ECHF Board, according to its policies, procedures and applicable law; reserves the right to adjust the usage of the fund towards a purpose that most closely meets the quasi-endowment funds original intent or dissolve any remaining balance and would get converted back to the unrestricted fund. Quasi-endowments shall be managed in a prudent and fiduciary manner, taking into consideration the ECH Investment Policy and attendant expenses.

F. INTERNAL PROCESS

1. Setting Up Quasi-Endowment Fund Internally
    a. To set-up a new Quasi-Endowment Fund, a minimum amount of $500,000 is required. Unrestricted contributions are grouped together 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.

2. Procedure to Ensure Funds Will Be Used
    a. Donations that are restricted by the Donor for a specific time, area or program will be placed in an appropriate Restricted Quasi-Endowment Fund.
    b. If a Quasi-Endowment Fund does not exist for the Donor's restrictions, the donation will be placed in the holding account until a new Restricted Quasi-Endowment Fund is created.
    c. The ECHF President and Director of Foundation Operations will submit a "New Quasi-Endowment Fund and Set-up Request Form" to the Program

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Manager of Gift Accounting.

d. The Program Manager of Gift Accounting will submit a request to the ECH Finance Team to set up the new Quasi-Endowment Fund.

e. Once created, the Quasi-Endowment Fund will be assigned by Finance, who will notify the ECHF President, Director of Foundation Operations and Program Manager of Gift Accounting.

f. ECH Finance Department will provide an Activity Report (QAR) of ECHF's Quasi-Endowment Fund(s) that summarizes fund activity to the ECHF Finance Committee, ECHF Executive Committee and ECHF Board through its regularly scheduled meetings.

g. Any discrepancies in the Quasi-Endowment Fund Activity Report needs to be reported to the ECH Controller for oversight, who will make any necessary changes.

h. Discrepancies must be reported to ECH and ECHF within thirty (90) days. Any requests for modifications to the QAR post-90 days will require the ECHF President's approval. Any approved changes will be reflected in the following quarter's QAR report.

i. The ECHF President will be responsible for administering the use of spendable funds to utilize the allocated spend amount from the Quasi-Endowment Fund and will have the authority and responsibility to request expenses/purchases of their respective assigned endowed funds expenditures with the exceptions in sections p., q. and r. listed below.

j. It is the responsibility of the ECHF President to ensure that the expenditure is in keeping with the restrictions of the Quasi-Endowment Fund. Questions regarding appropriate use should be directed to ECHF Finance Committee and ECHF Executive Committee with the ECHF Board approval.

k. All relevant ECH policies must be adhered to (catering, mileage reimbursement, travel, etc.) All item purchases must follow ECH's procurement policies.

l. 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 to ensure the existence of the fund is still needed and/or asked to provide an update on expected expenditures for the remainder of the fiscal year.

m. 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 ECHF Finance Committee who will then discuss with the ECHF Executive Committee and ECHF Board any fund(s) lacking activity to ensure the timely and responsible use of the fund(s) and/or to make a recommendation to close the Quasi-Endowment Fund(s).

n. If after the end of fiscal year review, there remains unspent monies in a Quasi-Endowment Fund spendable fund account at the end of the fiscal

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year the fund will be reviewed by the Chair of the Finance Committee, ECHF President, Director, Foundation Development and the ECHF Finance Committee to determine if funds should carry over to the next fiscal year for future expenditures or reinvested back into the Quasi-Endowment Fund.

o. All expenditures from Quasi-Endowment Funds used to fund a Full Time, Part Time, hourly or contract employee require the ECH Chief Operating Officer's pre-approval.

p. All expenditure from Quasi-Endowment Funds spendable funds used for Capital equipment (as defined in the Asset Capitalization Policy) requires the ECH Chief Operating Officer's pre-approval.

q. After the ECHF Finance Committee, ECHF Executive Committee and the ECHF Board's approval, all expenditures must also be approved by the ECHF President or ECHF Director of Foundation Operations through ECH's financial management tracking system.

G. Minimum Information Required to Establish a New Quasi-Endowment Fund

1. Quasi-Endowment Fund Name (Short Description):
2. Quasi-Endowment Fund Name Description (Long Description):
3. Fund Class (Research, Care, Program 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. Quasi-Endowment Fund 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:
12. Donor Intent Restrictions:
13. Key Words for Searches:

H. Corresponding Spendable Fund

1. A Quasi-Endowment Fund invested in the pooled funds must exist for a minimum of a full calendar year before any spendable funds are generated and available to move into a corresponding quasi-endowment fund's spendable fund. (Example: The Quasi-Endowment Fund is established in October 2025, the first spendable funds would be available after January 1, 2027).

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.

Quasi-Endowment Fund Policy

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
ePolicy	Patrick Santos: Policy and Procedure Coordinator	07/2025
Foundation Board	Dakota Atley: Dir Foundation Operations	06/2025
Executive Committee	Dakota Atley: Dir Foundation Operations	06/2025
Finance Committee	Dakota Atley: Dir Foundation Operations	06/2025
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> ePolicy 7/11/25 - Approved